SOMATIZATION AND CULTURE: A COMPENDIUM OF THEORY, RESEARCH, AND TREATMENT

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ABSTRACT

SOMATIZATION AND CULTURE: A COMPENDIUM OF THEORY, RESEARCH, AND TREATMENT

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Approximately 20-25% of primary care patients have multiple somatized symptoms that lead to medical care costs twice that of medically ill individuals. Somatization is a common problem across all cultures, but cultural beliefs influence the development, expression, meaning, course, and treatment of somatization. However, little has been written about how to best treat cultural minority persons who somatize. This dissertation attempts to fill that void by reviewing relevant anthropological, sociological, medical, political, and psychological literature, analyzing the influence of cultural beliefs on somatization, and extrapolating culturally competent treatment recommendations from that information. First, the definition of somatization, as a personality trait, cognitive pattern, behavior, symptom, and diagnosis, is discussed before the presentation of the author's definition. Somatization, as viewed by the four major theoretical orientations of psychology (Psychodynamic, Behaviorism/Cognitive, Family Systems, and Feminist Psychology), is examined. Acculturation level and heterogeneity within ethnic groups are influential variables on somatization behavior that must be acknowledged to avoid stereotyping ethnic groups. Following a review of epidemiological data that support and refute the hypothesis that people of color somatize more than Caucasian people, the influence of language and specific cultural beliefs are explored. Collectivism and

individualism are the primary constructs around which the analysis of these cultural values (Group concept of self, Interdependence, Importance of family, Stigma of mental illness, Cultural definitions of pathology, Harmony, Holism, Illness attribution, Communication style, Emotional expression, Conformity, Fatalism, and Minority status) are organized. The influence of cultural beliefs on somatization is summarized for African American, Asian American, and Latino/Hispanic American ethnic groups. Based on the above information, recommendations for somatization treatment by mental health practitioners include utilizing a biopsychosocial foundation, frequently collaborating and consulting with significant figures in the patient's life, including family members, and supplementing standard psychological assessment with appraisal of key cultural beliefs and social/interpersonal sources of distress. All of these recommendations culminate in the creation of client-centered, culturally sensitive therapeutic goals that meet the clients' needs while addressing their somatization and the possible sources of that behavior. These recommendations aim to create a practical somatization treatment that is applicable to people of all ethnic groups.

SOMATIZATION AND CULTURE: A COMPENDIUM OF THEORY,

RESEARCH, AND TREATMENT

This clinical dissertation, by Maile Kono-Wells, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of the
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DOCTOR OF PSYCHOLOGY

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Examination of Somatization

Introduction

Somatization is a behavioral concept that has been studied by many different cultures since antiquity. It continues to be the subject of current anthropological, sociological, medical, political, and psychological inquiry. Although nearly all branches of the social sciences have contributed to the current understanding of somatization, it remains a common problem in the United States and throughout the world.

The epidemiological literature reports widely varied prevalence of somatization. Roberts (1994) found physical complaints originating from psychosocial problems led to as many as 75% of all visits to American primary care. In a Danish study, 60.6% of general practitioner patients displayed at least one symptom that had no known medical cause (Fink, Sorensen, Engberg, Holm, & Munk-Jorgensen, 1999). A history of multiple medically unexplained symptoms was identified in 24.4% of patients of primary care physicians at a large urban hospital in New York City (Fedder, Olfson, Gameroff, Fuentes, et al., 2001). The World Health Organization investigated the prevalence of somatization in primary care settings in fifteen major cities in fourteen different countries and found a mean of 19.7% of primary care patients around the world sought treatment for at least four medically unexplained symptoms (Gureje, Simon, Ustun, & Goldberg, 1997). One year later, 45.9% of those that had displayed at least four medically unexplained symptoms still had four or more somatized symptoms (Gureje & Simon, 1999). In a community-based study, Escobar, Rubio-Stipec, Canino, and Karno (1989) found that 4.4%-20% of respondents in Puerto Rico and Los Angeles had four or more medically unexplained somatic symptoms.

Epidemiological studies utilize different definitions of clinically significant somatization, sample from populations with differing levels of physical or psychological pathology (e.g., inpatient, outpatient, or non-patient samples), investigate diverse environments (e.g., primary and secondary medical care, psychological services centers, or community samples), and often do not state the ethnicities of the participants. The discrepant structural designs of these studies likely result in the broad range of reported prevalence rates. Despite the variance of prevalence found in each of these studies, somatization was found to be a problem that affects a considerable percentage of the population.

Additionally, a significant amount of disability has been found to be a result of somatization. Just four or more medically unexplained symptoms were found to lead to high levels of disability (Escobar, Rubio-Stipec, Canino, & Karno, 1989). Katon, Lin, Von Korff, Russo, Lipscomb, and Bush (1989) found a significant positive correlation between the number of unexplained symptoms and disability. Female somatizers were more likely to receive disability payments than clinically depressed women, at 26% versus 20% respectively (Zoccolillo & Cloninger, 1986).

The identified patients are not the only people negatively affected by somatization. When compared to children with parents who somatize less severely, children with a parent diagnosed with somatization disorder are more likely to be diagnosed with a psychiatric disorder, attempt suicide, be hospitalized, and be maltreated by their parents (Livingston, 1993). Additionally, the children of those with somatization disorder have more somatized symptoms and are more likely to develop somatization disorder themselves (Livingston, 1993). Livingston, Witt, and Smith (1995) found that

parental somatization predicted children's somatization and that somatization in older siblings was significantly correlated with the number of unexplained symptoms in younger siblings. Kriechman (1987) also found a relationship between the somatized symptoms of siblings. Not only is somatization a common occurrence, but it also has a significant negative impact on somatizers and often their families.

Somatizers consider their somatic complaints to be biological and not psychological in origin, so they turn to medical care to remedy their symptoms far more frequently than they seek psychological treatment. However, since psychogenic symptoms do have psychosocial origins, traditional, somatically fixated medical treatment provides little respite for these patients and frequently leads to disappointment for all involved. Chronic somatizers' frequent use of medical care, the lack of adequate medical explanations for physical complaints, and the failure to relieve patients of their symptoms often incites great frustration in the treating medical professionals; "Of all the patients seen in primary care, probably none produce greater feelings of irritation, inadequacy, and concern than those with somatization" (Maynard, 2003, p. 20). The presence of somatization disorder was found to be the most significant predictor of physician frustration (Walker, Katon, Keegan, Gardner & Sullivan, 1997). The negative emotions invoked in medical professionals by their interaction with somatization are often transferred to the somatizing patients and can be transformed into hostility, which only further upsets these already distressed individuals (McDaniel, Hepworth, & Doherty, 1992). This unfortunate cycle and dysfunctional relationship between physicians and patients often only perpetuates symptom formation and maintenance in

patients, aggravates physicians (Walker, Katon, Keegan, Gardner & Sullivan, 1997), and indicates a need for treatment guidelines for medical professionals (Isaac & Janca, 1996).

In addition to being a common behavior that can extensively distress individuals, families, and medical experts, somatization also places a large financial burden on the community. Although "frequent attenders" with medically unexplained symptoms had an annual overall medical expenditure similar to that of those with medically substantiated ailments, the cost of medical investigations for the somatizing group was twice as large as that for the medically ill (Reid, Wessely, Crayford, & Hotopf, 2002). In a German study, patients hospitalized due to their substantial level of somatization incurred inpatient and outpatient charges approximately 2.2 times that of the average person (Hiller, Fichter, & Rief, 2003). Overall, it is estimated that approximately 10% to 20% of the United States' medical budget is spent on those who somatize and have hypochondriasis (Ford, 1983).

People of all cultures in all countries experience somatization; it affects all genders, age groups, social classes, and ethnicities (Kirmayer & Young, 1998; Reid, Wessely, Crayford, & Hotopf, 2002). Yet despite the ubiquity of this phenomenon, relatively little research has been done to determine the best treatment approaches for non-Caucasian people. Although many researchers agree that culture strongly influences the development, meaning, and expression of somatization, most of the clinical literature and research studies fail to consider culture or ethnicity when exploring treatment recommendations or efficacy. This void can be filled with culturally sensitive treatment guidelines that incorporate a comprehensive understanding of how cultural backgrounds mold the formation of bodily symptoms that stem from psychological distress.

Somatization is a substantial problem for the large number of people directly and tangentially affected by this behavior, as well as society on a whole. Although a great deal of theoretical and empirical literature exists on the topic, little has been written about how to best treat ethnic minority somatizers. Having identified a deficiency in the treatment literature of somatization, this dissertation aims to fill that gap by integrating a large body of theoretical and experimental literature from the medical, sociological, anthropological, political, and psychological fields to formulate culturally sensitive somatization treatment recommendations for mental health professionals.

To meet this goal, this dissertation must first discuss the various definitions of somatization, along with how it is represented in the world's primary diagnostic manuals. Included in this section will be the author's definition of this behavior. Next, somatization, as conceptualized by the psychoanalytic, behaviorist/cognitive psychology, family systems theory, and oppression/feminist psychology orientations, will be surveyed. The second portion reviews how culture and somatization are interrelated. It begins with a discussion of the problems that can ensue by conglomerating people from multiple cultures into broad ethnic categories. The crucial mitigating factor of acculturation is discussed next, followed by a presentation of evidence for and against the hypothesis that non-Caucasians display greater amounts of somatization. Then, the historical and cultural origins of the concept of somatization will be expounded, and the specific ways in which culture is theorized to affect somatization are put forward, such as guidelines for cultural expression and self-disclosure, communication styles, help-seeking behavior, the impact of mental illness stigma, and mind-body dualism. The effects will then be reviewed for the African American, Asian American, and Latino American

cultures. The third segment presents the literature on treatment of somatization and begins with a summary of historical approaches. Modern medical, psychotherapeutical, and culture-specific research on the treatment of somatization will be presented and critiqued; the cultural sensitivity of each approach will be considered. A general summary of some of the controversies surrounding the treatment of somatization will be included. Lastly, this dissertation will integrate all of the above to give treatment guidelines for an audience of health psychologists and other mental health professionals and finally suggest directions for future research.

Defining Somatization

Somatization, as a general concept, has been studied around the globe for millennia under a wide variety of monikers. Approximately 4,000-year-old Egyptian papyri contain the first written reference to what Greek physicians later titled hustera, or hysteria (Thompson, 1999). Until very recently in the history of the disorder, *hysteria* has been the predominant term used to describe what today is more commonly referred to as somatization. Both the definition of the phenomenon as well as the words used to describe it have evolved over time. Yet despite centuries of research, no singularly accepted definition or etiological paradigm exists for somatization. The next section will address theories regarding the etiology theories of this disorder, and this segment will discuss the elusive, chameleon-like nature of definitions of somatization, which has made constructing a definition so challenging. Then, a brief survey of somatization as defined as a personality trait, a cognitive pattern, a behavior, a symptom, and a diagnosis will be provided. Lastly, the importance of a culturally sensitive definition will be discussed before I present my own integrated definition of somatization.

Defining somatization is a difficult task. First created by a mistranslation (Marin & Carron, 2002) of the work of the psychoanalyst, Stekel, *somatization* was considered to be identical to Freud's concept of conversion (1943/1962), which will be discussed in detail later in this dissertation. Since its introduction, *somatization* generally has been used to refer to the presentation of somatic symptoms in the absence of an adequate medical explanation (De Gucht & Fishler, 2002; Keyes & Ryff, 2003). Many other terms have been used in reference to the same concept, a number of which are listed in Table 1. Some of the DSM diagnoses in which somatization is believed to play a role are listed in Table 2, and some culture bound syndromes that contain an element of somatization are listed in Table 3. The extensive range of definitions shows how complicated the semantics of somatization have become. Is it a symptom of a mental illness, like major depressive disorder, or a separate entity? Is it an exclusively Western notion or is it ubiquitous and evident in culture-bound syndromes? Is it a mental illness or a ubiquitous expression of distress, like sadness? These are just some of the questions that arise when exploring the definition of somatization.

Somatization has been conceptualized as a "mimetic disorder" (Showalter, 1997, p.15), because physical disease is imitated in the presentation of bodily complaints. Because somatization can emulate any physiologically based disease, and can only comprise a cluster of symptoms that do not resemble known diseases, a consistent definition of the "symptoms" of somatization is difficult. Adding to the complexity of the task is the fact that somatization reflects the culture in which it is being expressed. As Veith described in her cornerstone text on the history of hysteria, "Whenever it appears, it takes on the colors of the ambient culture and mores; and thus through the

Table 1 *Some Terms Used to Refer to Somatization and Conditions with an Element of Somatization*

Psychosomatic	Hysteria
Somatopsychic	Hysterical Neurosis
Psychogenic	Polysymptomatic Hysteria
Conversion	Acute Hysteria
Somatoform	Chronic Hysteria
Nonorganic Physcical Symptom	Briquet's Syndrome
Medically Unexplained Symptom	Neurasthenia
Psychophysiological Events	Abridged Somatization
Functional Somatization	Multisomatoform Disorder
Presenting Somatization	Polysymptomatic Somatoform Disorder
Functional Somatic Syndromes	Fibromyalgia
Somatic Fixation	Chronic Fatigue Syndrome
Idiom of Distress	Irritable Bowel Syndrome

Table 2 *Some DSM-IV-TR (2000) Diagnoses that Can Contain an Element of Somatization*

Somatoform Disorders
Somatization Disorder
Undifferentiated Somatoform Disorder
Conversion Disorder
Pain Disorder
Hypochondriasis
Somatoform Disorder Not Otherwise Specified
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
Pica
Rumination Disorder
Feeding Disorder of Infancy or Early Childhood
Tourette's Disorder
Chronic Motor or Vocal Tic
Transient Tic Disorder
Tic Disorder Not Otherwise Specified
Encopresis
Enuresis
Schizophrenia and Other Psychotic Disorder
Schizophrenia
Schizophreniform Disorder

(Table continues)

Schizoaffective Disorder
Delusional Disorder
Brief Psychotic Disorder
Psychotic Disorder Not Otherwise Specified
Mood Disorders
Major Depressive Disorder
Dysthymic Disorder
Depressive Disorder Not Otherwise Specified
Bipolar I Disorder
Bipolar II Disorder
Cyclothymic Disorder
Bipolar Disorder Not Otherwise Specified
Anxiety Disorders
Panic Disorder Without Agoraphobia
Panic Disorder With Agoraphobia
Specific Phobia
Social Phobia
Obsessive-Compulsive Disorder
Posttraumatic Stress Disorder
Acute Stress Disorder
Generalized Anxiety Disorder
Anxiety Disorder Not Otherwise Specified

(Table continues)

Sexual and Gender Identity Disorders
Hypoactive Sexual Desire Disorder
Sexual Aversion Disorder
Female Sexual Arousal Disorder
Male Erectile Disorder
Female Orgasmic Disorder
Male Orgasmic Disorder
Premature Ejaculation Disorder
Dyspareunia
Vaginismus
Sexual Dysfunction Not Otherwise Specified
Eating Disorders
Anorexia Nervosa
Bulimia Nervosa
Eating Disorder Not Otherwise Specified
Sleep Disorders
Primary Insomnia
Primary Hypersomnia
Sleep Terror Disorder

Note. From American Psychiatric Association. (2001). *Diagnostic and statistical manual of mental disorders* (4th ed. text revision). Washington, DC: Author.

Table 3 *Some Culture-Bound Syndromes that Contain an Element of Somatization*

Amurakh	Mal Puesto
Amok	Mali-mali
Ataque de Nervios	Menkeiti
Bah Tschi, Bah-Tsi, or Baah-Ji	Muina
Bilis	Myriachit
Boufee Delirante	Nervios or Nevra
Brain Fag	Noa truuE
Brujeria	Olan
Cafard or Cathard	Pasmo
Chibih	Perdida del Alma
Colera	Phii Pob
Dhat	Pibloktoq
Epanto	Plik
Falling-Out	Rok-joo
Ghost Sickness	Rootwork
Hwa-Byung orWool-hwa-byung	Sangue Dormido
Hmong Sudden Death Syndrome	SAA say prA saat
Iich'aa	Shenjing Shuairuo
Ikota	Shen-k'uei or Shenkui
Imu	Shin-Byung
Irkunii	Shinkeishitsu
Jinjinia Bemar	Shuk Yang or Shook Yong
Jiryan	Silok
Koro	Sukra Prameha
Kyol Goeu, Kyol Kor, Kyol Chabb, or	Suo Yang
Kyol Cap	Susto
Latah	Taijin kyofusho
Mal de Ojo or Mal'uocchiu	Toah
Mal de Pelea	Tripa Ida

ages it presents itself as a shifting, changing, mist-enshrouded phenomenon that must nevertheless, be dealt with as though it were definite and tangible" (1965, p.1). Presenting symptoms adhere to indigenous ideas of bodily functions or ethnophysiology, local concepts of people and their emotions or ethnopsychology, and culturally dictated illness behavior including help-seeking (Kirmayer & Santhanam, 2001). For example, a young, Caucasian Swiss woman might have a psychogenic seizure that resembles her understanding of a petite mal epileptic seizure to which she responds with emotional distress and seeks the assistance of a physician, who diagnoses her with Conversion Disorder. A middle-aged, Navajo man in the United States may display trembling, confusion, and brief loss of consciousness to which he responds with increased sadness and grief and goes to a shaman for spiritual guidance, who determines that he has ghost sickness. The two individual's emotional experiences, help-seeking, and understanding of these incidents were strongly shaped by their culture and were hence very different. However, their symptoms were relatively similar, and both of these episodes could be described as somatization.

Another example of somatization revealing the ethnophysiology, ethnopsychology, and culturally prescribed help-seeking is given by Spanos and Gottlieb (1979). As they hypothesized, exorcism of demonic possession in Europe up through the 17th century, medical and psychiatric treatment of hysteria from the 16th to the 19th centuries, and mesmerism treatment for disharmonious magnetic fluid in the 18th and 19th centuries have many similarities, including the symptoms of the disorders, their cultural meaning, and the social roles of the involved parties. In all three examples, the afflicted were usually passive, disempowered women who were believed to have succumbed to

forces beyond their control due to an innate weakness and were typically made well by socially powerful, dominant men. Each of these conditions reflected the dominant explanatory theory and means of divining the truth of the time period, whether it was religion and prayer, biology and medicine, or physics and magnetism. Showalter (1997) states that somatization "mimics culturally permissible expressions of distress" (p. 15), and these historic examples were no exceptions. When at their highest prevalence, each form of somatization was considered an acceptable means of expressing distress, even if it was not consciously recognized as such.

Contemporary Western concepts of somatization are shaped by cultural influences as well. *Psychosomatic* is a term that is often used to describe somatization, and it reveals the idea that both the mind (psycho) and the body (soma) are involved. This word reflects the dualism evident in Western European and North American cultures since Socrates in ancient Greece, who philosophized that the mind was separate from the body (Fabrega, 1991; Hunt, 1993; Kirmayer & Santhanam, 2001; Kirmayer & Young, 1998; Lee, 2001). Descartes later emphasized this dual existence (Hunt, 1993), and his work cemented the Cartesian split in the Western medicine. This division between mind and body led to the theory that diseases are ontological, or independently existing, and hence any illness, the subjective experience of being sick, should have corresponding signs of disease, observable physiological, biochemical, or anatomical changes (Fabrega, 1991). The perplexing situation of reported illness in the absence of disease made the construction of a term like *psychosomatic* a necessity to bridge the gap between the subjective and the objective, the psychological and the physical, a breach that simply does not exist in many cultures that are more holistic in nature (Fabrega, 1991; Lee,

2001; Okasha & Okasha, 1999). Ayurvedic and traditional Chinese medicine both maintain integrated models of health in which all disease is both somatic and psychological and the experience of illness is not separate from disease (Fabrega, 1991). In those and other holistic medical systems, a concept like somatization is redundant and often poorly understood (Nakane, 1999).

The DSM-IV-TR (2000) is the currently accepted guide for psychological diagnosis in the Western world. It is written and published in the United States by the American Psychological Association, and it is influenced by American society, which does not have state sponsored universal health care. Kleinman (1988) hypothesizes that the DSM validates nearly every psychological condition as a disease so that private medical insurance companies and government programs will compensate mental health practitioners for treating these legitimated diseases. In countries with government backed universal healthcare, this social use may not be present (Lee, 2001). In essence, the DSM may medicalize and pathologize some illness experiences for social instead of psychiatric reasons; this might be true for somatization, which many (Lipowski, 1988) feel is ubiquitous and not necessarily pathological. Having examined some of the ways in which Western concepts of somatization are influenced by culture and society, let us now review some of the definitions of somatization, most of which have been proposed by Western scientists.

Over the course of history, the definition of somatization has changed, grown to include multiple concepts, and left some ideas behind. One of the conceptions rarely seen in the literature today is that of somatization as a personality disorder. Long before *somatization* became the principal term used in medical and psychological texts, *hysteria*

was predominant. *Hysteria*, like somatization today, was a word that was broadly defined and used in a variety of ways, one of which was in reference to a disordered personality type. First used in the early 1900's, the phrase *hysterical personality* continued to be professionally accepted until well into the 1970's (Chodoff, 1974). Dramatic behavior combined with inappropriate seductiveness and shallow and labile affect were the primary characteristics of hysterical personality (Chodoff & Lyons, 1958), which actually contained no behavioral components related to somatic complaints. Although the disorder was included in the DSM-II (1968), objections against its continued use were made by 1974 (Chodoff), and hence it was excluded in the next edition of the manual (DSM-III, 1980) and subsumed within histrionic personality disorder.

Although hysterical personality is no longer considered a valid disorder, the concept that specific personality types or models are associated with somatization disorders persist. Mai (2004) reported that somatization disorder is positively correlated with cluster B disorders, namely histrionic, antisocial, borderline, and narcissistic personality disorders. Cloninger's (2001) multidimensional personality measure, the Temperament and Character Inventory, contains two dimensions, self-directedness and harm-avoidance, that were found to predict a diagnosis of conversion and somatization disorder. He stated that it would be neglectful not to utilize personality assessment in diagnosis and treatment of those with these disorders. Wickramasekera (1995) proposed a risk model for somatization disorder that incorporated nine factors, including three personality traits, to predict, diagnose, and treat individuals with somatization disorder. Although both Wickramasekera (1995) and Cloninger (2001) underscore the degree of

influence that personality traits have on somatized symptoms, they also emphasize that these characteristics are just part of what leads to somatization and are not sufficient to cause it. Cognitive factors, such as catastrophizing, one of Wickramasekera's (1995) nine predictive factors, have been proposed as other key components of somatization.

Although cognitive psychology and cognitive behavioral therapy (CBT) propose that multiple cognitive factors play a role in the development and maintenance of physical symptoms, the word *somatization* has been used to express four different but related cognitive processes or patterns: attributional style, amplification, alterations in perception, and hypochondriacal worry. The CBT portion of the Perspectives on Somatization section found later in this work provides a detailed discussion of these and other contributing cognitive processes, so those concepts considered part of the definition of somatization will be discussed here only briefly. Symptom attribution is the process of attaching a causal explanation to physical symptoms or sensations (Robbins & Kirmayer, 1991a). The tendency to provide a somatic or physical attribution to a symptom, opposed to a psychological or environmental/normalizing explanation, is associated with medically unexplained symptoms (Robbins & Kirmayer, 1991a) and has been closely associated with the word *somatization*. Partially based on this idea, Barsky (1992) theorized that somatosensory amplification involves increased attention to negative and infrequent or faint somatic sensations as well as the tendency to appraise those sensations as pathological. This cognitive progression is one of several ways to ascribe meaning to physical symptoms that is recognized by Kirmayer and Young (1998) as important in somatization, and it is related to Wickramasekera's (1995) predisposing factor of somatization, catastrophizing. The process of amplification emphasizes the importance

of attention to a symptom (Barsky, 1992), which is also highlighted by Brown (2004). As part of his cognitive model, Brown (2004) hypothesizes that medically unexplained symptoms are alterations in perception. More specifically, activation of memories can cause them to intervene during the process of attentional selection, which overly influences perception to allow inappropriate information to be processed. Therefore, a sensation can be more a reflection of memory than the current environment, and as a result, an individual will experience a physical symptom that has no medical basis.

All of the above cognitively based definitions of somatization culminate with hypochondriasis. Until the later part of the 19th century, *hysteria* and *hypochondriasis* were interchangeable terms (Baur, 1988), and this close relationship persists. Presented by Kirmayer and Robbins (1991) as one of three forms of somatization, somatic preoccupation or hypochondriacal worry is the persistent belief or concern that one has a serious physical disease (DSM-IV-TR, 2000). Although the DSM-IV-TR (2000) specifies that this conviction is based upon misinterpretation of somatic symptoms, it does not denote the exact cognitive process that leads to the misconception. It is possible that attribution, amplification, or perceptual alterations, individually or in combination, can result in hypochondriasis. Kellner (1991) supports this definition by noting that among other things, somatization may be a manifestation of disease phobia, also known as hypochondriasis.

Somatization has also been defined as a behavior, and behaviorism, discussed more thoroughly in the Perspectives on Somatization section of this work, is a theoretical orientation whose entire conception of somatization centers on it being an observable and measurable behavior. In his discussion of the concept of hysteria, Slavney (1990)

wrestles with delineating such a historically complicated term and presents several possible definitions, one of which is disease-simulating behavior. Although he does not support the notion that somatization is a conscious action, he purports that it is "clearly something patients *do* rather than *have*" (p. 135) most likely in order to obtain secondary benefits of being sick, such as exemption from one's regular responsibilities and often sympathy from others. Though the precise mechanisms of somatization may remain unclear, he highlights that the end result is always a form of behavior that resembles disease. The behavior in Slavney's definition is rather broad, however, Lipowski (1988) specifies medical help-seeking as a behavioral component in his multi-layered definition of somatization, which also includes the experience of and pathological attribution of unexplained somatic distress. Although persistent help-seeking is not sufficient to be considered somatization, it is a mandatory criterion within some definitions (Lipowski, 1988; Bridges & Goldberg, 1985).

An evolutionary psychology perspective is taken by Price, Gardner, and Erikson (2004) who propose that somatization, as well as depression and anxiety, is an appeasement (submissive) display behavior. The appearance of ill health, with or without a medical explanation, is believed to communicate a no threat status that decreases the level of aggression in prospective rivals (Price, Gardner, & Erikson, 2004). Although somatizing individuals relinquish the opportunity to compete for a mate by appearing diseased and hence evolutionarily unattractive, they also decrease the cost of losing the competition by avoiding potentially harmful conflict. These benefits of this primitive defense against attack have likely selected for the predisposition to somatize and may possibly explain the ubiquity of somatization cross-culturally and within all societies.

Perhaps the most ubiquitous use of *somatization* is in reference to a symptom, a sign of something else. The first use of the term was as a synonym of the psychoanalytic concept of conversion (Stekel, 1943/1962), which is an ego defense mechanism that prevents intrapsychic conflict from reaching consciousness (Freud, 1896/1948). Chodoff (1974) supports the definition of hysteria as a conversion symptom. From this perspective, somatization is a symptom of psychological conflict (Kirmayer & Young, 1998). Rooted in relational theory, a descendent of psychoanalytic theory, Arnd-Caddigan (2003) expands that definition to say that unresolved psychological conflict or "the failure to elaborate meaning" (p.110) for an affective experience can result in somatization. In the absence of an emotional meaning of affect, an individual will only experience the somatic component of affect, which then leads to somatization. Her viewpoint indicates that somatization is a symptom of a deficiency in the elaboration of meaning and/or psychological conflict that has the potential to induce significant psychological distress.

Somatization can also be defined as a direct symptom of general psychological distress. As Arnd-Caddigan (2003) mentioned, all affect involves physical and emotional components. The "physiological concomitants of emotional arousal" (Lipowski, 1988, p.1360) often result in somatization symptoms. For example, increased muscle tension, increased blood pressure, and increased rate of respiration may accompany the experience of feeling angry, and extreme fear or panic is a very visceral experience that involves tremendous arousal of the sympathetic nervous system. From this standpoint, the stimulating emotional experience is not necessarily pathological or indicative of a

psychiatric disorder, and nearly any strong affect has the potential to induce somatization symptoms.

The most commonly supported definition of somatization is one that depicts it as a sign of a psychiatric disorder. In a cross-cultural study of nearly 26,000 primary care patients, Gureje, Simon, Ustun, and Goldberg (1997) determined that depression and/or anxiety disorders accompanied 40% of the people with a significant number of medically unexplained symptoms. Based on this they support the notion that psychiatric disorders can induce somatization. Predominantly or purely somatic expressions of psychiatric disorders, usually depression or anxiety disorders, is the definition of presenting somatization (Bridges & Goldberg, 1985; Kirmayer & Robbins, 1991; De Gucht & Fischler, 2002). Many other studies have supported the theory that somatized symptoms are expressions of masked depression (Katon, Kleinman, & Rosen, 1982), anxiety disorders (Beidel, Christ, Long, 1991), or both (Escobar, Rubio-Stipec, Canino, & Karno, 1989; Katon, Lin, Von Korff, Russo, Lipsomb, & Bush, 1991; Kirmayer, Robbins, Dworkind, & Yaffe, 1993; Smith, Gardiner, Lyles, Sirbu, Dwamena, Hodges et al, 2005). However, criticism has also been voiced. Zoccolillo and Cloninger (1986) propose an inverse relationship between somatization and psychological distress, asserting that psychological suffering is a result of somatization disorder and not the cause. Although Kellner (1991) acknowledges the correlations between somatization symptoms and depression, he feels that "there is no conclusive evidence that somatization is a true depressive equivalent" (p.193) and so not an expression of depression.

A very similar concept defines somatization as an idiom of distress, which is a culturally distinct way of communicating distress that is understood by others within that

culture to be an expression of emotional distress (Kirmayer & Young, 1998). As Showalter (1997) has written, "throughout history, hysteria has served as a form of expression, a body language for people who otherwise might not be able to speak or even to admit what they feel" (p.7); it is "a cultural symptom of anxiety and stress" (p. 9). This differs slightly from presenting somatization in that it highlights that others within the community understand that the somatic symptoms are expressions of psychological distress. Often there is a symptom "vocabulary" in which specific ailments are metaphors for specific personal or social suffering (Kirmayer & Young, 1998). This definition of somatization has been supported by many studies (Keyes & Ryff, 2003; Kirmayer, Groleau, Looper, & Dao, 2004; Patel & Oomman, 1999).

The fifth and final definition of somatization as a symptom is that of functional somatization (Kirmayer & Robbins, 1991). In this concept, somatization is conceived as "high levels of functional somatic distress" (Kirmayer & Robbins, 1991, p.647), simple symptom counting, a tally of bodily complaints, and merely a sign of somatic distress (De Gucht & Fischler, 2002). In this usage there is no implied etiology or attempt to explain the mechanism by which the symptoms have developed. It has been proposed that another term, *medically unexplained symptoms*, is more appropriately applied to this definition (Deary, 1999; Mayou, 1999), because it is more impartial than *somatization*, which historically has been tied to many theoretical explanations. However, it is this neutral definition of somatization that has been adopted by the most influential diagnostic manuals, the DSM-IV-TR and ICD-10 (De Gucht & Fischler, 2002), most likely because they are written from a medical model of illness that focuses on common clinical features and does not depend on etiological assumptions (Guze, 1975).

The term *somatization* has also been used to signify a psychiatric diagnosis. In addition to the standard diagnosis of somatization disorder found in both the DSM-IV-TR (2000) and the ICD-10 (1993), this section will also review several alternatives to somatization disorder found in the diagnostic manuals from other cultures as well as some proposed diagnostic additions from Western researchers. Although multiple DSM-IV-TR (2000) diagnoses are considered to contain an element of somatization, especially conversion disorder, somatoform disorder not otherwise specified, and hypochondriasis, this current discussion will be focus on somatization disorder (SD).

Generally referring to a chronic history of multiple medically unexplained somatic symptoms occurring in multiple body systems that cause clinically significant distress and are not intentionally feigned, SD can be found in the somatoform disorder sections of both the DSM-IV-TR (2000) and ICD-10 (1993) nosological systems. Although not provided here, the discussion of the specific criteria for SD begins on page 486 of the DSM-IV-TR (2000). The ICD-10 (1993) criteria for SD can be found in Table 4. Several differences exist between the two versions, but two discrepancies stand out as seemingly more significant: the specified type and total number of requisite symptoms and the age of onset. The ICD-10 (1993) calls for of six or more of 14 possible specific symptoms from two of four listed body systems, whereas the DSM-IV-TR (2000) requires four pain, two gastrointestinal, one sexual, and one pseudoneurological symptoms, but there is no list of possible symptoms from which to choose. The DSM version also demands that the patient must be multisymptomatic prior to the age of 30, whereas the ICD-10 (1993) does not have any age restrictions. Because the DSM version specifies which body systems must be involved and the age by which symptoms must

Table 4 *ICD-10 Somatization Disorder Criteria*

A. There must be a history of at least 2 years' complaints of multiple and variable physical symptoms that cannot be explained by any detectable physical disorders. (Any physical disorders that are known to be present do not explain the severity, extent variety, and persistence of the physical complaints, or the associated social disability.) If some symptoms clearly due to autonomic arousal are present, they are not a major feature of the disorder in that they are not particularly persistent or distressing.

B. Preoccupation with the symptoms causes persistent distress and leads the patient to seek repeated (three or more) consultations or sets of investigations with either primary care of specialist doctors. In the absence of medical services within either the financial or physical reach of the patient, there must be persistent self-medication or multiple consultations with local healers.

C. There is persistent refusal to accept medical reassurance that there is no adequate physical cause for the physical symptoms. (Short-term acceptance of such reassurance, i.e. for a few weeks during or immediately after investigations, does not exclude this diagnosis.)

D. There must be a total of six or more symptoms from the following list, with symptoms occurring in at least two separate groups:

Gastrointestinal symptoms

(1) abdominal pain;

(2) nausea;

(Table continues)

(3) feeling bloated or full of gas;

(4) bad taste in mouth, or excessively coated tongue;

(5) complaints of vomiting or regurgitation of food;

(6) complaints of frequent and loose bowel motions or discharge of fluids from anus;

Cardiovascular symptoms

(7) breathlessness without exertion;

(8) chest pains;

Genitourinary symptoms

(9) dysuria or complaints of frequency of micturition;

(10) unpleasant sensations in or around the genitals;

(11) complaints of unusual or copious vaginal discharge;

Skin and pain symptoms

(12) blotchiness or discoloration of the skin;

(13) pain in the limbs, extremities, or joints;

(14) unpleasant numbness or tingling sensations.

E. Most commonly used exclusion clause. Symptoms do not occur only during any of the schizophrenic or related disorders (F20-F29), any of the mood [affective] disorders (F30-F39), or panic disorder (F41.0).

Note. From World Health Organization. (1993). *The ICD-10 classification of mental and behavioral disorders: Diagnostic criteria for research,* p. 105-106. Geneva: Author.

appear, it is more restrictive than the ICD version. Despite this and other divergences, it has been stated that the diagnoses are interchangeable (Mai, 2004; Schulte-Markwort, Marutt, & Riedesser, 2003). However, in a study designed to compare the DSM-IV-TR criteria to that of the ICD-10 and previous editions of the DSM, Yutzy, Cloninger, Guze, Pribor, Martin, Kathol, et al (1995) concluded that all of the DSM criteria sets displayed good concordance with each other and that the ICD-10 criteria displayed "barely adequate" (p.100) concordance with all the other criteria sets. This indicates that the DSM-IV-TR and ICD-10 definitions of SD are significantly different (Mayou, 1999) and not interchangeable.

Considering the wide, international audience that the DSM and ICD have, it is not surprising that much criticism of their general methodology and SD definitions has been published. The overall focus on symptomology that is found in both of these manuals is found wanting by Lee (2001) in his article on the Chinese Classification of Mental Disorders (CCMD) manual that combines an etiologic and symptomatologic approach to taxonomy. Because prognosis and treatment can be influenced by etiology, this is incorporated into the CCMD, reasons Lee (2001). He also suggests that the mere existence of the CCMD, which is applied to a fifth of the world's population, should cause North American psychiatrists to reflect on the diagnostic manuals they tend to take for granted. Kirmayer and Young (1998) also find fault with symptomology emphasis found in the DSM and ICD but for different reasons. They explain that by focusing on the individual's symptoms, be they psychological or physical, the clinician locates the source of the problem within the individual and ignores or belittles the possible social, situational, or interpersonal causes. A sociocultural approach is preferred, because it can

accommodate all the contributing factors of the problem and is more appropriate for all ethnocultural groups (Kirmayer & Young, 1998).

Concentrating their criticism on the SD definitions specifically, Simon and Gureje (1999) challenge the chronicity constituent and stability of the disorder as defined by the DSM and ICD. They concluded that somatization symptoms are not chronic based on their findings that 30-50% of the symptoms first reported to be lifelong in DSM-IV SD patients were not reported and often not even remembered just one year later. They also reported that only 25% of those diagnosed with SD met criteria for that diagnosis a year later and of those who met criteria the second year, only 27% had met criteria the previous year; this indicates that SD is not a stable diagnosis. These researchers propose that more attention be placed on current instead of chronic symptoms because patient self-reports are too inconsistent to be relied upon.

The specificity of SD and the overly inclusive miscellaneous diagnoses, undifferentiated somatoform disorder and somatoform disorder not otherwise specified, have been called into question (Kroenke, Spitzer, deGruy, Hahn, Linzer, Williams et al, 1997; Mayou, 1999; Smith, Gardiner, Lyles, Sirbu, Dwamena, Hodges, et al, 2005). Since SD is such a rare disorder, Mayou (1999) asserts that it is "relatively unimportant in the total picture of somatic complaints" (p. 32) yet more research is done on SD than on the moderately impaired patients who make up the bulk of those affected by somatization. Because SD as defined by the ICD-10 and the DSM-III identifies such an extreme end of the somatization spectrum, it is the opinion of Gureje, Simon, Ustun, and Goldberg (1997) that SD is useful only in psychiatric opposed to primary care or research settings. The data reported by Smith, Gardiner, Lyles, Sirbu, Dwamena, Hodges, et al

(2005) tend to support Mayou's assertions. They report that only 1.5% of high-utilizing patients due to medically unexplained symptoms met DSM-IV criteria for SD, but nearly 85% of their participants were diagnosed with either undifferentiated somatoform disorder or somatoform disorder not otherwise specified from the DSM-IV (2000). On this foundation, they propose that the next DSM edition incorporate the less severe medically unexplained symptom patients, perhaps by utilizing a spectrum of somatization disorders.

Somatization disorder as defined by the DSM and ICD has been deemed problematic for being deeply imbedded within European/North American mind/body dualism (Mayou, 1999; Lipowski, 1988) and attempting to use these diagnostic systems universally. The entire somatoform disorder concept as well as the translation of the word *somatoform* has been found perplexing in China (Lee, 2001) and Japan (Nakane, 1999), two holistic cultures that do not traditionally view psychological and physiological distress as separate entities. The term was introduced to those countries in 1980 with the publication of the DSM-III, and SD has had difficulty being applied within those countries ever since (Mayou, 1999). Kirmayer and Young (1998) criticize all diagnostic systems that do not attempt to accommodate local variations of symptom expression and idioms of distress, which include the DSM and ICD manuals. Because the criteria are based on lists of symptoms common to the US and UK, they are difficult to apply to non-Western cultures (Kirmayer & Young, 1998). Robert Cloninger (2001), who modified the DSM-III (1980) criteria for the DSM-IV (1994), which did not change with the text revision in 2000, stated that while the DSM-IV criteria are strongly recommended for use in "industrialized Western countries similar to the USA" (p. 53), "in other countries it

will be necessary for psychiatrists to define and test suitable criteria appropriate for their culture" (p. 54). The author of the SD criteria of the current DSM edition feels that it these criteria cannot be reliably applied cross-culturally.

Partially spurred by the above criticisms, several alternative somatization constructs have been proposed for the next edition of the DSM or to supplement the current edition. The most commonly used somatization diagnositic alternate is an abridged somatization construct called the Somatic Symptom Index (SSI) that was originally developed to complement the DSM-III somatoform disorders (Escobar, Burnam, Karno, Forsythe, & Golding, 1987; Escobar, Rubio-Stipec, Canino, & Karno, 1989). Defined as four or more medically unexplained physical symptoms in men and six or more in women, the SSI was designed in response to the overly restrictive DSM-III SD diagnosis (Escobar, Burnam, Karno, Forsythe, & Golding, 1987). This kind of restricted or partial SD has been suggested by others (Lipowski, 1988). Since its inception, the SSI has been commonly found in community samples (4.4% to 20%) (Escobar, Burnam, Karno, Forsythe, & Golding, 1987; Escobar, Rubio-Stipec, Canino, & Karno, 1989) and primary care (19.7% to 18.9%) (Gureje, Simon, Ustun, & Goldberg, 1997; Smith, Gardiner, Lyles, Sirbu, Dwamena, Hodges, et al, 2005). Although Smith Gardiner, Lyles, Sirbu, Dwamena, Hodges, et al (2005) determined SSI to be "the most useful DSM-derived construct" (p. 127), Gureje, Simon, Ustun, and Goldberg (1997) lent the construct only conservative support. They deemed it very useful in primary care, but they could not confirm it as a diagnosis, since data do not yet exist to clarify "onset, course, or prognostic indicators" (p. 995). Although more research is yet to be done on this definition of abridged somatization, the SSI appears to have much potential.

Multisomatoform disorder is another less restrictive somatization construct. Proposed by Kroenke, Spitzer, deGruy, Hahn, Linzer, Williams and colleagues (1997), it is defined as three or more current, significantly distressful, unintentionally produced, medically unexplained physical symptoms plus a two or more year history of somatization symptoms. It has been proposed as an alternative to undifferentiated somatoform disorder, has a "reasonable" (p. 356) prevalence of 8% of primary care patients, and reflects the authors' belief that medically unexplained physical symptoms are a continuous variable (Kroenke, Spitzer, deGruy, Hahn, Linzer, Williams, et al, 1997). The idea that somatization is a continuum rather a discrete dichotomous variable has been supported by Smith, Gardiner, Lyles, Sirbu, Dwamena, Hodges, et al (2005) and Katon, Lin, Von Korff, Russo, Lipscomb, and Bush (1991). The later group of researchers found that women with six to twelve and men with four to twelve medically unexplained symptoms had nearly as much distress, disability, and maladaptive illness behavior as those who met full criteria for the DSM-III definition of SD.

A multidimensional classification of somatization has been suggested by Mayou, Bass, and Sharp (1995) and Wickramasekera (1995). Disappointed in the current nosological system, Mayou, Bass, and Sharp (1995) proposed that a model with dimensions for physical symptoms, emotional state, cognitions, impairment, and pathophysiological disturbance would be more effective. Wickramasekera (1995) put forward a model of nine factors distributed within predisposer, trigger, and buffer subcategories in his model of somatization.

Though not a new diagnostic construct, neurasthenia is a related somatization diagnosis that deserves mention here. Generally used to refer to nervous exhaustion,

neurasthenia was once commonly diagnosed in North America and Europe but fell out of use prior to the printing of the DSM-III in 1980 (Kleinman, 1986). Though it continues to be listed in the ICD-10 (1993), neurasthenia is rarely applied within Western countries today. However, in some countries where the diagnosis of SD is culturally counterintuitive and rarely applied, such as China, this is the most frequently given diagnosis (Kleinman, 1986). Not all holistic countries commonly diagnose neurasthenia; Japan, for example, has drastically decreased their once fervent application of the term (Nakane, 1999). Though not being proposed as a replacement for SD, neurasthenia might be being used as an alternative diagnosis in countries for whom SD is not considered consistent with predominant models within their holistic cultures.

In sum, somatization is an enigmatic notion to begin with, and it has been further bedeviled by a long history of myth, speculation, and science. Culture has powerfully influenced the shape and construction of our understanding of somatization. Somatization has been conceptualized as a personality trait, a cognitive pattern, and a behavior. Others have declared somatization a symptom of psychological conflict, a failure to elaborate meaning, psychological distress, psychiatric illness, social distress, and somatic distress. Somatization as a psychiatric diagnosis has been endorsed and criticized by some of the greatest minds in the field. It is not surprising that a consistent definition of somatization continues to elude us.

The first tentative step towards ensnaring the definition of somatization may be to combine some of the perspective described above and accept that more than one hypothesis may contain an element of truth. Most likely many factors coalesce to result in somatization (Lipowski, 1988), so a constructed definition should reflect this. Another

step may be to propose a broad definition that is able to accommodate specific cultural variations and influences. By having a generalized definition, one is not restricted to using it only in reference to a specific psychiatric disorder or symptom. It need not be reserved only for problematic pathology but can reference the entire spectrum of somatization with added qualifiers if necessary. For example, the term *insomnia* is used much in this way. It is a general term referencing inability to fall asleep or low quality sleep, and there are qualifiers, such as initial, middle, and terminal (DSM-IV-TR), that give greater specificity when added. Insomnia, in its various forms, is considered part of the clinical picture for several very different disorders, and primary insomnia is a disorder all its own. I tried to take these two steps later in this paper while cultivating my own definition of somatization, which is based on that of Lipowski (1988).

According to Lipowski (1988), somatization involves "experiential, cognitive, and behavioral" (p.1359) aspects. He defined 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. (U)sually ... this tendency becomes manifest in response to psychosocial stress" (Lipowski, 1988, p. 1359). This characterization of somatization is primarily descriptive and not intended to be used as a diagnostic category (Lipowski, 1988). To reflect a more universal, culturally considerate conceptualization of somatization applicable to all cultures, I feel Lipowski's (1988) definition should be slightly altered. I propose that somatization is a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to a disruption in

health, and to persistently self-medicate or seek culturally appropriate help for them; this tendency often is triggered in response to psychosocial stress.

Let me discuss the various aspects of this definition and explain my reasoning for them. The experiential portion contains a behavioral component that requires that the felt physical distress be conveyed at least to those from whom they seek help if not others, such as family members. These physical symptoms can not be explained via medical tests or procedures or by other methods used to confirm theories of ill health. If organic pathology exists, it does not fully explain the intensity, frequency, or quality of the reported symptom(s). Since different cultures have unique ethnophysiologies and theories about the source of illness, attributing somatic symptoms to a disruption in health instead of physical illness makes the cognitive element of the definition more culturally appropriate. Attribution of a somatic symptom that is consistent with the culturally accepted understanding of disease causation (whatever that might be) is the cognitive aspect of somatization. Reflecting the individual's symptom attribution, the behavioral aspect of Lipowski's (1988) definition has been changed to a tendency to persistently self-medicate or seek culturally appropriate help instead of medical assistance. Not all people have access to medical resources due to geographical or financial reasons, and for many persons, it is not the cultural norm to seek medical care even if they did have access to it. In the instance of self-medication, an individual must doggedly take curative action.

The term *psychosocial stress* is used to reference all potential sources of emotional distress: personal, interpersonal, and social. For example, anxiety secondary to political unrest, family conflict, or purely individual concerns are all equally valid

sources of stress within this model. Although I believe psychosocial stress is often the source of somatization, negative consequences can result from an individual admitting that it is a part of their illness experience. In addition to social stigma, discussing one's emotional distress can infer a personal shortcoming, and highlighting oppressive social situations can result in retaliation (Kirmayer & Santhanam, 2001). Therefore, I do not believe the denial of a possible emotional component should be a definitional element. To give an example, this model would consider Phii Pob, a Thai culture-bound syndrome, somatization. A priest's help is often sought for the headaches, heart palpitations, and fainting spells that are attributed to spirit possession (Suwanlert, 1976). It is understood within the Thai community that this disorder develops after exposure to a trauma and so it is also a cultural idiom of distress (Suwanlert, 1976).

The boundaries established by this definition of somatization are equally important for what they exclude as well as what they include. My somatization definition does not incorporate minor, everyday somatization, like stress headaches or nervous nausea, unless the individual seeks treatment for them and regards them as a serious disruption in health opposed to a fleeting symptom. Symptoms, no matter how severe, are only considered somatization if the individual seeks outside help for them or uses extensive self-medication. Secondary organic symptoms brought on by stress reactions, such as a catching cold after long exposure to stress, are excluded. Extreme symptoms the individual considers to be psychosocial in origin and not the result of a disruption of health are not a part of this definition. What remains, is a significant pattern of self-medication or help-seeking behavior for physical symptoms that are believed to have

nonpsychosocial origins. This definition does not imply that somatization is unusual, pathological in any way, or indicative of a mental illness.

This definition seeks to be culturally sensitive in several ways. In acknowledging that there are multiple illness models, Western medicine is not presented as the only authority on health. A lack of endorsement for Western medicine or psychiatry does not imply somatization. Refusing to admit to the psychosocial origins of one's symptoms, which is akin to endorsing mind/body dualism, is not indicative of this definition. It does not counter the concept that somatization is a culturally sanctioned idiom of distress or suggest that this process is pathological. All of this taken together hopefully combines to create a useful and respectful definition of somatization.

Perspectives on Somatization

As one of the oldest diagnostic and behavioral concepts, it is not surprising that somatization has been conceptualized from a variety of points of view. Contemporary psychology has moved past the former theories of the wandering uterus, demonic possession, and magnetic fluids (Cushman, 1995; Fuller, 1982; Thompson, 1999) to provide new explanations for somatization. Several current psychological orientations each provide unique conceptions of somatization, and several other disciplines, such as sociology, anthropology, and medicine, also contribute to our understanding of the topic. In this section, current perspectives on somatization will be explored. The psychoanalytic perspective will be discussed first, as this approach formed the modern era's development of psychotherapy and theories on the psychological basis of physical illness. Next, the behaviorist, cognitive behavioral, and social learning positions are examined followed by the family systems perspective. Lastly, this study explores

somatization as a response to political oppression, a concept that has emerged from sociological and feminist perspectives.

Psychodynamic Orientations

Traditional psychoanalysis.

Most people consider the birth of psychotherapy to be the development of Freud's model of psychoanalysis in the later 19th and early 20th centuries. It is notable that Freud formulated much of his early theory based upon his training with the French neurologist Charcot, who felt that hysteria developed only in individuals with a neurological predisposition. Freud's models also emerged from his own limited clinical experience with a handful of hysterical, somatizing women. Therefore, in a way, psychoanalysis and psychotherapy began with the study of somatization. Yet despite over a century, the psychoanalytic world has failed to form a uniform understanding of somatization.

The first psychoanalytic theory of somatization discussed here is that of Freud. Hysteria, a commonly diagnosed ailment in Victorian women, was an extreme form of somatization and was the focus of Freud's theorizing. Freud began to develop his hypotheses about the etiology of hysteria during the late 1880's. Over the next decade, his theory evolved and took several forms. The first version closely mirrored Charcot's emphasis on heredity and resembles what is now known as the stress-diathesis model. In 1888, Freud theorized that hysteria developed only in people with a heritable, biological predisposition after exposure to a trauma (as cited in McGrath, 1986). In this model sexual desires are not indicated to be responsible for the development of hysteria.

The second version of Freud's theory on hysteria, the "seduction theory," took shape around 1895 (Freud, 1985/1895). According to the seduction theory, hysteria was

induced because fathers physically seduced their children, usually daughters, and this traumatic sexual abuse required repression on the part of the child (Breuer & Freud, 1957). Freud proposed that the memories of childhood abuse are far too painful and too socially unacceptable to remain accessible, and so they are blocked by the defense mechanism of repression. In this model, emotions are equivalent to sources of energy. Although memories and the emotions associated with them can be repressed from consciousness, their energy remains, which is then converted into physical symptoms; "hysterical symptoms are derivatives of memories operating unconsciously" (Freud, 1896/1948, p. 208). During this stage of Freud's understanding of hysteria, the trauma that incited hysteria is sexual in nature and is thought to have actually occurred.

Freud revised his theory yet again after concluding that the unconscious mind does not distinguish memories of true events from emotional fantasies (McGrath, 1986). The final stage of Freud's hysteria theory is that of the Oedipal myth. In *The Aetiology of Hysteria* (1896/1948), Freud theorized that all somatization and hysterical symptoms occur as the result of repression of unacceptable desires. The mechanics of the symptom development are much the same, but the source of repression is shifted from a focus on unbearable memories of *experienced* incestual sexual abuse to that of intolerable *imagined* sexual fantasies and desires. The fantasies may or may not include sexual contact with family members, but the conjured desires are just as painfully insufferable. Although real sexual trauma was still thought to be capable of inducing hysteria, imagined sexual trauma or unacceptable desires became possible sources of hysteria under this final version of Freud's theory.

In Freud's model, psychological conflict over sexuality is converted unconsciously and expressed as a symbolic physical symptom; this definition was the first to include the term *conversion*. (Another psychoanalyst, Stekel, coined the word *somatization*, which he considered to be identical to Freud's concept of conversion (1943/1962).) Somatization can be "invariably traced to a psychic conflict, arising through an unbearable idea having called up the defenses of the ego and demanding repression" (Freud, 1896/1948, p. 207). The resulting physical symptom is a compromise between the repressed desire and the defense mechanisms (Ammon, 1979; Duberstein, & Masling, 2000). Again, the resolution of the conflict succeeds in expelling the unacceptable thoughts and desires from consciousness, but as long as the conflict remains unconscious, its energy will be channeled into physical symptoms.

Treatment for such symptoms generally involves bringing the unconscious conflict or fantasy to consciousness (Freud, 1896/1948). Helping the patient verbalize in great detail the previously repressed memory that instigated the conflict along with experiencing the affect that accompanies the conflict was the goal of hysteria treatment in the initial model developed by Breuer and Freud (1893/1957). This cathartic treatment utilizes hypnosis (Breuer & Freud, 1893/1957) and/or free association (Wolman, 1988) to bring the repressed memory to consciousness.

Freud's abandonment of the seduction theory has become a controversial issue in the world of psychoanalysis. McGrath (1986) feels the theoretical shift to the Oedipal myth was beneficial in that hysteria and somatization were no longer the pathological abnormalities they were under the seduction theory. Hysterical symptoms could be possible in anyone and not solely in survivors of sexual abuse. Other authors, such as

Krueger (2002) and Malcolm (1981) find that this change was the downfall of Freud's hypothesis. For a more complete discussion of this controversy, see Malcolm (1981).

It is interesting to note that the physical body is of key importance in psychoanalytic theory. It is theorized that the ego develops through tactile stimulation of the body (Duberstein, & Masling, 2000). Fenichel (1945) theorized that infants differentiate external information originating on the surface of the body from internal desires; it is this distinction that develops into a sense of self that is separate from the rest of the world. One's sense of self, or body image, is the origin of what will develop into the ego. Additionally, the oral, anal, and phallic stages of development formulated by Freud are all named after parts of the body, with each stage representing an investment of psychic energy in the corresponding body part (Duberstein, & Masling, 2000).

Other psychologists have edited and expanded Freud's original explanation of somatization. As a result, any kind of psychic conflict, not just that originating from libidinal desires, might result in somatization. Other "instinctual drives," like anger or aggression can be responsible for conversion reactions (Sundbom, Binzer, & Kullgren, 1999). When uncomfortable desires or emotions that express instinctual drives, including those that do not stem from sexuality, are prevented from expression due to repression, their energy must be expressed in some way. When no other options are available, the physical body will release this energy through corporeal symptoms.

Many psychoanalysts have gone on to further emphasize the symbolic nature of conversion symptoms. According to Deutsch (as cited in Ammon, 1979), every single physical symptom has a symbolic meaning, a "body language." In his theory, conversion normally takes place on a continuous basis as the result of the repression of all instincts

and the necessary discharge of the resulting energy. All instincts and libidinal desires must be controlled and repressed, because culture demands this of us. In order to be socially accepted, one must not act upon every urge or want. In fact, he theorized that this constant process of conversion is necessary to maintain physical and psychological health. Without this process to disperse the excess energy, Deutsch hypothesized that more neuroses would develop. Specific symptoms are the result of identification with a person who has had similar symptoms and is considered important in the patient's life. A particular organ is unconsciously selected, in part, because it allows the patient to express a symbolic bond to the person with whom they have identified. Illness occurs when the constant stream of conversion is focused on the same representative organ too frequently. Therefore, specific symptoms are corporeal representations of a symbolic identification with a key person.

Fenichel (1945) proposed that all symptoms and every sickness could be considered psychosomatic since psychological factors are incorporated into all physical ailments. This attitude is very similar to the contemporary biopsychosocial approach to health, which posits that biological, psychological, and social aspects influence every disease to varying degrees. Fenichel (1945) also stated that somatic symptoms speak to an unresolved conflict, unmet need, or fantasy, usually involving sexuality; "the fantasies of hysterical individuals, after being repressed, find plastic expression in alterations of physical functions" (Fenichel, 1945, p. 217). For example, anorexia nervosa may represent a denial of sexual longing, and vomiting may be a symbol of resistance to pregnancy.

Sometimes the relationship between the symptom and the repressed conflict is very literal. The concept of psychosomatic specificity developed by Alexander (1950) states that specific symptoms or illnesses will result from specific psychodynamic processes. Precipitating emotional states directly lead to physiological responses. This holds true for normal, nonpathological responses, such as increased blood pressure following fear, as well as for the extreme, pathological reactions of somatization. For example, a strong need for emotional nurturance could lead to physical problems with nutritional nurturance, like gastrointestinal ailments or anorexia nervosa. Also, childhood asthma is a "suppressed impulse to cry for the mother's help" (Alexander, 1950, p. 68). Unconscious wishes are symbolically expressed in psychosomatic symptoms, according to Wolman (1988). House and Andrews (1988) argued that psychogenic dystonia, or difficulty speaking, was often preceded by a circumstance in which the patient was conflicted about "speaking out." The patients' inability to voice their complaints was symbolically expressed as a physical inability to speak. Similarly, Stekel speculated that the body translates psychological troubles into physiological symptoms as a means of communication (1943/1962). Marsella and Yamada (2000) take a slightly different approach when stating, "a symptom is a communication, an interpretation, and an experience... that reveals culture" (p.19).

A somewhat different stance was taken by Groddeck (1925/1977). He was a psychoanalyst of the early 20th century, who was a good friend to Freud and became quite influential following the birth of psychoanalysis. His explanation takes a different approach and highlights the influence of the "It," which Freud later made known as the id. In general, Groddeck posited that all types of physical ailments are warnings from the

id against continuing life as it is; they are a message that change is needed to remedy a problem of living. This is analogous to how pain is the body's warning system, alerting to the threat of serious harm so that one can protect oneself. Any single symptom can carry a variety of meanings. Specific symptoms can be unconscious wishes, desire for punishment, or a solution to a fear. For instance, paralysis of an arm could be an expression of a wish to be helpless and cared for like a child, a desire to suffer and do penance, or a way to prevent oneself from stealing or lashing out violently. Much later in 1961, Groddeck (as cited in Wolman, 1988) clarified his theory to state that psychogenic symptoms can serve to repress an internal conflict and also can help resolve the conflict. Although well respected by Freud, Groddeck's theory never became influential in the psychoanalytic world (Ammon, 1979).

Self psychology.

One of psychoanalysis' progeny, self psychology, posits another theory of the etiology of somatization. Self psychologists hypothesize that somatization results when strong emotions are transformed into physical symptoms as a means to preserve self-esteem and the "integrity of a weak self structure" (Sundbom, Binzer, & Kullgren, 1999, p. 184), and not simply to eliminate anxiety as traditional psychoanalytic theory proposes. This theoretical orientation states that early infant-caregiver interactions are key in the development of a solid sense of self and self-structure. Through appropriate mirroring and reflection, the caregiver adequately attunes to the infant, validates the infant's needs, and in a sense, validates the infant. This interaction is required to develop and maintain a positive cohesive sense of self. A consistent lack of appropriate responsiveness from the caregiver leads to the development of schemas that affect one's

perceptions, emotions and cognitions; these schemas organize the rest of life's experiences and result in the formation of pathology (Fosshage, 1992), including somatization. This is a self disorder (Rickles, 1995). Because the individual with a self disorder cannot step outside of their faulty schemas to observe themselves and cannot internally symbolize their emotions, their physical symptoms are not symbolic (Rickles, 1995). When later emotional experiences are not met with appropriate responsiveness, which are reminiscent of his or her childhood environment, an adult may revert to developmentally immature somatic expressions of emotions hopefully to elicit the desired responses from others (Sundbom, Binzer, & Kullgren, 1999). When the somatizer's equilibrium is threatened, somatic disorders result (Rickles, 1995). For example, a baby is repeatedly overwhelmed by her mother's rigid demands to be quiet and well behaved. The mother responds to most cries by ignoring the child or punishing her. The infant is not appropriately validated and develops a fragile sense of self. As a result, the baby develops a gastrointestinal problem that causes her to vomit frequently; the mother must respond to this behavior by picking up the child, washing her, and changing her clothes. Instead of feeling unworthy of her mother's attention, the child has protected her self-esteem by creating symptoms that require her mother's interest. This pattern repeats in adulthood with unexplained vomiting when the woman feels ignored or dismissed.

In support of this hypothesis, significantly higher levels of perceived parental rejection have been found in those diagnosed with conversion disorder compared to controls (Binzer & Eisemann as cited in Murase, Sugiyama, Ishii, Wakako, & Ohta, 2000). This study indicates the perception of being rejected by one's parents weakens one's self-concept, and conversion symptoms are utilized to protect the fragile remnants

of self-esteem. According to Wolman (1988), children develop psychosomatic ailments, such as ulcerative colitis, as a reaction to their mothers' attitudes, especially maternal rejection. In support of this idea, researchers found that among nineteen patients with conversion disorder, patients displayed poorer reality testing and ability to perceive negative emotions in a projective test when judged against a control group (Sundbom, Binzer, & Kullgren, 1999). They concluded that these results meant that those with conversion disorder had difficulty recognizing negative concepts that might threaten their self-image.

Object relations.

Another offshoot of the psychoanalytic orientation, the object relations perspective, reports a similar hypothesis on the origin of somatization. Object relations theorists state that a faulty sense of self can result if there is a failure in the mother-child dyad (Plante, 1999). As Campbell (1997) explains, should the child not securely attach to the mother during early infancy, he or she will not acquire a positive self-image and will lack an internal "other," or object, to help it distinguish and integrate emotions. Without this self-soothing mechanism, the child will be unable to symbolize affects and therefore will be unable to adequately distance himself or herself from his or her emotions in order to master them. Affects will be experienced as overwhelming, and the child may then resort to using the body to express these overpowering emotions. Stuart and Noyes (1999) also theorize that maladaptive, anxious attachment styles spur the development of an interpersonal approach that results in somatization.

Although there are many similarities between the object relations perspective and that of self psychology, there are some important distinctions between the theories as

well. Self psychology focuses on the cohesive sense of self, protection of self-esteem, and pathology primarily stems from the lack of attunement of significant others in one's childhood environment. Object relations, however, emphasizes the internal object to symbolize emotions, regulation of emotions, and attachment between the infant and caregiver as the source of pathology.

Relational theory is a fusion of several psychodynamic schools of thought, including interpersonal psychoanalysis, object relations, and self psychology (Mitchell & Aron, as cited in Arnd-Caddigan, 2003). It asserts that somatization will result in two possible ways if a child's social environment fails to explain the meaning of an experience (Arnd-Caddigan, 2003). If one's caregivers cannot provide a cognitive explanation for an affective experience that allows for the objectification of that affect, one is left with only the somatic component of emotion, which can eventually develop into somatization (Arnd-Caddigan, 2003). Alternatively, an individual may unconsciously choose to not develop meaning of affect as a defense mechanism that protects the self, which again leaves the individual with only the somatic components of emotion (Arnd-Caddigan, 2003). Treatment aims to enhance the elaboration of meaning on individual, interpersonal, and cultural levels and integrate meaning on all levels (Arnd-Caddigan, 2003). For deficits in individual meaning, Arnd-Caddigan (2003) recommends providing a nugget of information that the client can then elaborate on themselves. For deficits at the interpersonal level of meaning, the therapist is advised to "provide a social context that reflects and validates the client's individual meaning" (Arnd-Caddigan, 2003, p.115). For deficits in cultural meaning, provide the client with

"cultural products" (Arnd-Caddigan, 2003, p.116), such as religious material or movies, that supply meaning for the problematic experience.

In summary, all three of the psychoanalytic models discussed above theorize that overwhelmingly intense emotions are converted into physical symptoms as a way to protect the self. Somatization is used as a defense mechanism because an individual does not possess an adequate ability to internally regulate emotions that allows all emotions to remain at a conscious level. However, the traditional psychoanalytic model states that unconscious conflict over intolerable drives, usually either sexual or aggressive in nature, is responsible for the conversion process. Many traditional psychoanalysts also feel the psychogenic symptoms are symbolic of the internal conflict. A frail sense of self and tenuous self-esteem are prerequisite factors for the process of conversion according to self psychologists. In the model of object relations, an inability to symbolize emotions or self-soothe leads to the conversion of psychological to physical distress. Treatment of somatization from these three psychodynamic perspectives reflects these differences. Traditional psychoanalysis aims to bring the unconscious conflicts to consciousness and abreaction, thus eliminating the fuel that feeds the somatization fire. Self psychology aspires to strengthen the sense of self and self-esteem so clients can better tolerate the full spectrum of emotions and not resort to somatization to protection the self from negative affect. Object relations psychology attempts to help the client find meaning in their experiences to allow for objectification of experience, which will give the client the ability to fully experience their emotions and not just embody them.

Behaviorism and Cognitive Psychology Orientations

Behaviorism, cognitive behavioral therapy, and social learning theory have contributed significantly to psychology's understanding of somatoform disorders and somatization. The conceptualization and treatment of somatization presented by these related theories are significantly different from that proposed by the drive-based psychoanalytic orientation. Instead of solely holding intrapsychic conflict culpable for somatization, behaviorism, cognitive behavioral therapy, and social learning theory were the first to consider the influence the conditioning environment, including significant others, as it influences the mental processes that underlie somatization.

Operant conditioning and secondary gain.

Behaviorism was the first scientifically based psychology and is primarily focused on how reinforcement and punishment influence the development of observable and measurable behaviors. One key concept taken from behaviorism and applied to the study of somatization is reinforcement. Operant conditioning specifically emphasizes the significance of reinforcement, both positive and negative, in the propagation of a behavior (Plante, 1999), such as somatization. Somatization is thus seen as a pattern of behavior that is produced and maintained by systems of reinforcement in the environment of the patient. Depending on the theorist, behaviorists claim that learning can take place at either a conscious or an unconscious level.

Reinforcement is simply an increase in the frequency of a particular behavior when it is followed by a contingent event (Craighead, Craighead, Kazdin, Mahoney, 1994). Therefore, any multitude of things can act as reinforcers to give rise to somatization. What specifically is reinforcing for an individual will be influenced by his

or her own personal preferences, family history as well as sociocultural issues, such as gender, age, socioeconomic status, and especially culture. The application of the contingent event, or positive reinforcement, could include attention of family members or medical personnel, sympathy from friends, or financial rewards from a legal settlement. Avoidance of stressful work demands, a change of focus away from family discord and on to the patient's symptoms, and alleviation of marital or parental expectations are examples of negative reinforcement, or the conditional removal of an event. In addition to those examples already given, Wolman (1988) states that conversion symptoms also serve to alleviate the somatizer from traumatic situations, punish the somatizer to assuage their guilt, punish others by blaming the handling of the somatizer for the symptoms, perpetuate the benefits of illness that began with an organic illness, and induce iatrogenic, physician-generated symptoms.

As Celani (1976) concluded, family members and caretakers are thought to reinforce conversion symptoms and facilitate the perpetuation and formation of the symptoms. In addition to the reinforcers that provide the somatizer with obvious secondary gain benefits, like those mentioned above, social behavior also can be subtly reinforced by families from early childhood. An individual's ability to perceive specific bodily sensations can be heightened by habitual attention to those body parts (Kellner, 1991). For example, fearing her daughter may develop asthma, an overprotective mother, who comes from a family with a history of asthma, may be highly attuned to her daughter's breathing. The young child may learn it is important to be aware of her own breathing patterns and be hyperalert to any signs of wheezing. Although there are no benefits or secondary gain for this behavior, the girl's vigilance is reinforced by the

family's attitude toward illness. Whereas most children do not notice or dismiss being slightly out of breath, this hypervigilant girl may interpret any slight indication of breathing difficulties as extremely significant. As a result, she may panic, which causes her to hyperventilate and feel light-headed. With repetition, these sensations may be misattributed to asthma, and somatization has developed. Even if the young child never shows any signs of asthma in childhood, she may be predisposed to develop psychosomatic breathing difficulties in adulthood as the result of her fine attunement to her breathing.

It seems that the secondary benefits of being sick are learned early in life. Adult psychosomatic symptoms may develop based upon how much attention was or was not gained from childhood ailments. The amount of attention parents give to their children's symptoms is associated with adult somatization (Kellner, 1991). Craig, Drake, Mills, and Boardman (1994) found that adult somatization is associated with a combination of three characteristics: serious physical illness in the person before the age of 17, parenting problems related to lack of care, and the potential for secondary gain. In this study, 82% of somatizers experienced an event with the possibility of secondary gain within 38 weeks of their symptoms onset. This is compared to 64% of people expressing solely psychological complaints, 17% of those with organically based symptoms, and 18% of healthy control participants. These results are very similar to those of Raskin, Talbott, and Myerson (1966 as cited in Craig, Drake, Mills, and Boardman, 1994) who found secondary gain in 81% of somatizers and 28% of patients with organic ailments. Additionally, these data indicate that secondary gain is a significant aspect of the development of somatizers' symptoms. Craig, Drake, Mills, and Boardman (1994)

concluded somatizers learned that physical illness alleviated psychological distress due to poor parental care in childhood, and this learned behavior can persist into adulthood. Similarly, Barr and Abernethy (1977) commented that symptoms learned in childhood are used later in adulthood as a means of coping with stressful or frustrating experiences.

Behavioral treatment of somatization utilizes several techniques to modify the clients' behavior and help them use "rational methods, instead of psychosomatic symptoms, to attain their goals" (Wolman, 1988, p. 269). Discrimination training, systematic desensitization, and behavioral skill learning are the primary methods used by this model (Wolman, 1988). Discrimination training is utilized to identify a connection between stressful circumstances and the exacerbation of symptoms (Wolman, 1988). It often involves extensive self-observation and recording activities, thoughts, feelings, and symptoms (Wolman, 1988). Systematic desensitization is employed once the connection has been made between the client's symptoms and an anxiety triggering situation or thought. In this technique, the therapist and client construct together a hierarchy of anxiety-provoking stimuli. Then clients are brought to a state of relaxation by using one of several possible relaxation techniques. Once relaxed they are instructed to think about or visualize exposure to the least anxiety-provoking situation until their anxiety subsides. They then repeat this procedure moving up the hierarchy of anxiety-provoking stimuli until the stimuli no longer trigger anxiety. Behavioral skill learning actually encompasses a broad array of techniques that aim to teach the client to use more adaptive behaviors when it seems poor interactional skills play a role in their symptoms (Wolman, 1988). This broad term could include assertiveness training, conflict management training, stress management, or even financial planning to name a few. All of these

behavioral treatments primarily help the client cope with and manage their anxiety or depression, which will then decrease the client's somatization symptoms.

Other behavioral treatment is based directly on operant conditioning and focuses on reinforcing "healthy" behaviors that counteract reinforcement for "sick" behavior. In a small study of ten conversion disorder patients with gait problems, Speed (1996) utilized a simple behavioral management strategy to successfully restore normal ambulation. Hospitalized patients were rewarded with recreational activities when they made advances toward normal ambulation in physical therapy or occupational therapy (Speed, 1996). Though this treatment was not found to be successful statistically, seven of nine patients had retained their normal ambulation at follow-up (Speed, 1996).

The sick role concept.

The idea of sick role, a concept originating in the field of medical sociology (Parsons, 1951), can be applied to the study of somatization in a similar manner as behavioral psychology. Sick role also can be a strong reinforcer for illness and somatized symptoms. According to Schwartz, Calhoun, Eschbach, and Seelig (2001), learning theory and behaviorism suggest those who somatize have learned that the sick role gives them secondary benefits, and therefore they recreate their symptoms to receive those benefits. Parsons (1951) developed the concept of the sick role in the early 1950's as part of the burgeoning field of medical sociology. Like Freud, Parsons based his theory on personal experience. Only later was research found to be congruent with his statements. Since his conception of the term, innumerable studies have been conducted on the sick role in relation to other variables, such as personality (Jenkins, 1972), ethnicity (Segall, 1988), and diagnosis (Kassebaum & Baumann, 1965).

When describing the sick role, Parsons (1951) first asserted that to be sick is to be deviant; to be sick is to be unable to function properly in society. Being sick is associated with two rights and two obligations. One right granted by the sick role is that if one has been designated to the sick role, one is given the right to be free of normal demands and roles in society. For example a sick child is not expected to go to school; he or she is not expected to be a student. One is also given the right to be released from blame for being ill when one is fulfilling the sick role. It is not expected that a person will become well on their own, and others often help care for the sick person. It is not considered a child's fault for having the flu or for not getting well, and parents typically then provide extra care to the sick child. However, one of the sick role's requisite obligations is that one must desire health and wellness. The sick child is expected to want to get better. Additionally, the sick person is obligated to seek appropriate help to achieve wellness and cooperate with such help. The sick child must go to the doctor and take his or her medicine. Overall, the sick role places the symptom and the somatizer in relation to his or her ability to fulfill social obligations (Stark & Blum, 1986).

Since the sick role can only be viewed within the context of society and the unique meaning of illness within that society, it is not surprising that a great number of sociological variables influence how desirable the sick role is to a person and the degree to which an individual accepts the rights and obligations of the sick role. Ford's review of Parsons' sick role cites several interesting studies of these sociocultural aspects (Ford, 1983). As one increases in age, the cost of being sick decreases, and the more readily one may feel legitimate in the sick role (Twaddle, 1979). Since illness is often expected to

accompany age in Western society, it is more acceptable for an older individual to be sick.

Unexpectedly, neither gender nor socioeconomic status have been found to significantly influence sick role status. Despite considerable differences between male and female roles in western culture, no significant dissimilarities were found between the sexes on the acceptance of the sick role (Petroni, as cited in Ford, 1983). Although poverty, for a variety of reasons, is associated with poor health (Sapolsky, 1998), no social class was found to accept all aspects of the sick role significantly more than any other (Arluke, Kennedy, & Kessler, 1979). In opposition, Twaddle (1979) theorizes that the sick role is more descriptive of high status than low status people. Twaddle supported his conjecture with the ideas that to be considered equally sick, low status people must have more severe symptoms than high status people (Gordon, as cited in Twaddle, 1979) and that the frequent poor health of low status people made them more likely to normalize symptoms, and hence less likely to interpret them as indicative of sickness (Mechanic, as cited in Twaddle, 1979). Although Twaddle makes a case for his hypothesis, he is sure to note that his arguments for this supposition are based on inferences that are weakly substantiated.

If sick role was the primary cause of somatization, it might be predicted that those subpopulations with the greatest amount of somatization also would show the highest endorsement of sick role. However, research does not support this. Since somatization, as measured by somatization disorder, conversion disorder, and pain disorder diagnoses, occurs in women with much greater frequency than in men in the United States (Diagnostic and Statistical Manual of Mental Disorders–IV-TR, American Psychiatric

Association, 2000), more American women might be expected to adopt the sick role, if the sick role was largely responsible for the development of somatization. However, men and women accept the sick role with equal frequency. This discrepancy weakens the argument that sick role impacts somatization.

Yet despite the fact that the data are not consistent with expectations and appear to fail to support sick role as a primary factor in somatization, the sick role may still be influential in the development of somatization. Since multiple factors most likely contribute to the process of somatization, it is possible the sick role influences men in a proportionately larger amount when compared to the influence of other causal factors. Whereas women are influenced by the sick role as much as are men, women are also influenced by other factors more than men are. Following this explanation, men and women could adopt the sick role with equal frequency and women could still somatize more often than men.

Culture is a factor that has been found to significantly shape the acceptance of the sick role, primarily because attitudes toward all aspects of health and illness vary considerably between cultural groups. Additionally, the definition of deviance is very different from one culture to the next. A physical symptom might be perceived as abnormal in one culture, but completely ignored in another (Zola, 1989). In his 1979 book, Twaddle discusses the findings of his dissertation research in which Italian American Catholics rejected Parsons' sick role the most, Protestants were more accepting of the sick role, and Jewish Americans were the most accepting of Parsons' sick role. Consistent with Twaddle's results, Segall (as cited in Ford, 1983) found Jewish women showed a nonsignificant trend to more frequently adopt the sick role when compared to

Protestant women. However, Zola (1989) found Italian Americans report a greater number of symptoms in a wider variety of body areas and that those symptoms more significantly impair overall functioning when compared to the reports of Irish American Catholics and Anglo-Saxon Protestants. In fact, the Irish American Catholics demonstrated a great proclivity to deny the effects of their symptoms. This could be interpreted to mean that Italian Americans more readily adopted the sick role than their Irish American Catholic and Anglo-Saxon Protestant counterparts.

Although Parsons' concept of the sick role has made enormous contributions to the behaviorist understanding of health and health behaviors, including somatization, criticisms of his theory have emerged over the past 50 years. The significant discrepancy between the medical and psychiatric sick roles has much relevancy when exploring the application of the sick role to somatization. Typically, the more psychological the etiology of a disease is thought to be, the more personally responsible for becoming sick the person is assumed to be (Segall, 1976). Additionally, American society often expects one to be able to master one's emotions and appropriately modulate any affective expressions. These expectations contradict the aspect of Parsons' sick role that releases one from responsibility for one's condition. According to Denzin and Spitzer (as cited in Segall, 1976), psychiatric sick role behavior cannot be predicted by Parsons' medical sick role. Segall (1976) concludes that Parson's sick role is an ideal and not necessarily a description based upon reality.

This author has identified another quandary that is encountered when one is attempting to apply Parsons' sick role to the understanding of somatization. Since somatizers believe their symptoms have an organic etiology, they seek appropriate

medical treatment; this is consistent with Parsons' sick role. However, when medical authorities inform them that their symptoms are in fact psychological in origin, somatizers rarely seek psychological treatment. They are resistant to obtaining the treatment they most need. Moreover, somatizers are frequently resentful and emotionally upset by the insinuation that their intensely experienced symptoms are actually psychological fabrications. This strongly contradicts Parsons' model. In many societies, including American, physical illness is generally considered to be excusable and socially rewarded to a degree. Mental illness, on the other hand, is often considered inexcusable and shaming. Ironically, somatizers so desire and are attached to the sick role, they fail to fulfill the obligations of that role and consequently prevent themselves from reaping the rewards sick role can offer.

Though Parsons' sick role provides many insights into our understanding of somatization, it does not offer many treatment interventions directly based upon this theory. However, viewing the sick role simply as an explanation of reinforcement, an elaboration of operant conditioning, allows one to utilize appropriate behavioral therapy interventions mentioned above. Stark and Blum (1986) combined the sick role model and family systems theory to provide a theoretical understanding of the origins of psychosomatic disorders, but the approaches to treatments described in their article had little to do with the sick role. Perhaps because the sick role concept was originated in the field of medical sociology, sick role does not easily translate in to clinical psychology treatment. Despite the criticisms of the sick role concept, Parsons' relatively culture-free model has clarified some of societies' unspoken expectations around illness and illness behavior.

Cognitive behavioral therapy.

Cognitive psychology and cognitive behavioral therapy (CBT) present a slightly different perspective on the ways in which somatization is created and shaped, by focusing on the influence of thought processes. On the topic of somatization, CBT contains the idea that mental and physical illness, as well as somatization, result from the interaction of the social environment, cognitions, emotions, biology, and behavior (Sharpe, 1997). In particular CBT emphasizes cognitions and how they influence the development and maintenance of somatized symptoms. Some of the cognitive components in somatization include one's attention to the body, attribution of bodily sensations, illness worry, catastrophizing, and demoralization (Looper & Kirmayer, 2002). CBT interventions can be created for any of these elements, although the majority of CBT interventions address the process of symptom attribution. According to this orientation, cognitions can be self-reinforcing and self-perpetuating. The cognitive aspects of psychopathology are primarily tackled by CBT, because they are considered to be the most accessible via talk therapy (Sharpe, 1997). It is believed that more change can take place through psychotherapeutic discussion when addressing an individual's thoughts than by confronting the subconscious drives of psychoanalytic theories or through studying and changing the reinforcers that produce somatization as expressed in the behavioral models and the sick role concept.

A basic precept of cognitive behavioral therapy is that people have beliefs about themselves, and all of life's experiences exist in relation to those beliefs (Craighead, Craighead, Kazdin, & Mahoney, 1994). These underlying assumptions hold true in all situations, and the automatic thoughts one has from moment to moment can reinforce the

underlying assumptions and influence our emotional states and our resulting behavior. For example, if a woman maintains an underlying assumption that she is weak and sickly, she is likely to automatically attribute being winded when walking as a sign that she is unwell instead of imagining it to be a normal reaction to physical exercise. Her malignant interpretation, her thoughts, of that symptom confirms her belief that she is an ailing woman. Thus, the underlying assumptions are continually reinforced by the misattribution of events that seem to confirm the assumption of weakness.

Barsky (1992) presents another theory on the etiology of somatization that focuses on the process of amplification, which is the tendency to experience bodily sensations as unpleasant, disturbing, and intense and to interpret them as pathological. Amplification consists of "bodily hypervigilance (p.28)," a focus on faint or sporadic sensations, and a faulty attribution process in which there is a tendency to consider corporeal sensations indicative of disease. Regular physiological functions, such as perspiration or a change in heart rate, inconsequential dysfunctions, such as a twitching eyelid or belching, somatic effects of intense emotion, like blushing or increased respiration, as well as symptoms of severe organic disease can all be amplified. It is Barsky's hypothesis that psychological and emotional distress could cause amplification of somatic sensations and induce somatization in people with and without psychological disorders.

By overinterpreting the significance of harmless bodily stimuli (such as an increase in heart rate after climbing stairs at work) as indications of a potentially fatal illness (such as an impending heart attack), somatizers "catastrophize" what most people would ignore. If that same person had assumed their rise in pulse rate was simply due to

the exertion required to ascend the staircase, perhaps they would conclude they should exercise more or take the elevator next time. Possibly the person with the racing heart would suppose that the change in pulse was the result of their apprehension about entering the board meeting unprepared. Consequently, the resulting behavior is significantly influenced by which alternate explanation one believes in. The meaning ascribed to the symptom can cause it to be completely dismissed or it can have the power to induce fear and anxiety. The misattribution is a cognitive distortion that can lead to negative affects and harmful behaviors (Allen, Woolfolk, Lehrer, Gara, & Escobar, 2001), as well as help-seeking behaviors like consulting a physician (Hiller, Fichter, & Rief, 2002). Believing themselves to be ill directs many somatizers to progressively withdraw from normal activities in an attempt to avoid worsening symptoms or pain (Katon, Lin, Von Korff, Russo, Lipscomb, & Bush, 1991). After a prolonged period of time, muscle atrophy may then develop, which further reinforces the symptoms. Worry and resulting anxiety or depression about their symptoms contributes to somatizers' emotional arousal and only exacerbates their symptoms; they are now locked into a vicious cycle.

Robbins and Kirmayer (1991a) propose that there are three attributional dimensions: psychological, physical, and normalizing. To assume that physical symptoms (1) have a psychological or emotional origin, (2) are the result of physical illness, or (3) are insignificant signs of typical bodily functions are represented by the psychological, somatic, and normalizing attribution aspects, respectively. The Symptom Interpretation Questionnaire (SIQ) was developed to measure attributions along these three factors (Robbins & Kirmayer, 1991a). Robbins and Kirmayer (1991a) administered

a modified version of the SIQ to 140 students at Time 1 and then four months later at Time 2. Test-retest correlations were moderate, which supported the hypothesis that people have stable attributional styles. The researchers also noted that the modifications to the SIQ actually decreased internal reliability, which decreased the measure's ability to identify change over time and dampened the weight of the results. Additionally, the number of bodily complaints and the number of bodily complaints without a medical explanation were predicted by adherence to the somatic attributional style. Robbins and Kirmayer suggest that a somatic attributional style could lead to a pattern of translating psychological or emotional distress into physical complaints, a process that they state is equivalent to somatization. Misattributions do not necessarily take place because symptoms are experienced as noxious and disturbing (Robbins & Kirmayer, 1991b). Although the existence of different attributional styles could be consistent with Barsky's (1992) amplification theory, it does not confirm Barsky's hypothesis.

Cognitive behavioral therapy treatment of somatization tends to be highly structured, often with clearly defined stages (Chalder, 2001; Goldberg, Gask, & O'Dowd, 1989; Sharpe, Peveler, & Mayou, 1992), daily agendas set at the beginning of sessions (Sharpe, Peveler, & Mayou, 1992), and an agreed up number of sessions at the start of treatment (Chalder, 2001; Sharpe, Peveler, & Mayou, 1992). Generally, treatment is broken down into assessment, engagement or building a therapeutic alliance, development of treatment contract and goals, treatment, and generalizing progress and prevention of relapse stages (Chalder, 2001; Sharpe, Peveler, & Mayou, 1992). The primary goals of CBT are "helping the patient to change cognitions, to change behavior, and to deal with stressors" (Sharpe, Peveler, & Mayou, 1992, p. 524), and the use of CBT

for somatization is no different. Many different therapeutic techniques are used to reach these different goals. Cognitive restructuring is the most commonly used cognitive intervention to correct misattributions of physical sensations and symptoms often utilizes record keeping of symptoms, feelings, and thoughts. A wide variety of techniques are used to change somatization behavior, including assertiveness training, setting regular, graded, measurable goals addressing medical care usage, exercise, and social activities, creating a sleep schedule, and physiotherapy among others (Chalder, 2001). Relaxation training, biofeedback, anger management, conflict management, and regular pleasant activities help the client cope with stressors.

Reattribution, the correction of misattributions, is the focus of a CBT somatization treatment model to be used by physicians in one or two meetings that was created by Goldberg, Gask, and O'Dowd (1989). It is a barebones model that doesn't utilize any other aspects of CBT. The entire focus of their proposition is to guide patients to attribute their physical symptoms to psychosocial problems (Goldberg, Gask, & O'Dowd, 1989), which I think patients are likely to interpret as their physician trying to convince them that their symptoms are all in their head. Though they recommend taking time to help the patient feel understood, I question how effectively a physician can do that if the entire treatment is expected to take place in one to two appointments and physician appointments are usually last 15 minutes.

Overall, CBT has been found to be a successful treatment of somatization. In an impressive meta-analysis of CBT for all somatoform disorders, Looper and Kirmayer (2002) concluded that CBT is effective for these disorders and "should be considered the first line treatment for somatoform disorders" (p. 823). They found concluded that both

group and individual CBT can be effective. However, the multimodal approaches employed by most researchers make it difficult to determine which parts of the treatment strategies are the most effective. More research is needed to solve this quandary and to determine is different somatoform disorders respond differently to various CBT interventions.

Social learning theory.

Whereas cognitive behavioral therapy focuses on the internal thought processes of the individual, the next theory presented, social learning theory, emphasizes the influence other people have on the formation of somatization. Social learning is yet another behavioral theory that proposes a hypothesis about the etiology and maintenance of somatization. Also known as vicarious learning, modeling, and imitation, *observational learning* is a term that refers to the process by which a person mimics an observed behavior without the use of any type of external reinforcement (Berk, 2000). Researchers have applied this theory to the understanding of a wide variety of different behaviors in children and adults, including self-efficacy (Bandura, 1977), language acquisition (Hamilton, 1977), and courtship aggression (Gwartney-Gibbs, Stockard, & Bohmer, 1987). Based upon this theory, children and/or adults could learn to somatize if they observed someone else expressing physical symptoms, either due to organic or psychogenic illness, and the consequences of that person's somatic expression.

In his seminal book, *Social Learning Theory,* Albert Bandura (1977) stated that there are four component processes that take place between observing modeled events and recreating the events. The development of somatization behaviors can be analyzed through these steps. The first group is the attentional processes, which includes variables

related to the modeling stimuli and the observer's characteristics. People are more likely to pay attention to an important person in their lives when that person is intensely emotional than attend to a random stranger who does not seem to be experiencing strong affects. Additionally, the arousal level and prior reinforcement of the individual observer influences the amount of attention paid to the model. A child could be predicted to pay a great deal of attention to her father while he has a seizure. The episode is likely to emotionally arouse and upset both parent and child. This child knows from past experience she should pay attention to her father. The retentional processes, or remembering an event, are necessary in order to learn the event. Variables such as the ability to symbolically code the observed behavior and rehearsal, both mental and physical, influence how well an incident is remembered. If the child is developmentally able to give meaning to memories, it is probable that the image of her father in a grand mal seizure will be revisited frequently and hence remembered. The motor reproduction processes are the translation of the observed behavior into physical actions and are influenced by the accuracy of one's feedback and one's preexisting repertoire of behaviors. The child may attempt to recreate her father's seizure when telling her friends of the incident or simply out of curiosity. She would be better able to perfect her imitation if she had more accurate feedback, like that from a mirror. Lastly, the motivational processes include external, vicarious, and self-reinforcement. A learned behavior is more likely to be reproduced if it is thought to result in positive rather than negative effects. The young girl witnessed that her father was well cared for after his seizure, her parents refrained from arguing during his recovery, and she felt relieved her

father did not yell at her or enforce his strict rules while he recuperated. All of these things would make her more likely to later reproduce his seizure.

Several authors have linked the formation of childhood somatization with the presence of illness in family members. Eighty percent of the children with conversion disorder in Seltzer's (1985, as cited in Mullins & Olson, 1990) investigation and 87% of the children with referrals for possible somatoform disorders in Mullins' and Olson's (1990) study had exposure to a family member with similar somatic symptoms prior to the onset of the child's symptoms. Stuart and Noyes (1999) write that exaggerated pain and illness responses in parents are likely to be repeated in children. Similarly, Chambers, Craig, and Bennett (2002) found that reports of pain were highest in daughters with mothers who interacted with them in a pain-promoting manner. The lowest pain reports were from the girls whose mothers interacted with them in a pain-reducing manner, and the control group's pain reports were in between the pain-promoting and pain-reducing groups. Although no significant effects were found to result from mothers' interactions with their sons, the researchers concluded that their data supported the influence of social learning factors on the development of children's pain responses. The presence of an illness model, in either a family member or a close friend, was universal in all pairs of siblings with psychogenic symptoms that were investigated by Kriechman (1987). Additionally, each of the twelve sibling pairs examined displayed similar or identical symptoms to each other. Not only were these children exposed to an illness model, but also 41.7% of the mothers in the study were diagnosed with somatization disorder, indicating these children were also exposed to a model of somatization.

In 1993, Livingston found no correlation between parent and child somatization, and as a result he inferred that children do not develop somatization simply due to the presence of parental somatization. However, he concluded that in conjunction with other factors, such as parental anxiety levels, parental somatization may contribute to the formation of somatization in children. He still considered a child to be at an increased risk of developing somatization disorder if he or she has a parent diagnosed with the same disorder. Two years later Livingston, Witt, and Smith (1995) found that parental somatization predicted children's somatization and that somatization in older siblings was significantly correlated with the number of unexplained symptoms in younger siblings. This later study suggests children may learn to somatize from their older brothers and sisters as well as their parents.

Even a single exposure to the illness behavior of a casual acquaintance, such as a classmate's seizure or asthma attack, may provide an adequate opportunity for observational learning (Mullins, Olson, & Chaney, 1992). The mass media of modern society, especially television, exposes children to a plethora of dramatic, charismatic models (Bandura, 1977) that provide examples of various symptoms. Social learning theory considers the family, immediate social sphere, media, and culture all as possible sources of influence in the development of somatized symptoms.

In addition to looking towards society as possible examples of sickness, social learning theory also looks inward to one's own body as a model of illness. Seltzer (1985, as cited in Mullins & Olson, 1990) hypothesized that individuals can be their own illness models. Psychogenic symptoms can be modeled after an individual's own pre-existing organic illness (Mullins, Olson, & Chaney, 1992). It is not uncommon to find

somatization in the presence of previously diagnosed physical illness. For example, the children studied by Minuchin, Rosman, and Baker (1978) were categorized into two groups, one of which was considered to have a "primary psychosomatic disorder, [or an] emotional exacerbation of the already available symptom (p.29)." These were children with metabolically documented diabetes, but whose symptoms and hospitalizations were triggered by the presence of psychological stress. Although Minuchin, Rosman, and Baker formulated the family systems theory of psychosomatic symptoms based upon information from those children and their families, the presence of organic illness prior to the development of similar psychogenic ailments supports the hypothesis that somatized symptoms are modeled after pre-existing physical disease.

Social learning theory contains the element of social interaction that is not prominent in the previously mentioned psychological orientations. Bandura (1977) stated social learning theory involves "continuous reciprocal interaction of personal and environmental determinants (p.11)," which affects one's psychology and behavior. Humans are self-regulatory, meaning they affect their environment, which in turn affects humans and their cognitions to produce consequences to actions. The cycle of interaction then perpetuates to create a dynamic relationship between our thoughts, our surroundings, and ourselves. An emphasis on the circle of influence is also an essential component of the next theoretical perspective on somatization discussed here, family systems.

Social learning theory is considered an influential theory contributing to the understanding of somatization and its development, but it has not been widely used as the foundation for the treatment of this problematic behavior. Though I know of no somatization treatments that are based exclusively on social learning theory, Mullins and

Olson (1990) and Mullins, Olson, and Chaney (1992) have combined it with family systems theory and CBT techniques to form an approach to treating child and adolescent somatoform disorders. This innovative model is discussed further in the Family Systems Orientation section below.

In sum, the behavioral theories of operant conditioning, which includes the sick role, cognitive behavioral therapy, and social learning theory, each put forward different perspectives of somatization. However, a commonality can be found amongst them all. These theories and the treatments based off of them concentrate on the process of reinforcement and its role in the development and maintenance of somatized symptoms. Operant conditioning and the sick role look to outside, external sources for reinforcement, whereas cognitive behavioral therapy focuses inward to the reinforcing power of thoughts and appraisals of one's experiences. Social learning theory takes yet another approach by acknowledging the potential effects of vicarious and self-reinforcement, whether internal or external.

Family Systems Orientations

The application of family systems theory to somatization makes a dramatic leap not seen in any other theoretical orientation. Although some theories consider the environment or the context of the identified patient to be one of the many variables that combine to form symptoms, family systems theory goes one step further to highlight and concentrate on the context. It removes the focus of psychopathology from the symptomatic individual to the entire system in which the individual lives, namely the family. Based on this theory, to understand why a person is somatizing and how to treat the symptoms one must look to the context of the family.

In his summary of General Systems Theory, Green (1980) clarifies how systems theory, which was originally applied to biological systems, pertains to families. He states that families are open systems, which means they continuously interact with the environment and are in a constant state of flux. All open systems are composed of multiple components organized hierarchically. Not only are families composed of subsystems, such as the marital, parent-child, and sibling systems, which include the individuals' systems, but families are also included in the larger system of the community, which is a part of the even larger cultural system. All of the component subsystems are connected to create a whole, and any change in one of the subsystems ripples out to affect the other components. For example, illness in an individual will lead to change within the family, and reciprocally, change or problems within the family will lead to modification in the individual, possibly expressed as illness. *Circular causality* is a term that describes the pattern of mutual influence between and amongst components of the system. Extra-familial changes are processed through the specific intra-familial interaction patterns to determine behavior. This means the same environmental stimulus, such as unexpected unemployment or death of a grandparent, does not result in the exact same response in every family. Whereas some homes may be thrust into chaos, others may be relatively unaffected under the same circumstances. Additionally, it is the nature of systems to attempt to maintain homeostasis via negative feedback loops and control change through positive feedback loops. Healthy family systems must find the balance between this morphostasis and morphogenesis to prevent turmoil and still accommodate change.

Green's summary continues to explain that all open systems also have semipermeable boundaries that form the structure of the system. These boundaries determine the ease with which the family can relate to those outside of the family sphere. Due to the integrated configuration of influence, the family is greater than the sum of its parts, and the individual cannot be fully understood removed from the context of the family. Based upon this assumption, all studies on somatization that fail to consider the familial element fall short in explaining the etiology and maintenance of the symptoms.

Structural family therapy.

One of the first researchers to employ family systems theory to somatization was Salvador Minuchin, one of the most influential of all family therapists and primary founder of structural family therapy. Minuchin and his colleagues from the Philadelphia Child Guidance Clinic and the Children's Hospital of Philadelphia, Baker, Rosman, Liebman, Milman, and Todd (1975) made a distinction between what they termed "primary and secondary psychosomatic symptomatology (p. 1032)." Primary psychosomatic symptomatology involves the emotional exacerbation of a previously existing organic ailment. For example, an asthmatic child begins wheezing when emotionally upset. Secondary psychosomatic symptomatology is the direct transformation of emotional distress into physical symptoms without a preexisting physiological disorder, such as in the case of anorexia nervosa. Although a distinction is made between these two types of psychosomatic illness, the theory of the family organization as it pertains to the development of these disorders can be applied to both types of psychosomatic symptomatology (Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975).

Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975) focused their theory of the development of somatization in children. They posited that three requisite factors must be combined in order for children to develop extreme psychosomatic illness. First, the child must have a physiological vulnerability, although the necessity of this factor is questionable in the case of secondary psychosomatic symptomatology. Next, the presence of four family transactional patterns, enmeshment, overprotectiveness, rigidity, and lack of conflict resolution, is compulsory. These family transactional patterns will be further explored below. Lastly, the role of the sick child is crucial to the family's method of avoiding conflict, and this role reinforces the child's symptoms. These families tend to include the sick child in three patterns of involvement to evade conflict: triangulation, parent-child coalitions, and detouring. In triangulation the ill son or daughter is placed in a position that requires him or her to side with one parent or the other in a disagreement. The symptomatic child is firmly united with a parent in opposition of the other in a parent-child coalition. Detouring involves both parents uniting in their concern for the sick child, while disregarding their conflicts. Occasionally, parents come together to blame the ailing child for the burdens he or she brings to the family.

The four characteristic transactional patterns of these families are explained by Minuchin, Rosman, and Baker (1978) and Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975). Extremely enmeshed families are characterized by very permeable boundaries between subsystems, meaning individuals have very little autonomy or personal space and children may at times act parental in some way. The family, rather than individuals, has thoughts, feelings, and communications. The interdependence of family members is excessive, and perceptions of individual members are poorly defined.

Psychosomatically ill children come from families that are extremely nurturing and concerned about each other to the point of being overprotective. This is another method by which the ill child is prevented from maturing and becoming autonomous. While parents and siblings steadfastly protect the sick child, the symptomatic child can also be responsible for protecting the other family members by using his or her ailments to distract the family from potential conflict. Psychosomatogenic families are extremely rigid, are overly invested in maintaining homeostasis, and have been unable to make accommodations for change. As a result of their constant attempts to ward off change, family members are chronically stressed but insist there are no acknowledged problems except that of the child's illness. Again, a psychosomatic child will become ill to divert discord when there is pressure for the family's rigid patterns to be amended. Because these families have such a low tolerance for conflict, disagreements often are avoided or denied leaving them unresolved. Since no resolution is ever reached, the same disputes repeatedly threaten the family and activate the family's defenses against conflict, such as a psychosomatic child's symptoms.

Physiological evidence was found that indicated that (a) when children with psychosomatic diabetes are exposed to parental conflict, the children respond metabolically in a manner that induces symptoms, (b) parental emotional arousal decreases in the presence of the sick child, even though the child becomes emotionally aroused to the point of becoming ill, and (c) psychosomatically ill children respond physiologically more dramatically to familial conflict and have more difficulty returning to baseline than control groups (Minuchin, Rosman, & Baker, 1978). Wood, Watkins, Boyle, Nogueira, Zimand, and Carroll (1989) continued in this vein of research to explore

physiological evidence in support of the psychosomatic family model. They compared the families of children diagnosed with Ulcerative Colitis (UC), Crohn's Disease (CD), or Recurrent Abdominal Pain (RAP). Although all three disorders have similar gastrointestinal symptoms, UC and CD have organic pathology that is exacerbated by psychosocial factors, whereas RAP has no known organic pathology and is thought to be an expression of emotional disturbance. They found that enmeshment, rigidity, overprotection, poor conflict resolution, triangulation and marital dysfunction were correlated to each other to form a functional model of the psychosomatic family, and these features were positively correlated with metabolic evidence of disease activity. Although data linking marital functioning and triangulation to disease chronicity indicates that those two features are maladaptive for the patient, disease activity was negatively correlated with enmeshment, overprotection, conflict avoidance and resolution indicating these elements may be adaptive or neutral for the patient. It is possible that the concept of the psychosomatic family may actually be composed of two clusters "marital/triangulation and enmeshment/overprotection/conflict (Wood, Watkins, Boyle, Nogueira, Zimand, & Carroll, 1989, p. 409)." Based upon these findings, the researchers suggest the model of the psychosomatic family may need to be reconceptualized to include the possibility that some aspects of these transactional patterns are beneficial and protective. Relatively little has been written specifically on structural family therapy and the treatment of somatization. However, the combination of all forms of family systems theory with other therapeutic techniques is discussed below.

Family systems orientations combined with other theoretical orientations.

There is a growing body of literature regarding the combination of family systems theory and techniques with other theoretical approaches. Dickman and Prieto (1987) blended attachment theory and family systems theory to conceptualize and treat a child with psychogenic vomiting. They theorized that particular attachment styles determine behavior that then functions to preserve the subsystem organization of the family. Based upon their theoretical conceptualization, treatment addressed both the inadequate attachment problem and the structural problems of the family.

Medical family therapy is a biopsychosocial approach merged with family systems ideas that has been adopted by McDaniel, Hepworth, and Doherty (1992) to conceptualize somatization. Although they emphasize the influence that psychosocial factors, such as the family's communication style, can have on physical symptoms, McDaniel, Hepworth, and Doherty do not subscribe to the detailed psychosomatic family model proposed by Minuchin, Rosman, and Baker (1978). Based solely upon their professional observations, these clinicians note that severely somatizing patients come from families whose interaction patterns function to avoid or dampen emotional pain. The somatic symptoms experienced by these patients are considered to be communications that could not be expressed verbally. These researchers also move beyond the family to hold Western society's mind-body dualism and somatic fixation as partially responsible for the development of somatization in individuals.

The developers of medical family therapy, McDaniel, Hepworth, and Doherty (1992) combine therapeutic as well as theoretical ideas to for this model. Collaboration with the somatizer's physician is recommended for the entire length of treatment but

especially during the referral stage. Their recommendations for the early stage of treatment focus on 1) joining with the patient and his or her family by enlisting their help in gathering information about symptoms, work to understand the meaning of each symptom to the patient, identifying changes in the patient's role in the family, and creating a genogram; 2) not pressing the psychological source of their ailments by utilizing medical language, focusing on symptoms, and avoiding the use of too much emotional language; 3) helping them tolerate uncertainty about their illness. In the middle phase of treatment, McDaniel, Hepworth, and Doherty (1992) suggest 1) collaborating with the patient and family to create a mutually acceptable definition of the problem, 2) exploring how they respond to acute and chronic stressors, 3) gradually increasing the use of emotional language and decreasing the focus on somatic symptoms, 4) reinforcing increase engagement in relationships instead of symptomatic behavior and exploring the risks associated with getting well, and lastly 5) avoid psychosocial fixation by continuing to collaborate with the patient's physician. The later phases of treatment in McDaniel, Hepworth, and Doherty's (1992) model are extended preparation for termination, which is often especially difficult for somatization patients. These clinicians recommend 1) working with the patient and family to predict setbacks, 2) write a "prescription for illness" (McDaniel, Hepworth, & Doherty, 1992, p. 148) with the entire family that details what they would have to do to bring back the patient's symptoms, and 3) terminate with the patient and family but slowly taper off to meeting once a month to once every three months, etc. Part of treatment can also be to aid the medical providers in tolerating uncertainty about the patient's symptoms.

Family systems and social learning theory were synthesized to form an integrated concept of and treatment approach for somatization and somatoform disorders in children (Mullins & Olson, 1990; Mullins, Olson, & Chaney, 1992). These researchers state that somatization requires the presence of a social learning history of observation or personal experience of illness, a dysfunctional family, a stressful, distressing situation (Mullins & Olson, 1990), and a predisposition to express stress somatically (Mullins, Olson, & Chaney, 1992). A dysfunctional family was defined as including very strict rules of conduct, lofty expectations for accomplishments, a dysfunctional marital relationship, or pathology of personality (Mullins, Olson, & Chaney, 1992). Seventy-one percent of the 41 somatoform families studied were considered to be dysfunctional (Mullins & Olson, 1990). The significant presence of dysfunction in these families supports the general hypothesis that pathology within the family contributes to the etiology and maintenance of childhood somatization. These researchers suggest that treatment should be carried out in a collaboration of biomedical and psychosocial health providers that first involves a thorough assessment in which the presence of a model is determined, antecedents and consequences of the somatization behavior are evaluated, the individual's understanding of their illness is discussed, the nature of the stressful situation is explored, and the function of the symptom in the context of the family is determined (Mullins, Olson, Chaney, 1992). The actual treatment involves removing reinforcement for the somatization behavior, creating reinforcement for well behavior, cognitive restructuring and relaxation training for the individual, and family therapy (Mullins, Olson, & Chaney, 1992). In a small evaluation of 20 families with a child with a somatoform disorder,

Mullins, Olson, and Chaney (1992) report that the symptoms of 90% of their patients resolved in 2-15 days of treatment and had not returned at follow-up.

To summarize, systems theory provides psychologists with a unique angle from which to view and conceptualize somatization. By considering the context in which somatization takes place, the source of the pathology is removed from the individual expressing the physical symptoms. Circular causality prevents any one person or any event from being blamed for the onset of the behavior. The theoretical model of the psychosomatic family originated by Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975) goes far to elucidate the nuances of interaction and structure within families that can contribute to the formation and maintenance of somatization. The detailed construction of this model and that of researchers continuing to explore somatization from a systemic orientation provides many windows of opportunity for treatment.

Social Oppression and Feminist Psychology Orientations

Extending past family systems theory's focus on the family, the theoretical framework reviewed in this section based on social oppression literature and Feminist psychology emphasizes society at large as the source of somatization. A conglomeration of sociological, psychological, and historical literature indicates that psychopathology, including somatization, is related to social disempowerment, i.e. oppression. Data indicating that somatization occurs more frequently in traditionally disadvantaged groups, such as women and particular ethnic groups in the United States (Mitchell, 2000) raise the possibility that oppression is a contributing influence on the development and expression of somatization. For example, compared to men, women are reported to display higher prevalence of somatization disorder and conversion disorder as defined by

the American Psychological Association (2000), the ICD-10 definition of somatization disorder (Gureje, Simon, Ustun, & Goldberg, 1997), unexplained physical symptoms (Kroenke & Spitzer, 1998), hysterical conversion (Akagi & House, 2001), and an abridged somatization construct, the Somatic Symptom Index (Escobar, Rubio-Stipec, Canino, & Karno, 1989). Similarly, several minority ethnic groups living both within Western societies as well as within their own nations of origin are reported to have higher prevalence of somatization when compared to Caucasian groups. Asians living in the United Kingdom compared to Caucasians in the UK (Farooq, Gahir, Okyere, Sheikh, & Oyebode, 1995), non-Cuban American Hispanic youths compared to Cuban American and European American youths (Pina & Silverman, 2004), Black Americans compared to White Americans (Zhang & Snowden, 1999), South Americans compared to North American, European, Asian, and African peoples (Gureje, Simon, Ustun, & Goldberg, 1997), and depressed Thai patients compared to depressed European patients living in Thailand (Bourne & Nguyen, 1967) all displayed higher rates of somatization as measured in a variety of ways.

Feminist psychology and other supporting areas of research attempt to answer the complex question of how is oppression might be related to somatization. They begin with two basic tenants of feminist psychology, which state that the external reality of people's lives influences people's problems and that symptoms can be understood to be survival techniques used to manage that external reality (Enns, 1997, p. 8). Primarily based on this foundation, feminist psychology has contributed to our understanding of how patriarchy as a form of oppression influences somatization in three ways: the diagnosis of somatization as an act of oppression, somatization as a consequence of oppression, and

somatization as a protest against oppression. Although these are three separate concepts, they are not mutually exclusive and most likely overlap and interact with each other. They are more fully discussed below.

Diagnosis of somatization as an act of oppression.

Literature based on feminist psychology tells us that being diagnosed with somatization, as it is called in modern times, or hysteria, as it was commonly called for most of human history, is itself an act of oppression in several ways. For much of recorded history, medical systems, which were and continue to be male-dominated, have used hysteria as a label to disempower and denigrate women by providing biological theories that establish women as spiritually, physically, mentally, and psychologically weaker than men. These theories have been used to justify men's dominance in the social hierarchy, women's limited opportunities to participate in education and employment, and the dismissal of efforts to combat such inequalities, as well as the women who make them, i.e. feminism and feminists. Additionally, the assumption that women are prone to somatize may have led to the withholding of adequate medical care for women.

The evolution of hysteria as a disempowering label has a long and complex history. The term *hysteria*, which is etymologically rooted in the Greek word for womb *hustera*, is a concept that has been traced within medical literature as far back as Egypt in 2100-1900 B.C.E. and was originally used to describe a wide variety of illness behaviors in women thought to be the consequences of a wandering womb (Thompson, 1999). With the influence of monotheism and ecclesiastical Christian writers' demonizing of sexuality, especially that of females, an anomalous uterus was understood to be an indication of aberrant sexuality making hysteria a sign that a woman was "more or less

willfully possessed, bewitched, in league with the devil, and even heretical" (Veith, 1965, p. 46). To be diagnosed with hysteria meant that a woman was sinful; her illness was the literal embodiment of evil. Medical science was limited during that time, and hysteria was used as a "catch-all" diagnosis that was applied to everything from epilepsy to amenorrhea, making it a very commonly diagnosed disease that, in effect, marked nearly every woman as evil. Ussher (1992) theorizes that being spiritually labeled in this way by the misogynistic European clergy, "contributed to her [the hysterical woman's] subjugation, maintained her position as the Other, and prevented her from challenging the One – men" (p. 53).

Throughout the 18th century, women were thought to be physically dependent upon both men in general and sex with their husbands. The accepted theory of the time stated that a prolonged span without exposure to semen would cause the uterus to wander in search of moisture and cause hysteria (Veith, 1965). Pregnancy was believed to anchor the womb to prevent its wandering, so physicians prescribed pregnancy for married women with hysteria (Thompson, 1999; Veith, 1965) and marriage for hysterical widows and unmarried women as recently as 1840 (Laycock as cited in Silverstein & Perlick, 1995). The medical establishment's dictum that women will be unhealthy unless they are married implies that women are incomplete without men. This theory, which used a quasi-biological model to reify the idea of woman's place as below that of man, supported male social dominance as the natural order.

With the rise of Modernism, science became a defining element in the construction of truth, and biological "facts" became more influential than theological beliefs. Consequently, "woman's supposed physical infirmities won out over her moral

defects as the rationale for male supremacy" (Ehrenreich & English, 1973, p. 7). During the Victorian Era, belief that middle and upper class women had inherently weak physical constitutions kept generations of these women isolated, restricted to the home, and excluded from the male realms of higher education, employment, and politics lest they overtax their fragile bodies and develop hysteria. This "cult of female invalidism" (Ehrenreich & English, 1973, p. 17) was authenticated by the medical system that perpetuated the myth that femininity was synonymous with being sickly, i.e. hysterical. The financial ability to maintain a hysterical, ornamental wife who was completely idle as the result of her sickness provided Victorian era men with status that could not be achieved in any other way and was another reason to reinforce women's dependency on men. Based on the principle of conservation of energy, Victorian physicians theorized that if a woman was educated and energy was used by her brain to enhance her mental capability, she would not have enough energy to devote to reproduction and the uterus, and hysteria would be the result (Ehrenreich & English, 1973; Showalter, 1985; Silverstein & Perlick, 1995; Thompson, 1999; Ussher, 1992). Additionally, post-Darwinian psychiatrists considered women's "natural" role to be that of reproducer and nurturer; deviation from this role to be a thinker and pursue educational goals was unnatural and would result in "nervous disorders," of which hysteria was one (Showalter, 1993). These arguments against the education of women began partly in protest against the first wave of feminism that spread across Europe near the end of the 19th century.

As more upper and middle class women became disenchanted with their confined lives of forced leisure, they made strides toward equality, even though each step along this path was met with resistance. Every independent act by a woman was

conceptualized as hysteria (Ehrenreich & English, 1973), and this diagnosis was given to most outspoken, rebellious women (Ussher, 1992). At this time, hysteria was generally accepted to be more psychologically than physically based, so to label a woman as hysterical was to brand her as crazy. Patriarchal society labeled the rebellious woman's "campaign for access to the universities, the professions, and the vote as mentally disturbed" (Showalter, 1985, p. 145). By "dismissing women's anger as illness – and so exonerating the male oppressors... [they were] dismissing women's misery as being a result of some internal flaw" (Ussher, 1992, p. 167). Based on psychiatric science, the diagnosis of hysteria "physicalized, individualized, and depoliticalized" (Cushman, 1995, p. 107) women's complaints and attempted to firmly place women back in their places confined within the "gilded cage" (Ussher, 1992, p. 88). The association of feminism and hysteria continues today as an attempt to discredit women's political protest (Bartholomew, 1998; Showalter, 1997), as do the pejorative connotations linking hysteria and somatization to the stereotype of women as overly dramatic and irrational (Kirmayer & Santhanam, 2001). The diagnosis of mass hysteria also has been used similarly to "marginalize ethnic or ideological minorities holding dissident, unpopular or unfamiliar beliefs that differ from mainstream Western standards of normality" (Bartholomew, 2000, p. 156).

The advent of Freud and Breuer's seduction theory (more fully discussed earlier in this paper) in 1895 was concurrent with the fin-de-siecle Feminist movement in Europe. In this psychological theory, we see one of the first attempts to acknowledge the negative impact patriarchy can have on women; sexual abuse perpetrated by fathers on their daughters is designated as the source of hysterical symptoms (Breuer & Freud,

1957). However, just a year after publishing this controversial theory, Freud published the Oedipal theory in which the origin of hysterical symptoms was relocated to be within the intolerable imaginings of the afflicted women (1896/1948). Although Oedipal theory neither denied the existence of actual sexual abuse nor isolated women as hysterics, it did remove the onus of hysteria from patriarchy and returned it to the patient, who was usually a woman. It is unclear exactly why Freud chose to revise his theory in this way; many have speculated about his motivations (see Malcolm, 1981 for a more complete discussion), and some have suggested that he manipulated patient data to support his new theory in order to alleviate the self-image of Victorian men (Rush, 1996).

When psychological theories became the prominent explanations of hysteria, the female body was granted a limited reprieve, but hysterical behaviors were then conceptualized as "mere willfulness" (Porter, 1993, p. 266), and this made it even easier to blame the victims of hysteria for their own sickness. In general, psychological theories about emotions and symptoms distract from the "social problems and inequities that are signaled by the emotion" (Kirmayer & Young, 1998, p. 427) or symptom. During much of the Victorian era, women were traditionally provided excessive medical care for their somatized symptoms in lieu of treatment for their psychological suffering or acknowledgement of the socially oppressive origin of their symptoms. This was a time period during which medicine and physicians were still establishing themselves as the primary healing profession opposed to midwives, herbalists, and healers (Ehrenreich & English, 1973). It behooved medical doctors, who were almost exclusively men since women were prohibited from higher education, to cast women, especially wealthy women, in the sick role; conceptualizing women as sick gave physicians a plethora of

patients and simultaneously discredited the competing female healers and midwives (Ehrenreich & English, 1973). However, in the post-Freudian western world during the second wave of feminism, feminist psychologists began to theorize that the opposite had become more common. Many posit that legitimate organic symptoms are being ignored, incompletely investigated, or dismissed as psychogenic when physicians blame women for their symptoms and assume that patients are being merely "hysterical" (Munch, 2004). It is hypothesized that the medical system, which is patriarchal in nature, is using the diagnosis of hysteria, contemporarily defined as somatization, as a means by which they can deny women equality, fair medical treatment in this instance (Munch, 2004).

Somatization as a consequence of oppression.

The second model of somatization presented by feminist psychology simply posits somatization is the result of oppression, specifically that being a victim of oppression is stressful, and stress then results in somatization. Siegrist and Marmot (2004) propose a causal link between social inequalities similar to oppression and overall well-being, including mental health, as well as poor physical health. They posit that self-efficacy and self-esteem are components of positive self-experience, and that "enhanced stress responses" (p.1464) will likely result if these aspects are hampered by a negative psychosocial environment, such as an oppressive social world, which in turn impair health and well-being. Essentially they hypothesize that by living in an oppressive society, the underprivileged are stressed by their disempowerment and that this stress is deleterious to physical and mental health. Support of this hypothesis comes from Terre, Carlos Poston, Foreyt, St. Jeor, and Horrigan (2004), who reported that a low internal locus of control, related to self-efficacy, is correlated with somatization, and by Godin

and Kittel (2004), who explored how a segment of one's social sphere, the work environment, can impact an individual's mental and physical health. Godin and Kittel (2004) found that employment environments in which the employees experienced low control, low social support, and were poorly rewarded for their efforts were related to higher levels of somatization and other measures of physical and mental health. King (2005) emphasizes that "experiences of discrimination are stressful to the extent to which they are appraised as central or important to the personal well-being of members of oppressed groups" (p.203). Her data support the theory that prejudice is stressful because one perceives the negative interpersonal experience to be the result of discrimination against one's own gender/ethnic group, making it a personal threat.

Gender-based discrimination has been linked to somatization, as well as several other psychiatric symptoms. Landrine, Klonoff, Gibbs, Manning, and Lund (1995) determined that subtle "everyday" sexist discrimination is responsible for more symptom variance in women than generic stressors, such as getting fired or losing one's wallet. Interestingly, the percentage of somatization variance explained by reports of both recent and lifetime sexist discrimination differed significant depending on the ethnicity of the female participants suggesting a complex relationship between gender and ethnicity. Women of color were more influenced by lifetime sexism than were white women. These researchers propose a stress-diathesis model to explain how generic and discriminatory stressors influence symptoms. Generic stressors are thought to be the diathesis that predisposes women to symptom development, and sexist discrimination experiences are the stressors that trigger the symptoms. Additionally, Klonoff, Landrine, and Campbell (2000) determined that high rates of sexist discrimination experiences

explained the differences in psychiatric symptom rates between the genders. They found that only women who experienced frequent sexism displayed more symptoms, including somatization, than men. Women who did not experience high rates of sexual prejudice had symptom rates similar to those of men. This study did not include brutal acts of misogyny in its measure of sexism, but the researchers hypothesize that gender-specific stressors, such as sexual abuse and domestic violence experiences, strongly influence the elevated rates of psychiatric symptoms in women.

It is theorized that traumatic events, in general, and gender-specific traumas, in particular, cause somatization. Although men and boys are not excluded as victims of rape, childhood sexual abuse, or domestic violence, women and girls are more often the victims of these crimes (Root, 1996). Even if not specifically targeted as victims, all females are held in "domestic captivity" (Root, 1996, p.363) by living under this threat of violence, which contributes to male domination, and the resulting stress may lead to somatization. Although the manner in which trauma results in somatization has yet to be determined, Engel (2004) hypothesized that "traumatic events may lead to MIPS [multiple idiopathic physical symptoms] and that PTSD [posttraumatic stress disorder] may be a mediator of that effect" (p.192). This hypothesis is supported by Escalon, Achilles, Waitzkin, and Yager (2004), who found that PTSD was the best predictor of somatization in American female veterans. Another theory about the relationship between abuse and somatization comes out of relational theory, an offshoot of object relations. From this theoretical orientation, Arnd-Caddigan (2003) proposes that somatization is the result of a failure to create linguistic meaning out of the emotions created by abusive experiences, which leaves the individual with nothing but the somatic

aspects of the intensely affective experiences. This develops into a pattern in which the abuse survivor somatically experiences emotions, and this bodily existence results in somatization.

Childhood and adult sexual abuse histories and domestic violence have been linked to somatization. Walker, Katon, Roy-Byrne, Jemelka, and Russo (1993) found that patients with histories of severe sexual maltreatment had significantly greater numbers of medically unexplained symptoms and that the greatest predictor of severe sexual victimization was female gender. Stein, Lang, Laffaye, Satz, Lenox, and Dresselhaus (2004) report that a history of sexual assault was associated with significantly higher somatization scores in American female veterans. Modestin, Furrer, and Malti (2005) investigated how somatization was specifically predicted by the trauma of severe child sexual abuse. Although childhood sexual abuse predicted somatization, sexual assault in adulthood predicted only borderline personality characteristics and not somatization. Creed, Guthrie, Ratcliffe, Fernandes, Rigby, Tomenson, Read, and Thompson (2005) examined the relationship between sexual abuse, impaired functioning, and treatment response in patients with irritable bowel syndrome (IBS), considered by some a modern somatization diagnosis. They found that self-reported sexual abuse is associated with somatization, and although those reporting sexual abuse display lower functionality before treatment, they also respond more favorably to treatment than those without a sexual abuse history. Intimate partner violence has been linked to somatization symptoms. In a study with specifically Mexican American female participants, Lown and Vega (2001) reported physical and/or sexual intimate partner violence was associated

with self-reports of "fair/poor" mental health and higher scores on a somatization screener, as well as poor physical health as determined by multiple measures.

In addition to active, obvious acts of oppression, patriarchy also exerts social control over women in more subtle ways, such as anger suppression, which can then influence the development of somatization. Those at the top of social hierarchies rarely encourage, permit, or even acknowledge the expression of anger from those who are at the bottom rung of the social ladder, since the open expression of anger and discontent by masses of oppressed people could pose a threat to the social order. In most patriarchal cultures, it is considered unlady-like, inappropriate, and unacceptable for women to be angry; many women have internalized this belief and continue to have difficulty even tolerating their own anger. This has led many women to suppress their anger at any cost, even their physical or mental health. Cox, Van Velsor, and Hulges (2004) found that women who divert their anger have higher rates of somatization than women who cope assertively with anger. Specifically, the highest rates of somatization were seen in women who divert anger by using anger internalization, in which they utilized self-blame and self-punishment to alter their anger, and externalization, in which they project their anger on others. Koh, Kim, Kim, and Park (2005) stated anger suppression has an indirect effect on somatization measures via depression. In their mixed-gender group of Korean participants, repressed anger was related to increased somatization only if the participants were also depressed. Although the authors mention possible cultural influences on somatization, they conclude "the transcultural factor...in the study seems small enough to be ignored" (p. 490). I think that it would have behooved the authors to have more fully considered cultural and gender norms related to anger.

Another subtle aspect of patriarchy is considered by Silverstein and Perlick (1995) in a discussion on the societal and familial prejudices against women pursuing success in realms traditionally reserved for men, such as political, academic, and professional spheres. They propose that success in "masculine" areas of achievement causes young women to question and devalue facets of their feminine identities, and the resulting ambivalence is expressed through anxious somatic depression, a combination of depressive, anxious, disordered eating, and somatized symptoms. They argue that this syndrome, once called hysteria, peaks in women during historical periods with evolving socially prescribed gender roles, because the transition causes conflict in nontraditional women who value both "masculine" and "feminine" pursuits, and during adolescence, because gender identity is of heightened importance when girls are transforming into women. The authors "attribute the high rate of this disorder among women not to some peculiar female weakness but to the gender biases that permeate most societies" (p.72). Discontent with the gender-based limitations experienced by women is stressed as a key factor in the development of symptoms, and the syndrome is believed to exist cross culturally.

Feminist psychology's theory that sexism causes somatization in women by being stressful could be applied to categories other than gender. Perceived discrimination in all of its various forms is a universally stressful experience, and heightened stress levels, whatever their exact cause, may be expressed as somatization. Ethnicity, gender, religion, disability, sexual orientation, body shape, health status, and many others are all characteristics on which society discriminately treats others. Although Showalter (1993) briefly mentions that gay activists and black activists are being labeled hysterical and

Kleinman (1986) remarks Communist China's oppression of its citizens may contribute to somatization, scant research exists that explores the possible relationship between different forms of discrimination and somatization, and what little does exist inconsistently supports this theory.

Somatization as a protest against oppression.

The third somatization concept that comes from feminist psychology is that somatized symptoms are acts of protestation against misogyny. This model also can be applied more universally to explain protest against other types of oppression as the source of somatization. The nature of oppression is to disempower its victims, and patriarchy specifically disempowers women. The resulting powerlessness prevented women from raising a political voice in objection to their inequitable treatment or, as was discussed previously, when organized groups of women began to articulate disapproval of their oppression in the late 1800's, Victorian society labeled their protests as madness. So women used madness as a form of protest. Their voices muted, their limbs paralyzed against political action, their anger swallowed, women were left with one tool with which to fight millennia of misogyny: their bodies. All other means by which to create social change were stifled, so women used their physical bodies to unconsciously express all that was denied them on a conscious level (Ussher, 1992). They highlighted their social plight by embodying their oppression in somatic symptoms. According to Cushman (1995) each type of symptom experienced symbolically represented a particular kind of silencing or limitation. Respiratory distress and allogia, the inability to speak, represented the prohibition against open verbal expression. Paralysis and anesthesias signified women's inability to move about freely in public. Globus hystericus, the

sensation of having a lump in the throat, expressed the swallowed anger and misogynistic discourse stuffed down their throats. Willing participation in the "rest cures" and bed rest symbolized their confinement to narrowly defined roles. Hysteria has been envisioned as a metaphorical body language in which people can express themselves without words or conscious knowledge of their emotions (Kirmayer & Young, 1998; Showalter, 1997); French feminists in the 1960's went one step further and interpreted hysterical symptoms as a separate language, the "Mother Tongue that contests patriarchal culture" (p. 57), that is in need of decoding.

Juliet Mitchell (2000) emphasized, while hysteria is "the protest of the inferiorized...it is [also] the deployment of weakness as power" (p. 5). By reveling in frailty instead of fighting this pejorative characterization, Victorian women repossessed the label of hysteria and removed the sting of the appellation. Like racial minorities who have reclaimed racial epithets as their own, feminists in the 1970's embraced hysteria as the first stage in the feminist movement and as a source of pride (Showalter, 1993). One way of expressing this is that hysterical symptoms allowed women in the late 1800's to permit themselves to be guided by their emotions instead of relying on masculine logic and control. Today, feminist writers herald hysterics of the 19th century as "champions of a defiant womanhood, whose opposition, expressed in physical symptoms and coded speech, subverted the linear logic of male science" (Showalter, 1985, p. 5).

By wearing the guise of hysteria, afflicted women could express emotions and display behaviors that were considered inappropriate and immoral for their gender (Cushman, 1995). Somatized symptoms allowed Victorian upper class women the ability to protest their denigrated state by boycotting their household responsibilities as well as

to obtain sympathy from family members. However, the negative impact on men and the benefits for women were minor. While women became progressively disabled by this form of silent protest, most men were only mildly inconvenienced and remained oblivious to the underlying political message in their wives', daughters', and sisters' infirmity. Those in power tolerated somatization as a form of dissent and an expression of dissatisfaction, because it was an ineffective method of social change (Showalter, 1993). Elaine Showalter (1985) states:

> In its historical contexts in the late nineteenth century, hysteria was at best a private, ineffectual response to the frustrations of women's lives. Its immediate gratifications – the sympathy of the family, the attention of the physician- were slight in relation to its costs in powerlessness and silence (p. 161).

In other words, women were allowed to make themselves sick as a way to protest misogyny because men knew that it would not threaten their social dominance.

Criticism has been directed at the feminist reinterpretation of hysteria. Wilson (2005) expressed concern that in an attempt to fully explore the social context of somatization and hysteria that has been long ignored by the bulk of science, feminists overlook the potential real biological components than may predispose women to experience physical symptoms, experiences that are as important as other socially constructed variables. Chesler (1997) finds fault with the common feminist depiction of women as passive victims of patriarchy. She feels that "by buying into the myths that the patriarchal world has woven for them [and] by willingly marrying father figures, women contribute to their subjugation into permanent childlike roles of servitude" (p. 61). Similarly, Silverstein and Perlick (1995) stress the intergenerational influence mothers have on daughters as role models who can influence the next generation to challenge or accept traditional gender roles. The concept of hysterics as heroines has been contested.

Some feminist writers nearly deified the Victorian women with hysteria in famous case studies as a way to inspire, empower, and historicize their social movement. Although the manufacturing of saints may have been necessary in the 1960's, Showalter (1997) questions the usefulness of that action now: "Today's feminists need models rather than martyrs" (p.61). Ussher (1992) concurs that making Victorian hysterics into icons of modern day feminism is "ultimately useful only as a rhetorical device," (p. 291) and in fact continues to separate women from men, which is a disservice to both genders. Kirmayer and Young (1998) also question the usefulness of labeling somatization symptoms as strategic attempts to protest existing social structures, because "attributing more power and consciousness to the oppressed than they themselves experience, ...may delegitimate the very means they have stumbled on for protest" (p. 428)

In sum, this critique of feminist psychology's contribution to the understanding of somatization first reports the prevalence of somatization in women and ethnic minorities. As reported earlier, many sources report that non-Caucasian peoples and women have higher rates of somatization when compared to Caucasians and men. However, other studies provide data indicating no significant differences in the frequency of somatization between the genders (Beidel, Christ, & Long, 1991 as cited in Canino, 2004; Piccinelli & Simon, 1997) or cultural/ethnic groups (Bhatt, Tomenson, Benjamin, 1989; Chun, Enomoto, & Sue, 1996; Escalona, Achilles, Waitzkin, & Yager, 2004). Although this discrepancy could be explained away by a nearly infinite number of reasons related to the structure of the studies, it could also call into question the influence of oppression on the development of somatization. Additionally, some of the literature counters the data relating sexual abuse to somatization. Several studies have been conducted that fail to

find any significant difference on measures of somatization between participants with and participants without histories of abuse (Blanchard, Keefer, Lackner, Galovski, Krasner, & Sykes, 2004; Raphael, Widom, & Lange, 2001 as cited in Engel, 2004; Lackner, Gudleski, & Blanchard, 2004; Salmon, Skaife, & Rhodes, 2003). Although Nelson (2002) accepts that women with sexual abuse histories present with multiple physical symptoms, she speculates that the symptoms seen in adult survivors of sexual assault, especially in survivors of childhood abuse, may actually be the direct result of injuries sustained during the assault and not somatization at all.

Feminist psychology is another theoretical orientation that does not have recommendations specifically for the treatment of somatization. However, based on feminist therapy in general, hypotheses can be made about how this treatment modality would be applied to somatized symptoms. Social sources of problems of living, such as somatization, should be explored so that the oppressive environment is held accountable instead of isolating the problem within a "deficient" individual (Enns, 1997). It may also be helpful to recognize somatization symptoms as "behaviors that arise out of efforts to influence an environment that is constricting or oppressive" (Enns, 1997, p. 10). Women are not faulty for experiencing symptoms, but their symptoms might signify that attempts to counter the oppressive society they live in are not wholly successful. Their symptoms as a form of communication should not be stifled, but they could be redirected in a direct, productive way (Enns, 1997). Though the primary focus of feminist therapy is on the elimination of symptoms in the individual, part of treatment is focused on the advancement towards equality (Enns, 1997). Empowerment and self-nurturance are other means by which feminist therapy treats all problems of living, including somatization.

In summary, feminist psychology has broadened our understanding of somatization to include a purely social etiology that focuses on how oppression can result in negative mental health, in general, and somatized symptoms, in particular. This process has been presented in three intersecting and intermingling concepts. As an act of oppression, the diagnosis of somatization or hysteria was and is used to disempower women, to label them as "the Other" in order to isolate them from those in power, namely men, and to dismiss the feminist movement. As the result of oppression, somatization is understood to be a consequence of the stress induced by subjugation. Experiences of commonplace discrimination, brutal acts of misogyny, and the subtle influences of patriarchy are all thought to contribute to the stress of being a woman in a culture dominated by men. As a protest against oppression, somatized symptoms provided women the opportunity to communicate their outrage against their inequitable status and gave 20th century feminists a source of inspiration. These three concepts developed by feminist psychology increasingly are being applied to other forms of oppression, such as racism and classism, to further our understanding of somatization, and they serve to remind clinicians to consider the potential social and political circumstances of somatization. Treatment of somatization with feminist therapy would focus on acknowledging the oppressive origins of somatized symptoms, recognize symptoms as communications of one's oppression, and empowering the client to gain more control over one's life circumstances, to make strides towards equality on a social level, and to nurture and value oneself.

Summary

This review presented somatization from the perspectives of four dominant theoretical orientations in clinical psychology – psychodynamic, behavioral, systems theory, and feminist psychology. Beginning in Victorian Europe with Freud's study of women with hysteria, traditional psychoanalytic theory, self-psychology, and object relations make up the psychodynamic orientation that was discussed first. These theories state that somatization is a defense mechanism that converts overly intense emotions, which are often aggressive or sexual in nature, into physical symptoms, which may directly symbolize the internal conflict, in order to protect the self. A fragile sense of self with poor self-esteem and a limited ability to symbolize emotions or self-soothe are the key factors to the development of somatization process according to self-psychology and object relations, respectively. The second group of theories presented highlighted somatization as a behavior reinforced by external forces in the case of behaviorism and the sick role, by internal forces for cognitive behavioral therapy, and by vicarious and self-reinforcement in the instance of social learning theory. Systems theory was introduced third and emphasizes the context in which symptoms develop. It posits that somatization, via circular causality, is the result of dysfunctional family transactional patterns and develops as a means by which families can avoid conflict and change. Lastly, feminist psychology brings us full circle to Victorian Europe's hysterical women and reinterprets somatization as an act of, a result of, and protest against oppression.

In this exploration of psychological orientations, explanations of causal factors in the development and maintenance of somatization have traversed the spectrum from solely internal to purely external. Consequently, responsibility and blame for

psychogenic symptoms has similarly traveled the continuum from being given to the individual patients to the entire social system. The treatment of somatization from each of these different perspectives concentrates on what is believed to be the source of the problem and similarly shifts focus. Therapy primarily involves only the individual person with somatization in the psychodynamic orientations and the behavioral perspectives, the family and possibly other people in the community that interact with the somatizing individual in the family systems orientation, and the individual and the oppressive environment in which the somatizing client lives in feminist therapy. As different as all of these theories are, they each contribute to psychology's understanding of somatization and to the treatment of those who somatize. Now grounded in theory, this dissertation proceeds to examine how culture shapes somatization before contributing an original theory to the treatment of somatization.

Culture and Somatization

Epidemiology

Across the globe, numerous epidemiological studies on somatization have been performed. Although many researchers fail to report the ethnicity of participants, the cultural heritage and ethnic background of somatizers have been of great interest to some culturally conscious clinical psychologists and those in the ever-growing field of medical anthropology. Beginning with early anecdotal accounts, it became commonly reported that people of color somatize with greater frequency than Caucasians. Some psychodynamic literature purports that somatization is a "primitive" psychological defense mechanism that is used more commonly by people in "primitive" cultures who are developmentally psychologically immature (Bourne & Nguyen, 1967; Tseng, 1975).

It remains unclear how much ethnocentric or possibly even prejudiced beliefs might have influenced the development of this view. Asian and Hispanic cultures have been emphasized as associated with higher rates of somatization. However in recent years, the often taken for granted belief that somatization is more widespread in non-Caucasians has been challenged by multiple studies that report that somatization is ubiquitous within all cultures and that European descendents may, in fact, have higher rates of somatization than other ethnic groups. The heterogeneity within broad ethnic labels, such as Asian American or Latino, is significant and could dramatically alter the validity of blanket statements referring to such labels, including research on the prevalence of somatization. Level of acculturation is a crucial mediating factor on the presentation of somatization that is frequently overlooked in research. Additionally, the experience of being a cultural minority emmersed in the cultural majority is markedly different from the experience of being a person of color whose cultural background is the cultural majority. For example, a Guatamalan immigrant living in Boston and an African American residing in rural Mississippi are exposed to very different stressors and likely significantly more stressors than a native Guatamalan living in the Republic of Guatamala or an Ethiopian living in Addis Ababa. Consequently, data on these two kinds of groups of people of color, such as Chinese Americans and Chinese nationals, cannot be treated as equivalent and comparisons of majority culture persons and minority culture persons, such as Caucasian Canadians and Vietnamese Canadians, are likely to be complicated by additional cultural variables that are rarely fully acknowledged by researchers. All of the above topics will be discussed in greater detail below.

The proposal that people of Asian descent somatize psychological distress in lieu of expressing psychological symptoms has become deeply embedded in multicultural clinical theory and is commonly referenced in texts on multicultural psychology (Gaw, 1993; Sue & Sue, 1999). This notion was initially based upon anecdotes and clinical experience, but little research existed to either confirm or negate this impression (Bhatt, Tomenson, & Benjamin, 1989; Cheung & Lau, 1982; Okazaki, 2000). Now several research studies have compiled data that appear to support the hypothesis that Asians somatize more than Caucasians. Although numerous articles have been published reporting that Asians have high rates of somatization (Kim, 1999; Pang, 2000; Parker, Gladstone, & Chee, 2001; Srinath, Bharat, Girimaji, & Seshadri, 1993; Tseng, 1975; Westermeyer, Bouafuely, Neider, & Callies, 1989), only epidemiological inquiries that were designed to directly compare ethnic groups will be reviewed here.

In an epidemiological comparison of all the hospitalized "neuropsychiatric casualties" (p. 904) in the Vietnamese and American Armies during six months of the Vietnam War, 324 and 757 men respectively, Bourne and Nguyen (1967) reported that significantly more Vietnamese Army patients presented with "chronic anxiety reactions with somatization" (p. 909) than did United States Army patients. Although the authors felt that "similar combat conditions" (p. 904) and similar psychiatric approaches to military patients provided enough likeness to allow for comparison of these patients based on culture, some confounding factors remain. In addition to the absence of a clear definition of somatization, the authors did not report the ethnicities of the participants. Considering that the US military is comprised of people from a wide variety of races, cultures, and ethnicities, one must assume that this sample of soldiers with

neuropsychiatric conditions was also heterogeneous; the Vietnamese Army also was ethnically mixed by the use of Chinese draftees (Bourne & Nguyen, 1967). This makes one unable to compare these samples based on ethnicity, culture, race, or even nationality. Although combat situations may have been similar for each army, the experience of participating in a war in one's native country differs greatly from war experience on foreign soil. Consequently, the psychological stress to which the Vietnamese soldiers were exposed was likely qualitatively different than that of the American military personnel, which further confounds the results of this study.

When Chinese, Japanese, and Caucasian American college students were compared, Marsella, Kinzie, and Gordon (1973) found that the Chinese American group was the only one that appeared to manifest depression with a clearly defined somatization pattern. Both Japanese American and Chinese American participants commonly experienced gastrointestinal symptoms when depressed, but the Caucasian American group did not.

Primary care patients of Indian, Pakistani, and Bangladeshi descent residing in Britain were found to report significantly more somatic symptoms than British Caucasians (Farooq, Gahir, Okyere, Sheikh, & Oyebode, 1995). "Asian" ethnicity was the strongest sociocultural correlate in this study that utilized a measure of somatic symptoms validated for use in Urdu and English (Mumford, Bavington, Bhatnagar, Husain, Mirza, & Narghi, 1991). However, this measure did not distinguish between organic or somatized physical symptoms, weakening it as a valid measure of somatization. In another British study, people of Asian descent demonstrated a pattern of greater somatization than Caucasians, which was concluded to be related to higher rates

of anxiety (Bhatt, Tomenson, & Benjamin, 1989). These researchers admirably utilized a multifaceted method of determining ethnicity that included country of birth, preferred language, and religion, but since these three variables generally overlapped, they created three groups based on preferred language: English, Gujarati or Urdu. Compared to the English group, the Urdu group closely followed by the Gujarati group had significantly higher scores on the somatization measure that was administered in their language of choice. Although these researchers hypothesized that the differences in somatization prevalence might be due to differing levels of anxiety, they did not speculate on the possible causes of those anxiety differences or mention the possible impact of being a member of a minority culture as a possible stressor.

Asians are not the only racial or ethnic group believed to somatize more frequently than Caucasians. Latino/Hispanic people are also commonly reported to have a greater prevalence of somatization (De Snyder, Diaz-Perez, & Ojeda, 2000; Escobar, 1987). Multiple comparative studies have been conducted involving Latinos and Hispanic participants, several of them led by Javier Escobar, who has been a leader in the field of Latino/Hispanic epidemiologic research often specializing in somatization. In an exploration of somatization symptoms in a community sample of "non-Hispanic Whites" (Escobar, Burnam, Karno, Forsythe, & Golding, 1987, p. 714) and Mexican Americans in the Los Angeles area, a research group headed by Escobar found that Mexican American women reported significantly more somatization symptoms and more often met criteria for an abridged definition of somatization when compared to non-Hispanic White women. Interestingly, in male participants, ethnicity was not associated with somatization. In another investigation, Escobar, Rubio-Stipec, Canino, and Karno

(1989) compared the somatization symptoms of a community sample of Puerto Ricans to the data obtained in the previous 1987 study of Mexican Americans' and Non-Hispanic Whites' somatization scores. Puerto Ricans reported significantly more somatic symptoms than Mexican Americans, indicating that both Hispanic groups somatize more than Caucasians but that there is variation in prevalence between subgroups of Hispanics.

Greater although variable rates of somatization also were found in Hispanic subgroups of Floridian youths with anxiety disorders when compared to European American youths with anxiety disorders (Pina & Silverman, 2004). Though the participants reported origins from 12 different Caribbean, Central American, and South American countries, insufficient sample sizes required the researchers subdivide the participants into only three groups: European American, Cuban American, and non-Cuban American Hispanic/Latino. Both Hispanic groups were given the choice of completing the assessment in English or Spanish. In a parent report measure, Non-Cuban American Hispanic/Latino youths were reported to experience significantly more somatic symptoms than Cuban American or European American youths; this finding held true regardless of which language was utilized in the assessment of the Hispanic groups. When the Spanish-language group was asked to rate how distressing their somatic symptoms were, Cuban American youths reported more distress than Non-Cuban American Hispanic/Latino youths, who reported more distress than European Americans. However, when the same was asked of the English-Language group, the Non-Cuban American Hispanic/Latino group reported more distress than the Cuban American group followed by the European American group. It is possible that conglomerating people from so many ethnic backgrounds into the Non-Cuban American Hispanic/Latino group

has led to a misinterpretation of the data. This finding also reflects the multifaceted, complex nature of culture and suggests that a one-dimensional measure of culture is likely to be inadequate.

The two South American sites demonstrated notably higher rates of ICD-10 defined somatization disorder and the Somatic Symptom Index (SSI), an abridged definition of somatization, when compared to 13 other primary care sites in 12 nations around the globe (Gureje, Simon, Ustun, & Goldberg, 1997). This World Health Organization study revealed that the greatest overall prevalence of somatization disorder and SSI were found at the Santiago, Chile site at 17.7% and 36.8%, respectively; the Rio de Janeiro, Brazil site had the second highest rates at 8.5% and 32%. When compared to the international rates of 2.8% for somatization disorder and 19.7% for SSI the higher prevalence rates of these sites become more dramatic. This study supports the common conclusion found in all of the previously mentioned Hispanic/Latino somatization studies: there are higher rates of somatization in the Hispanic/Latino population when compared to other ethnic groups as well as differences among the subgroups of the Hispanic/Latino population.

To a much lesser degree than Asians or Hispanic/Latinos, people of African descent have been reported to display high rates of somatization (Binitie, 1987; Carey, Stein, & Zungu-Dirwayi, 2003; Gaw, 1993; German, 1983). In a comparison of the prevalence of DSM-III somatization disorder among "White, Black, Hispanic, and Asian Americans" (Zhang & Snowden, 1999, p. 134) across five different US communities, African Americans were diagnosed with somatization disorder significantly more often than any of the other three ethnic groups. However, when data from the Los Angeles site

was analyzed independent of the four other sites, African Americans were significantly less likely than Caucasians to have somatization disorder. Epidemiological studies comparing prevalence of somatization among people of African descent to that of Caucasians and other ethnic groups are rare, and those that do exist fail to support the notion that African Americans are more like to somatize.

Overall, an increasing number of studies are published that oppose the theory that people belonging to non-Western cultures somatize more frequently than people from Western cultures. Evidence is accumulating that 1) discounts specific ethnic groups as somatizing more than Caucasians and 2) all ethnic groups somatize with similar frequencies. In a review of the literature, Chun, Enomoto, and Sue (1996) concluded "little empirical evidence exists to support the notion that Asian Americans have a higher prevalence of somatization." (p. 349). This conclusion is supported by studies such as that of Hurwich and Tori (2000) who found that men from Hong Kong reported low rates of somatization even during the socially stressful transition from independence to Chinese rule. It was determined that elderly Chinese Americans reported lower rates of somatization than elderly Caucasian Americans (Raskin, Chien, & Lin, 1992). In the previously mentioned study conducted by Zhang and Snowden (1999), Asian Americans had significantly lower rates of somatization than White Americans at the Los Angeles site specifically and all five US sites overall. This same study also reported that when compared to White Americans, Hispanic Americans had lower somatization prevalence at the Los Angeles site specifically and equal prevalence over all five sites. In an investigation of female Caucasian and Hispanic primary care patients at a VA Hospital, somatization was not linked to ethnicity (Escalona, Achilles, Waitzkin, & Yager, 2004).

The hypothesis that somatization rates do not vary between ethnicities, developed versus developing countries, or Western versus non-Western cultures is supported by several articles based on analysis of data obtained from the World Health Organization Collaborative Project on Psychological Problems in General Health Care mentioned above. Despite higher somatization rates at the South American sites, Gureje, Simon, Ustun, and Goldberg (1997) concluded that generally "unexplained symptoms did not vary according to geography or level of economic development" (p. 989). Utilizing the same data set, Piccinelli and Simon (1997) concur that there are few differences across cultures in patterns of somatized symptoms. Gureje (2004) continued this analysis and notes that while the similarities between the Latin American sites support culture as being influential on somatic distress, cultural and economic development factors cannot sufficiently explain all of the incident differences across the sites. For example, there is no discernable cultural pattern to explain the lowest rates of somatization disorder, which were found in Japan, Italy, Nigeria, and England.

The research on the relationship between ethnicity and somatization remains contradictory and inconclusive. Most studies that attempt to quantify a concept as complex and as indefinable as ethnicity or culture are likely to have imperfections. One important factor that is often overlooked during discussions about ethnicity and race is the significance of intraethnic or intraracial heterogeneity. Overarching labels such as *African, Asian*, and *Latino* or *Hispanic* are used as though they refer to specific and homogenous groups of people, when in fact they are applied to extremely diverse conglomerations of persons that vary in "cultural origins, religion, immigration history, foreign/domestic upbringing, generational upbringing, gender, and other characteristics"

(Tanaka, Ebreo, Linn, & Morera, 1998, p.59). The diversity that exists within these terms of race makes comparison of the subgroups complicated (Salant & Lauderdale, 2003). When data pertaining to several subgroups are averaged together under an umbrella race term, potential epidemiological differences are masked. For example, if the SSI prevalence data from the Indian (19.6%), Japanese (10.5%), and Chinese (18.3%) sites of the World Health Organization Collaborative Project on Psychological Problems in General Health Care (Gureje, Simon, Ustun, & Goldberg, 1997) were averaged to form an overall Asian prevalence, the resulting figure (16.1%) would only slightly differ from the global overall prevalence (19.7%). The overall Asian prevalence percentage would not reflect that the Indian and Chinese rates were very similar to the global average and that the Japanese site was nearly half of the global average; important differences would go unnoticed.

The heterogeneity of American racial minorities is significant and growing. The Black American population is becoming increasingly diverse through migration primarily from the Caribbean and African nations (Miranda, Siddique, Belin, & Kohn-Wood, 2005). Asian Americans are comprised of 50 different subgroups that utilize more than 30 languages (Chun, Enomoto, & Sue, 1996), and the ethnic, cultural, and socioeconomic heterogeneity of the Asian immigrant population continues to increase (Salant & Lauderdale, 2003). The 2000 U.S. census information included 24 different subtypes based on nation of origin within the Latino or Hispanic ethnicity (U.S. Census Bureau).

Ethnic identity and level of acculturation are other key variables pertaining to issues of ethnicity and culture that are rarely acknowledged. While *ethnic identity* refers to the degree of identification one has towards an ethnic group and generally is more

applicable to minorities born in the "new" country, *acculturation* emphasizes the scope of knowledge one has of a culture and generally applies to immigrants (Sue, Mak, & Sue, 1998). Most literature on acculturation assumes that a Western culture is the one being adopted, and terms like *Westernization* and *Americanization* have been used as synonyms for acculturation. How acculturated one is to the host culture and how strongly one identifies with one's ethnic or cultural background determine how influential the beliefs associated with those cultures will be on behavior, including physical and mental health. It is not enough to simply note patients' country of birth or the ethnicity of their parents as an accurate measure of culture. As Marsella and Yamada (2000) comment, "Clearly, what is important is not an person's ethnicity, but rather, the extent to which they actually are identified with and practice the lifestyle of that group" (p.13). This distinction is even more important for the world's growing multiracial, multiethnic population, which often identifies with more than one ethnicity or cultural group.

Acculturation level and/or ethnic identity have played a small role in somatization literature to date. A scant number of somatization studies have commented on the importance of taking acculturation into account without actually incorporating it into the study (Bhui, 1999; Escalona, Achilles, Waitzkin, & Yager, 2004; Pang, 2000). Even less research has explored empirically the relationship between somatization and acculturation. Although level of acculturation was not a direct predictor of somatization, low to medium levels of acculturation were correlated with higher somatization scores in older, depressed, Mexican American women in the previously mentioned study by Escobar, Burnam, Karno, Forsythe, and Golding (1987). In an investigation of Hmong refugees, Westermeyer, Bouafuely, Neider, and Callies (1989) found that low levels of

acculturation were associated with higher levels of somatization. Though a little research exists on the relationship between acculturation and somatization, the studies to date seem to indicate that greater acculturation to Western cultures is correlated with lower levels of somatization and hence being less acculturated to European-based cultures and strongly identifying with one's culture of origin are correlated with higher somatization levels.

The discrepancies within the literature about minority somatization rates compared to Caucasian prevalence could be explained in several ways. Initial reports of higher prevalence in Asians were primarily based on hearsay and could have been highly influenced by racial stereotypes of Asians as having a cold, unsophisticated culture that lends itself to a primitive syncretism akin to somatization. Later epidemiological studies rarely take the context of the investigation into consideration. Cheung and Lau (1982) found that somatic complaints were predominant in medical settings in which Asian participants anticipated there to be a focus on the body, but somatic complaints merely accompanied the presentation of psychological symptoms in psychiatric settings in which there was no assumption about a concentration on the physical body. This suggests that studies performed in medical environments may produce inflated rates of somatization for Asians, and possibly other minority groups, which create a prevalence difference between the cultural groups that does not truly exist.

Overall, I find the somatization epidemiological differences between minority and majority culture peoples difficult to fully explain. One could argue that the differences, if any truly exist, are not due to anything inherent within these minority cultures but rather reflective of American social structure and the difficulty of the immigration experience.

Being a minority in the United States exposes African Americans, Asian Americans, and Latino/Hispanic Americans to added stresses, such as racism, classism, and less dramatic but more pervasive discrimination and oppression, when compared to Caucasian Americans. Likewise, immigrants or refugees have been the focus of several studies, and as a whole this population has experienced significantly more general stress and trauma, which is correlated with somatization, than the average Caucasian American to whom they are later compared. It appears that the data indicating African and African Americans as greater somatizers when compared to European Americans are weakest, followed by the data on Asians and Asian Americans and the data on Latinos and Latino Americans are strongest. This is also the order, smallest to largest, of percentage of recent immigrants of these minority groups in the United States. Generally, there are fewer recently immigrated Africans to America than Asians and fewer recently immigrated Asians to the United States than Hispanic/Latinos. One could argue that somatization is more strongly correlated with recency of immigration or acculturation level rather than ethnic background. Though this may be a viable theory, there are not enough studies to neither confirm nor deny it. Another argument is that extreme forms of somatization vary little between ethnic groups, but that less severe somatization is normalized and sanctioned by many cultures via cultural beliefs. This is the conclusion I have reached and the argument I make in the following portions of this dissertation.

Cultural Beliefs and Their Influence on Somatization

In earlier sections, this dissertation has indicated that the degree of acculturation and the strength of one's ethnic identity moderate the influence of culture on somatization. Accepting these premises, this section explores specific cultural beliefs

and how they affect the expression, maintenance, and treatment of somatization. First, I will discuss language as a universal influence on thought and experience and therefore its influence on health, emotions, and behavior, including somatization. Then, the multidimensional nature of cultural beliefs and the fundamental influence of living in either a collectivistic or individualistic culture will be examined in terms of their pervasive effect on somatization. Emphasizing the group or the individual influences characteristics as varied as belief in fate to belief in the primacy of family, and all can impact somatization.

In this work, culture is broken down into component beliefs instead of being examined in its multi-layered whole for several reasons. Because the members of ethnic groups are heterogeneous and differ in their support of their cultural beliefs, I believe it is adherence to culture-specific beliefs and not simply identification with an ethnic group that influences behavior. This approach allows for a better appreciation of cultural diversity (Landrine & Klonoff, 1996), a more accurate understanding of the complex interaction between culture and somatization, and helps provide a more culturally competent and respectful treatment. Practically, it is beyond the scope of this dissertation to include a comprehensive study of all cultural groups, however it is possible to delve into the general cultural beliefs that impact somatization, because many different cultures embrace very similar ideals, a fact noted by Belgrave and Allison (2006). Draguns (1997) states that dissecting culture in this way allows us to take steps toward "unpackaging culture and pinpointing the focus of its influence" (p. 231). Although, as an influencing factor, culture is surely greater than the sum of its parts, I believe that the benefits to this method outweigh the potential deficits. Later in this work

the influence of these cultural beliefs will be summarized for the three largest ethnic minority groups in the United States, African Americans, Asian Americans, and Latino/Hispanic Americans.

Language

Language is the medium in which the mind exists. Often we take for granted the intimate and vital association thoughts have with language just as we usually forget our bodily dependence on the invisible air that constantly surrounds us. Our experiences of and in the universe are shaped by the words and structure of the language we speak. First proposed by Benjamin Whorf (1956), this insightful theory became known as the "Whorfian hypothesis. " This hypothesis is summarized by the editor of a collection of Whorf's writings as "the structure of the language one habitually uses influences the manner in which one understands his environment. The picture of the universe shifts from tongue to tongue" (Chase, 1956, p. x). This idea can be applied to an individual's understanding of their physical body and emotional experiences; in particular, figures of speech and words used to describe emotions can impact the somatic body (Hinton & Hinton, 2002). For example, Chinese is a language that primarily describes emotions via physical metaphors (Parker, Gladstone, & Chee, 2001), such as "blocking of air" for frustration and "hearts being pressed" for depression (Cheung & Lau, 1982). Based on this use of language, Tseng (1975) goes so far as to posit that the Chinese have a "hypochondriacal culture trait" (p. 242) that teaches people to worry about their physical body and contributes to somatic complaints. Kleinman posits that somatization thrives in China in part because "expression emphasize[s] bodily and other idioms of distress over psychological and social ones" (1986, p.67). In English the phrases "pain in the neck,"

"butterflies in the stomach," and even the word *disgust* all describe emotional states by referring to body parts or processes; these emotional states are associated with visceral sensations in those particular body regions. Hinton and Hinton (2002) theorize that "tropes may generate symptoms as a somatization of distress, amplify certain symptoms, and profoundly affect the personal and interpersonal meaning of the ... sufferer's complaint" (p. 165). They illustrate this theory by referring to the Khmer phrases "my brain is spinning" to express great distress and "I spin here, I spin there" to refer to busy stress, noting that dizziness is a prominent symptom in this ethnic group (Hinton & Hinton, 2002). Additionally, using a non-dominant language may leave an immigrant without the fluency to adequately express complex, nuanced emotional experiences (Altarriba & Santiago-Rivera, 1994). As a result, he or she may appear to over emphasize somatic complaints simply because that concrete experience is easier to communicate.

Collectivism and Individualism

Perhaps the singularly most influential cultural characteristic on somatization development, maintenance, and treatment involves the dialectic between collectivism and individualism. This variable has significant influence on an array of cultural beliefs that impact somatization by shaping fundamental ways of feeling and being, such as communication styles and capacity for self-efficacy, and broad health beliefs, such as holistic as opposed to reductionistic models of illness, and legitimizing or failing to recognize symptoms. Below, some components of collectivist and individualist cultures will be compared and some cultural values will be explored. Many of these dimensions are highly interrelated; however, I will try to describe them as distinctly as possible.

Although I dichotomize some of these beliefs for the sake of comparison, I do not intend to imply that these are categorical variables; rather they are opposite ends of a continuum with multiple gradations in between.

Group concept of self, interdependence, the importance of family, and the stigma of mental illness.

The first cultural element to be discussed is the fundamental concept of self. In individualistic cultures the self is defined as an autonomous individual, a single unit, whereas in collectivistic cultures, the self tends to be delineated as a part of a larger whole, a collective such as a family or community (Armstrong & Swartzman, 2001). Draguns (1997) describes this difference in terms of dynamics with the individualistic self being a conglomerate of constant traits and the collectivistic self being a flexible combination of roles in relation to others. This is not to say there is no sense of individuation within collectivistic cultures, but individual needs are generally overshadowed by those of the group, and conformity to prescribed norms is emphasized. The boundaries of the self are more fluid in collectivistic cultures compared to individualistic ones (Nilchaikovit, Hill, & Holland, 1993), and this alters one's body boundaries making one more vulnerable to external sources of illness (Armstrong & Swartzman, 2001; Koss, 1990). In a collectivistic society, the inability to fulfill one's roles in relation to others as the result of some bodily complaint is experienced by the collective and hence is more significant than a somatic symptom that merely is felt and experienced by only the individual. The stigma associated with mental illness is a shared experience and a reflection on all levels of the self for those in collectivist societies. Help-seeking in collectivist cultures, especially for emotional problems, is first performed

within the family or the closest members of the community as they are parts of the afflicted's idea of self. Treatment of somatization must include a clear definition of the identified patient and may require incorporation of the individual patient's family members, all of whom may feel affected by the individual's symptoms.

Related to the concept of self is the appraisal of independence and interdependence. The greater "we-ness" found in the collective self concept incurs an emphasis on interdependence with other members of the group, whereas the "I-ness" inherent in an individual concept of self promotes independence (Nilchaikovit, Hill, & Holland, 1993). In a country that celebrates independence, freedom, and individuality as much as the United States does, it is often difficult to recognize that this is not a universally valued trait. However, in collectivistic, also known as sociocentric, cultures, being free of ties to others, making decisions without the input from others, or living by one's self are not only unattractive but perhaps quite discomforting or frightening. Instead, honoring reciprocal obligations among family members, reliance on others and their opinions, and continued habitation with their family of origin are desired. In regards to its relationship to somatization, this culturally-prescribed mutual dependency may provide a great deal of familial support, serve as a buffer against many kinds of external stress and depression, and hence potentially reduce somatization. Without the additional support obtained in extremely close networks of family and extended family members often found in collective societies, individualists may have higher somatization levels. However, Koss (1990) proposes that the tight ties stemming from interdependence may sometimes result in feelings of invasion. Without any other culturally sanctioned way to withdraw and reinforce one's individual boundaries, "feelings of intrusion are expressed

as somatic complaints" (Koss, 1990, p.20). By fulfilling the sick role an individual is better defined as a separate being with stronger bodily boundaries (Koss, 1990), and this is accomplished without confrontation or interpersonal disruption. For immigrants to individualistic cultures from collectivistic ones, familial interdependency and its related traits, such as noncompetitiveness, lack of motivation for individual achievement, and self-depreciating comments, may be judged as inappropriate by the majority group or cause one to be taken advantage of. This lack of fit may increase stress levels and consequently increase somatization.

"Interdependency is the basis of a strong sense of family" (Nishio & Bilmes, 1987, p. 344) seen in many collectivistic cultures, though not all (i.e. Israeli kibbutzim). Although individualistic societies tend to strongly value family as well, the independent focus also found in them generally limits the amount of influence this has on other behaviors like somatization. However, in collectivistic cultures the importance of family is supreme. The belief that familial needs take priority before those of the individual is known as familism (Landrine & Klonoff, 1996) and is common in collectivistic cultures. Similarly roles and responsibilities within the family are often considered to be more important than those found outside of the family or within the individual. Together these ideas can mean that attending to an individual's emotional problems, professionally or personally by the individual in question, will only occur if it does not interfere with the needs of the family or the responsibilities that person has to their family. If an individual never finds the time or resources to take care of him/herself emotionally, his or her emotional troubles may fester and eventually expand to include somatized symptoms. Additionally, it is possible that putting the group before oneself could result in

resentments that are especially intolerable in a collectivistic culture, and this affective conflict could spur somatization, much as the psychodynamic model proposes. It is likely that immigrants from a collectivistic culture could experience the conflict between individual and familial needs as they become acculturated to an individualistic society and these opposing values are simultaneously reinforced (or punished).

Families share the success of each other's accomplishments and the burden of each other's problems (Gaw, 1993; Pang, 2000); pride and shame are shared, including the stigma of mental illness. Some communities view a mentally ill person as unmarriable, and by association, this disgrace could be applied to other members of the family (Gaw, 1993). Others view insanity to be the result of "weakness of character" (Parker, Gladstone, & Chee, 2001), which is stigmatizing. In collectivistic societies, conformity is necessary to belong to the group, and as a deviation from the norm, mental illness ostracizes the people diagnosed with it, which shames them (Fujii, Fukushima, & Yamamoto, 1993). It is hypothesized that because the stigma against mental illness is so strong in these circumstances, emotional complaints are channeled into physical symptoms (Kleinman, 1986; Nishio & Bilmes, 1987; Parker, Gladstone, & Chee, 2001). In other words, somatization "may be a reflection of ... cultural values that emphasize avoiding shame and maintaining the honor of the family" (Uba, 1994, p. 183). Often this stigma takes shape as an unwillingness to seek any outside help for mental illness due to the intense fear that family honor will be slighted by making the mental illness known to the community (Gaw, 1993; Uba, 1994). The stigma of mental illness is believed to be partially responsible for the underutilization of mental health services of many people from collectivist cultures in the US (Narikiyo & Kameoka, 1992; Fujii, Fukushima, &

Yamamoto, 1993). Should they enter psychological treatment, it is important that the therapist not emphasize their somatized symptoms as psychogenic opposed to organic in origin, which would stigmatize the client further and likely limit willingness to engage in psychotherapy.

Cultural definitions of pathology.

Another way in which culture can shape somatization is by determining which emotional, physical, cognitive, or spiritual experiences are worthy of concern. Adhering to individualist or collectivist ideology influences the judgment of what constitutes a symptom and also helps give meaning to those symptoms. Religion is an aspect of culture that impacts a wide variety of behaviors, including health and illness. Many collectivist cultures follow Buddhist tenets, and one of the four noble truths in this faith is that life is suffering (Kim, 1993). With this as a pillar in one's construction of the world, one's standard of normalcy includes more negative physical and emotional experiences than accepted in a culture that does not believe in that metaphysical statement. Many people in collectivist cultures have a much higher tolerance for the negative, because it is seen as a necessary and desired balance to the positive. Emotionally, collectivistic cultures "emphasize receptivity, which means to be receptive to both positive and negative features of the context" (Mesquita & Walker, 2003, p. 783), and balance instead of happiness seems to be sought in collectivistic groups. Some collectivist peoples have a higher tolerance for negative emotions, like anxiety or depression (Parker, Gladstone, & Chee, 2001), along with their corresponding physical components, such as chest tightness or change in appetite. Physically, illness is a part of normal life in collectivist society (Nilchaikovit, Hill, & Holland, 1993), and so multiple somatic complaints seen in

somatization disorders may not be considered exceptionally abnormal or problematic. This accepting attitude toward physical symptoms could increase the likelihood of their development, as physical symptoms are not viewed as something to ward off. In fact, Morita therapy, based in Japanese Zen Buddhism encourages "submitting to symptoms in defeat and resignation, 'uniting' with his or her illness" (Fujii, Fukushima, & Yamamoto, 1993, p. 334) so that the patient can learn to live with suffering. This mode of therapy does not consider the suffering as the problem. Instead, the patient's inability to accept the suffering is the target symptom. However, in individualist cultures pleasure, happiness (Mesquita & Walker, 2003), and control over one's life and health (Nilchaikovit, Hill, & Holland, 1993) are the goals, making anything short of those objectives problematic and a symptom worthy of intervention. Therefore the somatic elements in negative emotions and somatized complaints are considered deviations from the norm and hence symptoms to be fought and eliminated. Because physical complaints are viewed negatively as signs of the failure to control one's health, somatization may be less frequent in individualistic cultures.

Taoism is another religion that plays a strong role in many collectivist cultures (Chen & Swartzman, 2001) and influences somatization. Considered "the essence of Oriental philosophy" (Kim, 1999, p. 71), Taoism emphasizes "no-action," doing what is natural and spontaneous (Kim, 1993). According to this philosophy, passive attitudes and peacefulness are necessary for physical and psychological health (Chen & Swartzman, 2001). This could impact somatization by discouraging people from seeking outside assistance, including medical care, for psychogenic symptoms, which would mean they would not meet criteria for my definition of somatization. However, if help

eventually is sought, venerating passivity as an avenue toward health may make people disinclined to comply with treatment recommendations. This may frustrate Western medical practitioners, especially if they do not recognize this as a possible cultural factor.

Confucianism includes principles that profoundly affect the social and moral conduct in multiple collectivist societies. The focus of Confucianism is the prevention of social discord, and this moral goal is considered supreme above all others. "In fact, achieving individual health is a goal that is secondary to maintaining social harmony, upholding moral standards, and obeying social rules" (Chen & Swartzman, 2001, p. 390), and health generally is acquired by conforming to moral and social standards (Chen & Swartzman, 2001). Living in an individualistic society that requires behaviors that are considered morally reprehensible by their culture of origin, immigrants from cultures strongly influenced by Confucianism are likely to experience somatized physical symptoms as a consequence of violating the social rules of their culture of origin. Even situations over which the individual has little or no control, such as being unable to care for ageing relatives in the old country, could be a possible source of somatization symptoms in immigrants who follow Confucianism. Additionally, mental health practitioners with good intentions who advocate individualistic values, such as independence and speaking out, in actuality could induce somatization in followers of Confucianism by advising violations of moral standards. In this philosophy, the true symptom is socially inappropriate behavior and any resulting physical or emotional symptoms are side effects.

As previously mentioned, in collectivist cultures individual problems are not always considered as legitimate as dilemmas that impact the group. Emotional problems,

by their nature are experienced only by an individual, although they may have secondary consequences that involve others. For this reason, emotional problems are not considered legitimate in many collectivist cultures. However, because physical problems are accepted as justified, "the patient is reinforced in presenting somatic symptoms rather than emotional ones" (Tseng, 1975, p. 240). Somatization is likely to be more prevalent in groups that invalidate emotional or psychological symptoms, as people will have no other acceptable way to communicate their distress (Kleinman, 1986).

Cultural health models not only shape what is considered a symptom but also influence the meaning ascribed to symptoms. "Culture, as it is reflected in our internal schemas, influences how we interpret symptoms, feelings, and behaviors" (Angel & Williams, 2000, p. 33). The meaning of the symptom and help-seeking decisions are based on these interpretations of symptoms, whether they are organic or psychosomatic in origin. For example, neck tension will probably be dismissed completely or judged to be a remediable problem related to a bad night of sleep or stress by the average Caucasian American. The same symptom experienced by a Khmer person is likely to be interpreted as a sign that "neck vessels are distended and may rupture, causing death" (Hinton, Ba, & Um, as cited in Hinton & Hinton, 2002, p. 169). Based on these differing assessments, the former probably will not seek outside assistance nor feel distressed whereas the later will almost certainly experience both.

Harmony, balance, holism, and illness attribution.

Harmony and balance is another central theme found in most collectivist cultures. The basis of collectivism is being a part of the larger whole, which in itself necessitates a balance and implies a sense of harmony. All of the elements that compose the whole

must complement each other and coordinate. This theme often is paralleled in multiple layers of collectivistic cultures: in the spiritual realm, in nature and the universe, in the community and interpersonal spheres, and within the bodies of individuals. Balance between these domains must be reached as well, in order to achieve health and well-being (Belgrave & Allison, 2006). In many African cultures, "ma'at is a cardinal principal that governs the dynamic functioning of the universe and refers to balance and cosmic order" (Belgrave & Allison, 2006, p. 40). This emphasis on harmony differs greatly from individualistic cultures that generally attempt to conquer and control their natural environments, including their physical bodies (Nilchaikovit, Hill, & Holland, 1993) and their emotions. Even the concept that one can control such things seems to be a characteristic of the individualistic Western world (Peng & Nisbett, 1990) and is an important determinant of pleasure in Western cultures (Mesquita & Walker, 2003). While standing apart from the group, being different, speaking one's mind no matter the consequences, competing, and winning at all costs are desired by many individualists, all of these values would be abhorred by most collectivists.

Being as tied and interconnected to others as one is in collectivistic cultures necessitates and facilitates interpersonal harmony. Multiple researchers (Chun, Enomoto, & Sue, 1996; Mesquita & Walker, 2003; Mulatu & Berry, 2001; Narikiyo & Kameoka, 1992; Nilchaikovit, Hill, & Holland, 1993) have noted the importance of interpersonal harmony to collectivistic cultures. In her deconstruction of Asian cultures, most of which are collectivistic, Uba (1993) singles out interpersonal harmony as the driving cultural value that shapes nearly all other aspects of Asian cultures, much as I have focused on collectivism and individualism. Because having good interpersonal relationships are

central to many collectivists, anything that could potentially disrupt relations are discouraged. Open expression of emotions, especially negative feelings like anger is disapproved of, because of its potential for disturbing social harmony (Chen, Enomoto, & Sue, 1996). Self-control, indirect communication, being accommodating and nonconfrontational are promoted for their likelihood of maintaining harmony (Uba, 1994). Each of these factors can result in suppression of emotion that can eventually find expression as somatization, and can increase somatization prevalence in collectivistic cultures.

How the emphasis on harmony and balance affects the health models in collectivistic societies is the most important aspect of this discussion of somatization. There are many collectivistic cultures in existence, and many have their own models of health and illness. However, only two, traditional Chinese and Ayurvedic medicine, will be summarized here to illustrate how somatization is affected. In traditional Chinese medicine, there are two primary concepts, the five phases and yin-yang that together regulate ch'i, the vital energy force that permeates the entire universe and the human body (Gaw, 1993). The five phases, also known as the five elements (Kim, 1999), each have corresponding seasons, body organs, bodily orifices, colors, emotions (Gaw, 1993), tastes, directions, and environmental factors (Chen & Swartzman, 2001) that all interact with each other. Yin is a negative energy force that is associated with femininity, subcutaneous tissue and "six viscera (liver, heart, pericardium, spleen, lungs, and kidneys)" (Kim, 1999, p. 70). Yang is a positive energy force that is associated with masculinity, skin, and "six bowels (gall bladder, small intestine, stomach, large intestine, bladder, and three foci)" (Kim, 1990, p. 70). Yin and yang are involved in a constantly

dynamic relationship of opposition and support called mutual restraint, that when balanced induces health and when off balance causes illness (Mulatu & Berry, 2001). Nature, the weather, diet, supernatural forces, and the social environment can all impact one's emotional and physical health according to this theory.

Ayurveda is the classic Sanskrit theory of Indian medicine. It is based on the theory that there are three humors made up of natural elements (Armstrong & Swartzman, 2001). The emphasis on balance permeates Ayurveda, for when the humors are in balance there is health, and illness occurs when homeostasis is not met (Armstrong & Swartzman, 2001). Emotions are believed to raise or lower humor levels and hence alter physical health, and imbalanced humors can cause psychological symptoms (National Institute of Ayurvedic Medicine). Natural and supernatural elements, like the weather and the seasons, diet, and ancestor spirits, can all have an impact on the physical and mental health of an individual (Armstrong & Swartzman, 2001).

These models of health and illness are intimately tied to the entire universe and forces far greater than that of humanity; the position of relative powerlessness in which an individual is placed tends to result in people resigning themselves to what fate brings them. Believers in these illness models feel that they can have little control over their health and so illness is to be accepted serenely and calmly treated instead of controlled and fought heroically (Nilchaikovit, Hill & Holland, 1993). Much like Taoists, the attempt to not resist their illness may result in people who accept these illness models not seeking outside help; however typically people do seek the assistance of practitioners of their preferred medical model. Conversely, they are unlikely to have confidence in most Western mental health practitioners who are likely to focus on a psychological sources of

somatized symptoms (Chen & Swartzman, 2001) and do not even recognize a connection between the physical and emotional. With a model of illness like these, people are likely to present with somatic problems when emotionally distressed (Tseng, 1975), because the physical and psychological are experienced simultaneously as one unitary experience. In fact, the conceptualization of the mind and body being separate is not even present under these frameworks, which are holistic at their cores.

Many have compared holism, which is common to most collectivistic cultures, to the mind-body dualism widespread throughout individualistic cultures, and they have discussed their differing influences on somatization. In the Western, typically individualistic world, the mind, along with all psychological and emotional experiences, has been considered distinct and unconnected to the physical body and somatic sensations. This division pervades most modern psychological orientations and Western biomedicine, and as a result, somatization, which is the connection of the corporeal and mental spheres, is viewed as pathological. On the other hand, holism refers to the belief that humanity is tied to and part of the greater universe (Belgrave & Allison, 2006; Chen & Swartzman, 2001), including nature, the earth, and spiritual plains. Holism can also refer to the concept of a unification of the affective, psychological, physical (Pang, 2000), and often the social and spiritual aspects of a person (Chen & Swartzman, 2001). These realms are not considered independent of one another, and they all interact with each other.

Many researchers have theorized that believing in a holistic medical model increases somatization (Angel & Guarnaccia, 1989; Cheung & Lau, 1982; de Snyder, Diaz-Perez, & Ojeda, 2000; Koss, 1990). Within the holistic state of mind the physical

body is a natural and normal venue in which to express distress originating in any of the other realms (Angel & Guarnaccia, 1989; Pang, 2000). Unless taken to a debilitating extreme, somatizing symptoms is not considered pathological (Koss, 1990), and, in fact, compartmentalizing one's distress and restricting it to only one category likely would be considered bizarre and pathological in holistic collectivistic cultures. For some societies with a holistic model the connection of emotions to the physical body is so strong that it is believed that mental illness and affective problems, with or without physical complaints, always should be treated somatically (Pang, 2000). This is because psychiatric problems are considered to stem from organic or somatic factors (Kleinman, 1986; Sue, Wagner, Ja, Margullis, & Lew, 1976). This idea will make a somatizer far more likely to seek help from medical practitioners and will significantly decrease the faith he or she has in psychotherapy, making a collaborative treatment with the client's physician crucial. In other holistic cultures, somatic complaints occur due to physiological disorders and are also always either the result of social and interpersonal problems or an attempt to redress those problems (Koss, 1990). Belonging to a holistic culture in which one is an interactive part of the entire universe is also likely to impact the likelihood of believing in a collective concept of self in which one is part of the larger community. By recognizing a connection between the somatic, social and spiritual systems, holism opens the physical body to be influenced by and possibly made ill by forces external to corporeal boundaries, such as interpersonal conflict, ancestral spirits (Koss, 1990), or political oppression.

Attribution of illness is impacted by collectivistic or individualistic beliefs and can be coarsely broken down into internal or external sources of illness. In fact, most

cultures and health models have multiple theories about the causes of sickness that involve both internal and external sources and differ depending upon the symptoms at hand. However, in general, individualistic cultures ascribe internal sources of illness more often than collectivistic peoples, who are more likely to ascribe external origins of illness.

The greater focus on internal attributions reflects individualists' belief in control over their health. Biomedicine primarily focuses on internal sources of illness, such as genetic factors and biochemical imbalances as a cause of for physical illness and psychodynamic conflict or maladaptive thinking for mental illness. Western biomedicine predominates in individualistic cultures and rapidly is becoming the official medical system in many non-Western countries (Mulatu & Berry, 2001) and collectivist cultures as well. Another internal illness attribution was found in a one study of typically collectivistic peoples. An unspecified group of Asian American college students reported that they believed that mental illness stems from "organic" problems and that mental health is due to avoiding "morbid thoughts" (Sue, Wagner, Ja, Marcullis, & Lew, 1976), both of which are internal attributions. The authors hypothesize that these attributions are related to belief in a holistic health model and self-control, which is a characteristic typically valued by collectivists. It is possible that suppressing and avoiding negative cognitions will give the appearance of mental health but may in fact result in physical symptoms via somatization. According to Kim (1999), Taoists believe that excessive thinking, as a violation of the "no action" tenet, can lead to mental and/or physical illness as well.

The focus on external sources of illness points toward belief in holism, fatalism, and the importance of harmonious interpersonal relationships that are highly valued in most collectivistic cultures. Supernatural forces, such as invading spirits of dead ancestors (Armstrong & Swartzman, 2001; Kim, 1999), devils (Kim, 1999), malevolent spirits (Kim, 1993; Nishio & Bilmes, 1987), and gods (Gaw, 1993), are often thought to be responsible for mental illness in many holistic, collectivist cultures. Bad luck and karma (Nilchaikovit, Hill, & Holland, 1993) are also held responsible for illness in many of these cultures. Collectivists typically attribute mental illness to disharmonious interpersonal relationships (Armstrong & Swartzman, 2001; Koss, 1990; Narikiyo & Kameoka, 1992). In the case of angered ancestral spirits, supernatural elements and familial relationships are both involved. Somatization can be attributed to either of these two external sources of illness.

Communication, emotional expression, conformity, fatalism, and minority status.

Communication style is another variable that is strongly influenced by culture and by collectivism/individualism. In most individualistic cultures, communication tends to be direct, with the emphasis placed on what is explicitly said (Nilchaikovit, Hill, & Holland, 1993). Furthermore, one isn't expected to know what is implied and left unsaid, the unspoken is largely ignored (Armstrong & Swartzman, 2001), and the responsibility for communicating information is on the speaker rather than the listener. Collectivists communicate more indirectly, rely more on context and nonverbal communication (Armstrong & Swartzman, 2001; Nilchaikovit, Hill, & Holland, 1993), and the listener is more responsible for the communication than the speaker. Being so closely tied to others makes collectivists better able to empathize and infer the thoughts and emotions of other

people without being told explicitly, and they expect reciprocity in that others will be able to read their needs and emotions without having to directly express them (Armstrong & Swartzman, 2001). Collectivists prefer communicating more indirectly, because it tends to safeguard interpersonal harmony by eliminating direct confrontations (Nilchaikovit, Hill, & Holland, 1993). Conversely, extremely direct expression that is common to most individualistic Caucasian Americans can be viewed as crude, off-putting, and uncomfortable by minority collectivists.

Being assertive or accommodating is strongly related to one's preferred style of communication. Those who value direct communication often admire assertiveness and being confrontational, and in the United States it is an admired skill that is sometimes taught in psychotherapy. Indirect communicators usually value being unassertive (Marsella, Kinzie, & Gordon, 1973), being receptive and approachable, withholding free expression of opinions, and restricting conversations to neutral "safe" topics (Uba, 1994). By saying little that can be disagreed with, collectivists can better met the primary goal of preserving group harmony. However, Western physicians or mental health providers who are unaccustomed to indirect exchanges and are often short on time may find themselves frustrated by this style of communication (Nilchaikovit, Hill, & Holland, 1993). Likewise, patients that value indirect communication may be offended by the brash questioning about personal information that occurs when they seek the assistance of Western medical or mental health professionals. In these circumstances it is often the quality of the professional relationship and not the quantity of minutes spent together that has the greatest impact on the amount of information conveyed.

Having a style of communication that differs markedly from that of their new countrymen, immigrants to the United States may have difficulty bonding with those around them or establishing community networks even if they do speak English. Considering that the immigration experience has separated many from family members, friends, and the rest of their local community, the additional challenge to establish new connections is especially weighty, as community and social support is of even greater importance to the average collectivist than the typical individualist.

Style of communication can impact somatization in several ways. Somatization can be considered at times to be an indirect mode of expression that allows individuals to express their social, political, or interpersonal distress in a culturally approved way. This may be especially true in cultures whose language utilizes many figures of speech that incorporate somatic references. It is possible that if this indirect method of communication does not effectively convey the distress to those accustomed to direct, verbal expressions, the individual's symptoms may intensify in a compensatory attempt to be heard. A clash in communication styles may result in indirect communicators making frequent visits to their physicians, because (1) they feel they need to establish a rapport with their physician prior to disclosing delicate personal information, (2) their previous indirect attempts to disclose to their doctors were not accurately interpreted, (3) they have not yet felt heard by the medical practitioner, or (4) the clash resulted in a misunderstanding that needs to be resolved. Each of the separate reasons behaviorally can appear to be related to somatization, even though they are actually merely the result of miscommunication. Pang (2000) posits that for immigrants "the breaking-down of

communication patterns and lack of time for meaningful interactions with significant others may reinforce somatization" (p.209).

Another culturally influenced norm that pertains to somatization is attitude about public displays of emotion. Individualistic cultures generally are emotionally expressive (Nilchaikovit, Hill, & Holland, 1993), and collectivist cultures tend to avoid expressing or discussing their emotions (Cheung & Lau, 1982), especially negative feelings (Tseng, 1975), though not all collectivist groups disapprove of emotional expression. In contrast, personal expression of feelings is encouraged (Nilchaikovit, Hill, & Holland, 1993) and often deemed necessary for good psychological health for individualists. Many Western-based psychological orientations promote emotional catharsis and expression. Collectivists, on the other hand, usually ascribe to holistic health models that propose that any strong emotion, either positive or negative, can induce physical illness and so should be avoided (Chen & Swartzman, 2001). Open display of emotions is discouraged, because it could threaten social harmony (Uba, 1994), which is of highest importance; emotional self-control is considered a core value in many collectivist cultures (Kim, Li, & Ng, 2005; Uba, 1994). "Confucianism holds that self-control in both emotional and behavioral reactions in social interactions is necessary for the establishment and maintenance of harmonious social relationships and group functioning (Chen & Swartzman, 2001, p. 398). A collectivistic person believes it is ideal to be calm, in control of his or her emotions, and stoic even when emotionally distraught (Nilchaikovit, Hill, & Holland, 1993). Because control and regulation of emotion is acquired with age, emotional restraint is valued as an indication of psychological maturity (Chen & Swartzman, 2001).

In cultures that stress relational harmony, as most collectivist cultures do, expansive expression of happiness is rare (Mesquita & Walker, 2003), because happiness could be interpreted as an indication that the individual is evading social obligations (Lutz, 1987 as cited in Mesquita & Walker, 2003). However, in individualist cultures happiness is an important motivator and is experienced more often than in collectivist societies (Mesquita & Walker, 2003). Similarly expressions of anger and aggression generally are uncommon in collectivist groups because they threaten interpersonal harmony, but are more common in individualist cultures and can be seen as indicators of the valued competitive spirit. "Aggressive and happy expansiveness may universally emphasize individuality and self-other boundaries but this is consistent with some cultural models- and thus good- and inconsistent with others- and therefore bad" (Mesquita & Walker, 2003, p.786).

Alexithymia is a term that is related to the display of emotions and non-verbal communication; it has been defined in two parts: (1) difficulty identifying emotions and distinguishing them from somatic sensations and (2) difficulty communicating affect (Apfel & Sifneos, 1979). It is possible that collectivist people do not actually have difficulty communicating their emotions but simply choose not to for many of the reasons mentioned above. In comparisons of Caucasian Americans, who are likely individualistic, to Asians and Asian Americans, both of who are likely collectivistic, Le, Berenbaum, and Raghavan (2002) found both collectivistic groups had higher scores on a measure of alexithymia. Additionally, they found that culture and gender indirectly influenced alexithymia levels via parental socialization of emotions. If parents tended not to display overt signs of emotion, their children were more likely to grow into adults

with higher alexithymia scores. Collectivistic cultural background and male gender were positively correlated to few displays of emotion. In a meta-analysis of 16 empirical studies examining the relationship between somatization and alexithymia, De Gucht and Heiser (2003) consistently found a small to moderate relationship between these two variables. Together these two studies suggest that collectivistic cultures are more likely to have higher rates of somatization via an indirect relationship involving alexithymia.

Disapproving of open, direct displays of emotion can increase the likelihood of somatization in several ways. One way of understanding this is the idea that by requiring frequent, long-term suppression of affect while unconscious conflict continues to exist, this psychic conflict eventually will be expressed somatically if not verbally, as psychodynamic theory proposes. As mentioned above, somatization can be an indirect expression of emotional distress that results from a suppression of direct displays of emotion. It has been hypothesized that somatization is actually masked depression (Katon, Kleinman, & Rosen, 1982), anxiety disorders (Beidel, Christ, Long, 1991), or both (Escobar, Rubio-Stipec, Canino, & Karno, 1989; Katon, Lin, Von Korff, Russo, Lipsomb, & Bush, 1991; Kirmayer, Robbins, Dworkind, & Yaffe, 1993; Smith, Gardiner, Lyles, Sirbu, Dwamena, Hodges, et al, 2005). Because of the stigma associated with mental illness, some collectivists initially may not openly express their emotional distress but may report and communicate physical complaints instead (Chun, Enomoto, & Sue, 1996). However, most can admit to psychological symptoms after additional probing (Chun, Enomoto, & Sue, 1996).

Related to the expression of emotion is the reception of the emotional communication or the ability to appropriately read a communication. Individualists tend

to devalue and often ignore all but direct communications (Armstrong & Swartzman, 2001; Nilchaikovit, Hill, & Holland, 1993). Few open displays of emotion and heavier reliance upon indirect communication of emotions have given many collectivists a heightened sensitivity to subtle affective cues from others. Belgrave and Allison (2006) propose that having a collectivist orientation that emphasizes consideration of others gives collectivists the ability to be more emotionally receptive. Highly attuned social sensitivity also exists in many collectivist cultures (Uba, 1994). Somatization treatment may be effected by this trait. Context and non-verbal communications of the service provider often are going to be relatively more important to collectivists than verbal communications, because of their sensitivity to these more subtle expressions. Additionally, the professional that is working with a collectivist must attempt to be more aware of the non-verbal information coming from the client.

The degree to which one conforms to norms is influenced by culture, including individualism or collectivism, and pertains to somatization. Collectivist cultures, epitomized by the principles of Confucianism, place much emphasis on fulfilling roles and following social rules so as to maintain the ever-important social harmony. Based on these values, behavior is often judged as to whether or not it meets social expectations, and attention is focused on the possibility of falling short of those expectations (Mesquita & Walker, 2003). The resulting anxiety this process produces (Mesquita & Walker, 2003) is at least partially reduced by attempting to conform to social norms, which has been recognized as a core value for some collectivist cultures (Kim, Li, & Ng, 2005). Uniformity, sameness, and blending in is desired, because it means that an individual has not come to the attention of the community for failing to met expectations. This differs

immensely from individualistic cultures that generally idolize independence, being unique, and distinguishing oneself from others (Mesquita & Walker, 2003). Minority collectivists living in predominantly Caucasian areas may find it hard to blend in when they are the only person or family of that particular ethnic background in the area; this stress could potentially contribute to somatization. As the progeny of collectivist immigrants become increasing acculturated, those later generations may find that their adoption of some individualist values cause them to violate the social norms of their culture of origin, which again can be stressful and possibly increase somatization. For many collectivists it would be atypical to seek psychotherapy for somatization, and the breaking this social norm may deserve acknowledgement once in psychological treatment.

Degree of agency, self-efficacy, and desirability of active control over life events and circumstances differs cross-culturally and also can shape somatization. "Claiming responsibility and a personal sense of control are at the center of what it is to be a person in Western culture" (Mesquita & Walker, 2003, p. 785). Individualists also tend to consider themselves to have emotional situations under control (Mesquita & Karasawa, 2002), as well as their physical health (Nilchaikovit, Hill, Holland, 1993). For collectivists, who often view themselves as a small part of a much larger whole that includes spirits, gods, and the forces of nature, individuals are not considered to have much agency or self-efficacy. Although collectivists highly value emotional self-control, as mentioned above, they typically feel that illness is "inevitable and one can do nothing to change its course" (Nilchaikovit, Hill, & Holland, 1993, p. 46). Collectivists tend to encourage more passive responses to illness and emotional distress, such as Toaism's

"no-action," acceptance, and adjustment to the situation, instead of promoting personal agency to change the circumstances. Many collectivists blame "family members, closely related others, ancestors and gods, and God" (Pang, 2000, p. 209) for things going well or poorly. Based on this belief, it may be difficult to convince collectivists that they have the power to control their somatized symptoms, and treatments that encourage self-efficacy, such as self-management, may not be effective for this group. However, Zen Buddhist-based Morita therapy encourages "submitting to symptoms in defeat and resignation" (Fujii, Fukushima, & Yamamoto, 1993, p. 334) and continues to be used in Japan with some success.

Help-seeking.

Help-seeking behaviors for somatization are influenced by cultural factors, including individualism and collectivism. Obviously, where and from whom one seeks help is going to largely depend on how one conceptualizes the problem. This cognitive process relates to health models, conceptualization of symptoms, and attribution of illness, all discussed above. When they believe their somatic complaints are organic in origin, collectivists often take unexplained physical symptoms to physicians for help (Bhui, 1999), as do individualists. This pattern resembles somatization. When problems are deemed to be purely emotional in nature collectivists are likely to seek help from lay sources (Bhui, 1999), such as drug-store pharmacists, herbalists (Kim, 1999), trusted members of the family or friends (Nishio & Bilmes, 1987). Some health models common to collectivists indicate somatic ailments are due to imbalances of natural forces and energies, which require the assistance of traditional medicine practitioners, or inharmonious interpersonal relationships, for which one might seek to make amends with

the person or persons with which one was in conflict. Frequently, family oriented collectivists turn to their family members for support before seeking outside help. Other illnesses can be the result of supernatural or religious problems, which require the help of spiritual advisors, such as shamans, monks (Kim, 1999), or root doctors (Landrine & Klonoff, 1996). However in some cultures with a holistic model of illness, psychological symptoms always should be treated somatically (Pang, 2000), because they all have organic or somatic origins (Kleinman, 1986; Sue, Wagner, Ja, Margullis, & Lew, 1976). Based on this belief, collectivistic somatizers are far more likely to seek help from medical practitioners than other sources of assistance, especially mental health services that do not acknowledge the mind-body connection.

The stigma of mental illness is a strong deterrent that keeps many people from seeking mental health services, especially those from collectivistic cultures with an exceptionally strong sense of shame associated with insanity (Narikiyo & Kameoka, 1992). Even if an individual conceptualizes their problem as psychological, this stigma may cause them to seek help from medical personnel or lay persons rather than subject themselves and their families to such dishonor. Once help is sought, either from a physician or a mental health professional, the respect for authority that is common in many collectivistic cultures, along with the desire to avoid confrontation (Uba, 1994), makes many collectivist clients reluctant to bring up any complaints they have about services or counter anything the professional suggests. Based on this, it would behoove the professional to ask the client if he or she would like anything to be different in treatment and if they feel comfortable with the suggestions made, even though cultural proscriptions may prohibit them from answering fully.

Available resources and expectations of service also influence help-seeking behaviors. When in a medical setting, in which one anticipates receiving treatment for physical complaints, a group of collectivists primarily presented with somatic symptoms (Cheung & Lau, 1982). However, when in a psychiatric setting, in which emotional problems are expected to be targeted, collectivists presented with psychological and somatic complaints (Cheung & Lau, 1982). Most collectivists who initially present to physicians with somatized symptoms, are able to discuss psychological problems with further questioning (Chun, Enomoto, & Sue, 1996). Often people, especially non-English speaking immigrants, do not know about available mental health services or do not have access to those services in their native language. In many cultures, psychotherapists, psychiatrists or any kind of mental health worker simply do not exist (Nishio & Bilmes, 1982), and it is quite understandable that immigrants from those countries would not be aware of mental health services or have much faith in their effectiveness. However, immigrants are more likely to have access to medical services and may seek emotional help from their physician, who may be their only known source of help.

Influential Cultural Beliefs on Somatization in Three American Ethnic Minority Groups

This section discusses the cultural beliefs that influence somatization for each of the three largest ethnic minority groups in the United States: African Americans, Asian Americans, and Latino/Hispanic Americans. As it is not always possible for mental health practitioners to perform an exhaustive assessment of cultural influences on each client's behavior, it is beneficial for the clinician to understand those cultural beliefs that are most likely to play a role in the client's clinical presentation. This subsection

provides a collection of hypothetical cultural influences to investigate with a somatizing minority client. As Triandis and Singelis (1998) stated, "while cultural differences may be the most important consideration when making a 'first-best guess' about an individual, within-culture differences are also important" (p. 36). In other words, it is important to entertain these *possible* influences on somatization without stereotyping, because within each ethnic minority group are a heterogeneous collection of subcultures and individual differences. Level of acculturation also mitigates the degree of influence these beliefs have on somatization.

African Americans

It is often generally assumed that acculturation and adoption of majority cultural beliefs increases over time. Furthermore, it is often presumed that later generations are more acculturated than the first generation of immigrants. By that rationale many African Americans, whose ancestors were forcibly brought to North America through the slave trade, would be so acculturated that little of their original African cultures would remain. However, Landrine and Klonoff (1996) state that acculturated or bicultural African Americans can reconnect with their African roots and become "neotraditional" (p. 46). Additionally, Belgrave and Allison (2006) hypothesize that "isolation of Blacks through slavery and oppressive conditions in this country helped to preserve African values" (p. 30). Taken together these statements suggest that some African Americans will adhere to many traditional African cultural beliefs that can influence somatization, making a separate cultural analysis of this group of peoples relevant.

In the literature, I have found nothing that speaks to how African or African American language might influence somatization. Although the majority of African

Americans primarily speak English, there are many immigrants who speak a wide variety of African languages or who are from South America or the Caribbean and speak Spanish. Potential Spanish language influences will be discussed in the Latino/Hispanic portion of this section below.

Many authors have described collectivism has been cited as a core value in African American culture (Belgrave & Allison, 2006; Cokley & Williams, 2005; Karenga, n.d.; Wallace & Constantine, 2005). Maulana Karenga (n.d.) established seven principles of African American culture called the Nguzo Saba as the foundation of Kwanzaa, a Pan-African cultural celebration. Four of these seem to incorporate elements of collectivism. Karenga (n.d.) defines these principles as follows

> Umoja (unity): to strive for and maintain unity in the family, community, nation and race. Ujima (collective work and responsibility): to build and maintain our community together and make our brother's and sister's problems our problems and to solve them together. Ujamaa (cooperative economics): to build and maintain our own stores, shops and other businesses and to profit from them together. Nia (purpose): to make our collective vocation the building and developing of our community in order to restore our people to their traditional greatness.

With collectivism as a fundamental aspect of African American culture, a group-self and a sense of interdependence are fostered (Belgrave & Allison, 2006).

Most African American cultures stress the importance of family and have a flexible definition of family. Familism, "the belief that the family's needs take priority over those of the individual" (Landrine & Klonoff, 1996, p. 63), is a central feature of African American cultures (Wallace & Constantine, 2005). Landrine and Klonoff (1996) theorize that informal adoption of children and the elderly into African families common to modern African American families likely predates slavery; however, the frequent separation of family members and general disruption of family structure due to decades

of slavery probably reinforced and expanded this practice. Belgrave and Allison (2006) view the adaptable definition of family and "the strong commitment to the family, extended family and fictive kin" (p. 36) seen in African American culture as an expression of collectivism. As mentioned above, Karenga's first principle of African American culture, Umoja, highlights family.

The stigma of mental illness seen in many African American cultures is related to family loyalty. Mental illness is viewed as shaming and likely will be hidden by both the individual as well as their family (Thompson, Bazile, & Akbar, 2004), because it reflects poorly on the family. Some African Americans may feel that by sharing their problems with mental health professionals, who are likely members of the majority ethnic group, they might contribute to the negative stereotypes that exist about their cultural group (Thompson, Bazile, & Akbar, 2004) or that they will "misrepresent the integrity of their larger ethnic group" (Wallace & Constantine, 2005, p.372). Higher levels of Africentrism were found to be positively associated with amount of perceived stigma (Wallace & Constantine, 2005), meaning the more strongly one adhered to African beliefs, the more stigmatizing one viewed mental health treatment.

Culture and ethnic history impact the interpretation of symptoms. Because African American history is filled with tragedy and adversity, this has given many Black Americans the expectation that life will be difficult, but that they have the strength to overcome such hardships (Thompson, Bazile, & Akbar, 2004). This belief may make African Americans less likely to seek help for psychological or physical problems, because symptoms are anticipated. However, since the individual is expected to triumph over these problems on his or her own, failing to meet that expectation and requiring

outside help for such tribulations may intensify the stigma and shame associated with them. In Nigeria, the Aro village treatment method of addressing psychological symptoms developed by Lambo, "the father of psychotherapy in Africa" (Awanbor, 1982, p. 211), involves admitting multiple family members with the identified patient, because the individual's symptoms are considered to be a problem of the family and community.

Harmony and balance with nature and within one's mental, physical, and spiritual aspects of self are believed by many African Americans to be necessary for health and wellness (Belgrave & Allison, 2006). Imbalance in one plane will be reflected in the others; for example, mental disruptions will have negative effects on the body and on the spirit. In many African cultures, "ma'at is a cardinal principal that governs the dynamic functioning of the universe and refers to balance and cosmic order" (Belgrave & Allison, 2006, p. 40). Interpersonal harmony is valued by Black Americans, as well. "In order to preserve the well-being and balance of themselves, family members, and even close friends, some African Americans may not disclose their problems to important others to preserve harmony or to not burden them with their concerns" (Wallace & Constantine, 2006, p. 372). This practice may extend to interactions with mental health professionals and lead to greater self-concealment (Wallace & Constantine, 2006) and decreased mental health service usage.

A holistic orientation is "central to Africentric thinking ... [and] provides an overarching framework for Africentric beliefs" (Belgrave & Allison, 2006, p. 34). As the foundation of Africentrism, holism influences many other African American cultural beliefs, such as health models and illness attribution. Most indigenous African modes of

healing stem from a holistic "magico-religious belief system" (Awanbor, 1982, p. 206) that incorporates physical, spiritual, and social elements (Constantine, Myers, Kindaichi, & Moore, 2004). Seeking psychosocial equilibrium treats both physical and mental illness. Those who have faith in this belief system often attribute illness to external causes. Supernatural sources are frequently blamed for physical and emotional problems, such as "zar spirit" possession in people from northeastern African nations like Ethiopia, Sudan, and Egypt (Mulatu & Berry, 2001) and "elements of omnipotent supernatural forces, witchcraft, sorcery, [and] magic" (Awanbor, 2004, p. 206) in the Edo people of Nigeria. In America, this belief system is often referred to as rootwork and "ascribe[s] illness to hexing, witchcraft, sorcery, or the evil influence of another person" (DSM-IV-TR, 2000, p. 902). Common amongst African Americans in the southern United States and from Caribbean cultures, rootwork is applicable to physical and psychological symptoms (DSM-IV-TR, 2000).

Conflicting information exists on the communication style of African Americans, which makes it unclear how style of communication of Black Americans might affect somatization. According to Sue and Sue (1999), in African American families assertiveness is esteemed. Another of Karenga's (n.d.) seven principles of African American culture is Kujichagulia (self-determination), which is "to define ourselves, name ourselves, create for ourselves and speak for ourselves" and clearly has an element of assertiveness in it. On the other hand, Wallace and Constantine (2005) state that like other collectivist cultures, African Americans may not directly communicate their problems to others as a means to preserve internal and interpersonal harmony. In interactions with non-African Americans, non-verbal communication often is more

highly valued and trusted by Black Americans. The long history of oppression of African Americans by Caucasian Americans has lead to a general mistrust of the majority culture in many Black Americans. As a result, non-verbal communications are felt to be more trustworthy than direct verbal statements, which easily can be fraudulent. Considering the continued racism in this country, it is sometimes unsafe for Black Americans as a minority group to fully express negative emotions that are focused toward the majority culture. This makes emotional control and suppression of negative emotions necessary at times, which could lead to somatization. Reliance upon non-verbal communications also allows many African Americans to be more emotionally receptive and sensitive to affective clues (Belgrave & Allison, 2006).

Passive acceptance of fate generally is not common amongst African Americans. The last two of Marenga's (n.d.) principles of African American culture assert an active stance toward life and its trials:

> Kuumba (Creativity): to always do as much as we can, in the way we can, in order to leave our community more beautiful and beneficial than we inherited.
> Imani (Faith): to believe with all our heart in our people, our parents, our teachers, our leaders, and the righteousness and victory of our struggle.

It is expected that one can overcome life's difficulties (Thompson, Bazile, & Akbar, 2004).

Though a proactive outlook might imply an acceptance of seeking outside help for psychological problems, African American culture commonly disapproves of assistance from mental health professionals. Seeking help outside of the family or close friends for personal problems often is seen as a sign of personal weakness, because strong African Americans should not need support to overcome their problems (Thompson, Bazile, & Akbar, 2004). There are mores against "airing problems or 'dirty laundry' in public"

(Wallace & Constantine, 2005, p. 380), which is often interpreted to be anyone outside of the family. In addition to family loyalty, other cultural barriers prohibit many African Americans from seeking traditional psychotherapeutic help, such as the fear that men's pride will be diminished or that women will no longer be the strong anchors of their family (Thompson, Bazile, & Akbar, 2004). However, instead of going to psychologists, psychiatrists, or counselors, it is more typical for African Americans to rely upon family members, friends, or their church for help with mental illness (Thompson, Bazile, & Akbar, 2004).

Asian Americans

Each language contains unique phrases and commonly used metaphors that impact an individual's experience of the world. Two Asian languages are discussed here for their particular influences on illness concepts and somatization. Though the Chinese language has a rich vocabulary to describe emotions, it is considered more socially appropriate to utilize symbols and metaphors related to the body as a means by which to indirectly express affect (Cheung & Lau, 1982; Parker, Gladstone, & Chee, 2001). Tseng (1975) states that this is reflective of a Chinese "hypochondrical culture trait" (p. 242) that permeates the culture. Hinton and Hinton (2002) discuss the power language has on symptoms and somatization; they give examples of the Khmer metaphors of dizziness to describe emotions that correspond to their cultural health model that is based on wind. Even the Khmer word for anxiety (pronounced "wul") approximately translated means spinning and has an auditory link to the sound of whirling wind (Hinton & Hinton, 2002).

Several researchers (Armstrong & Swartzman, 2001; Chen & Swartzman, 2001; Uba, 1994; Yeh, Inman, Kim, & Okubo, 2006) have noted that most Asian and Asian

American cultures are collectivistic. This was confirmed when Kim, Li, and Ng (2005) found that collectivism is one of five components of the Asian American Values Scale, which is based upon the Asian Value Scale. Confucian principles are believed to be the foundation of the collectivism found in these cultures (Chen & Swartzman, 2001).

Congruent with collectivism, a group and family sense of self and interdependence are important aspects of Asian and Asian American cultures. A familial self is found in most cultures of East Asia, Southeast Asia, and India (Marsella, Kinzie, & Gordon, 1973; Nilchaikovit, Hill, & Holland, 1993; Yeh, Inman, Kim, & Okubo, 2006). Interdependence is common within Asian and Asian American families (Kim, 1993; Sue, Wagner, Ja, Margullis & Lew, 1976; Yeh, Inman, Kim, & Okubo, 2006), including Southeast Asian Americans (Nishio & Bilmes, 1987), East Asians, and Indians. Community-wide interdependence is also an important part of many Asian cultures, especially Chinese cultures (Chen & Swartzman, 2001).

Family is a supremely important aspect of many Asian cultures (Chen & Armstrong, 2001; Gaw, 1993; Nishio & Bilmes, 1987; Sue, Wagner, Ja, Margullis, & Lew, 1976; Uba, 1994), though Villarreal, Blozis, and Widaman (2005) consider the Asian American concept of family to be based on filial piety and hence different than Hispanic familism. As Nilchaikovit, Hill, and Holland (1993) state, "In working with Asian patients, the importance of family cannot be overemphasized" (p.48). This cultural value is expressed in several ways. The definition of family is broad and includes extended family members, who are considered as close and as important as immediate, nuclear family members (Yeh, Inman, Kim, & Okubo, 2006). Obligations toward their families are felt more strongly than responsibilities to themselves by Chinese and

Japanese Americans (Marsella, Kinzie, & Gordon, 1973). During times of crisis, Asian Americans often turn to their families for support and comfort, but fear of worrying or burdening those they care about prevents many Asian Americans from sharing their feelings with their important others (Yeh, Inman, Kim, & Okubo, 2006). However, professional assistance is rarely sought either, because a strong sense of family loyalty inhibits the discussion of problems beyond the bounds of the close system (Yeh, Inman, Kim, & Okubo, 2006). Based on the importance of family to Asians and Asian Americans, it is recommend that family members be included in medical appointments and kept informed of treatment decisions (Nilchaikovit, Hill, & Holland, 1993).

Mental illness is considered stigmatizing by most Asian and Asian American cultures (Chen & Swartzman, 2001; Gaw, 1993; Kim, 1999; Kleinman, 1986; Nishio & Bilmes, 1989; Yeh, Inman, Kim, & Okubo, 2006). In Japan, mental illness is viewed as a sign of deviation from the norm, which is shaming in and of itself (Fujii, Fukushima, & Yamamoto, 1993). Asians and Asian Americans often consider psychiatric illness to be a sign of weakness in the individual (Kim, 1993; Narikiyo & Kameoka, 1992; Parker, Gladstone, & Chee, 2001), degrading (Parker, Gladstone, & Chee, 2001), jeopardizing the marriageablity of the identified patient and their family members (Fujii, Fukushima, & Yamamoto, 1993; Gaw, 1993; Kim, 1993), and shaming for the entire family who failed to properly care for the distressed individual, who as a result requires outside assistance for psychological problems (Uba, 1994). During the Cultural Revolution in China, psychology was declared a useless, bogus science that was banned by the Maoists in power (Bond as cited in Parker, Gladstone, & Chee, 2001), and depression became associated with counter-revolutionaries (Zhang as cited in Parker, Gladstone, & Chee,

2001). These political ideologies further stigmatized mental illness for the Chinese (Parker, Gladstone, & Chee, 2001). Yet, physical illness and symptoms, such as neurasthenia (Parker, Gladstone, & Chee, 2001) and headaches (Nishio & Bilmes, 1989), are not considered shameful and do not damage the family reputation (Chen & Swartzman, 2001). Somatic complaints are considered more socially acceptable than emotional distress in Chinese society (Kleinman, 1986; Parker, Gladstone, & Chee, 2001), and this reinforces somatization of affective distress (Tseng, 1975). Somatization allows Asian American and Chinese peoples to avoid the social stigma of mental illness (Chen & Swartzman, 2001; Parker, Gladstone, & Chee, 2001) and maintain the honor of the family (Uba, 1994).

As discussed in detail above, Buddhism (Nilchaikovit, Hill, & Holland, 1993), Confucianism, and Taoism are strongly influential Asian religions and philosophies (Uba, 1994) that impact concepts of health (Chen & Swartzman, 2001), interpretations of symptoms, and somatization. For example, traditional Japanese Americans consider tolerating and adjusting to the situation as a helpful way to cope with mental illness (Narikiyo & Kameoka, 1992). This concept is most fully expressed in the Buddhist-based Japanese Morita therapy in which the focus of treatment is on acceptance of oneself as one is, with a goal "to learn to live with suffering" (Fujii, Fukushima, & Yamamoto, 1993, p. 334). Additionally, Korean shamanism regards suffering as a requirement for maturation (Kim, 1993). Chinese culture indicates that one will have a "predetermined life of stress and suffering" (Parker, Gladstone, & Chee, 2001, p. 862), as well as the ability to tolerate hardships. Based on these beliefs, many negative experiences won't be viewed as pathological, making help seeking unnecessary;

however, requiring professional help indicates the personal failure to meet cultural expectations of self-control and stress management, which intensifies the stigma. For many Asians, an individual's psychological stress (Yeh, Inman, Kim, & Okubo, 2006) or illness is viewed as a family problem (Nilchaikovit, Hill, & Holland, 1993) or even a community problem (Chen & Swartzman, 2001). Being more task oriented as opposed to feeling oriented (Nilchaikovit, Hill, & Holland, 1993), Asian families are more likely to consider an individual's inability to function in the family as more symptomatic and pathological than an individual's emotional distress.

Harmony on many levels is considered crucial for health and wellness in most Asian cultures. According to Chinese culture, intrapersonal, interpersonal, and environmental harmony are necessary for health (Chen & Armstong, 2001). Being open to and accepting of both positive and negative emotions is valued by East Asian cultures (Mesquita & Walker, 2003) and is reflective of the value of intrapersonal balance and harmony generally valued by these cultures. A strong majority of rural Koreans believe that it is vitally important to live in harmony with nature and the environment in order to have good health and that illness will result if there is an imbalance (Kim, 1999). Uba (1994) posits that the emphasis on relationship harmony is the cornerstone of Asian American culture and that most other beliefs of this cultural group are rooted in this value. In Asian cultures, interpersonal harmony is highly regarded (Mesquita & Walker, 2003), is the focus of Confucianism (Chen & Swartzman, 2001), and is more strongly valued than individual experience and expression (Kleinman, 1986). Humility, which increases the likelihood of interpersonal harmony, was determined to be one of five components of the Asian American Values Scale (Kim, Li, & Ng, 2005). Forbearance, or

withholding one's problems from significant others, is commonly used by Asian Americans as a means by which social harmony can be preserved (Yeh, Inman, Kim, & Okubo, 2006). Lack of interpersonal harmony is believed to have the potential to cause mental illness by Japanese Americans (Narikiyo & Kameoka, 1992).

Most Asian cultures are holistic – in other words, these cultures believe that mind, body, spirit, and universe are interconnected, and do not adhere to a mind-body dichotomy (Bhui, 1999; Nishio & Bilmes, 1989). Traditional Chinese medicine, as described in detail above, is a holistic health model that is founded upon the belief that one must find "balance among the elements of the body, the mind, the spirit, and the natural environment" (Mulatu & Berry, 2001, p.53) in order to maintain health; any imbalance in any of these spheres potentially can produce physical symptoms (Gaw, 1993; Kleinman, 1986; Parker, Gladstone, & Chee, 2001). For centuries traditional Chinese medicine has been the dominant medical model in many Asian countries, such as China, Japan, Vietnam, Hong Kong, Taiwan (Armstrong & Swartzman, 2001), Singapore, Indonesia (Chen & Swartzman, 2001), and Korea (Kim, 1999). This holistic health/illness model strongly influences many Asians' conceptualization of their problems and symptoms (Cheung & Lau, 1982; Chun, Enomoto, & Sue, 1996) and influences somatization by normalizing the physicalizing of distress. Pang (2000) hypothesizes that the holistic understanding of the mind and body as one system based on traditional Chinese medicine influences Korean Americans' expression of somatization. Similarly, Tseng (1975) posits that Chinese patients present somatic symptoms of psychiatric problems based on traditional Chinese medicine concepts. Ayurvedic medicine is the traditional Indian holistic health model that posits that balance and

harmony of three humors is required for health (Armstrong & Swartzman, 2001); it influences concepts of illness and expressions of somatization in many analogous ways.

Generally, Asian cultures attribute illness to external sources, such as supernatural elements and social influences (Armstrong & Swartzman, 2001). Traditional Chinese and Ayurvedic medicine both credit supernatural elements, for instance spirits and dead ancestors, and social factors with the power to cause physical or psychological symptoms (Armstrong & Swartzman, 2001; Gaw, 1993). Cambodian culture believes ancestral spirits can cause mental illness (Nishio & Bilmes, 1989). "Spirit intrusion, violation of taboo, soul loss, disease sorcery and object intrusion" (Kim, 1999, p.70) are the primary sources of illness in traditional Korean Shamanism (Kim, 1993). Chinese folk beliefs include a bevy of gods that can invade the body and feed upon vital energies to produce illness (Gaw, 1993). In Chinese culture, it is believed that supernatural forces will cause illness if social order isn't maintained (Gaw, 1993). Though no longer popularly believed in modern Japan, fox possession had long been considered responsible for psychiatric illness (Fujii, Fukushima, & Yamamoto, 1993). Asians and Asian Americans also commonly attribute illness to interpersonal problems. In a study by Narikiyo and Kameoka (1992), interpersonal problems were more likely to be considered the cause of mental illness in Japanese Americans when compared to Caucasian Americans. Attributing illness to internal sources is unusual in most Asian cultures. However, Sue, Wagner, Ja, Margullis and Lew, (1976), found that Asian American students reported that mental health was the result of avoiding negative thoughts. This reflects the common Asian value of self-control and likely makes psychotherapy, in which one is typically encouraged to discuss negative emotions and thoughts, an unsuccessful and unwelcome

treatment (Sue, Wagner, Ja, Margullis & Lew, 1976). Additionally, the consistent avoidance and suppression of morbid thoughts or emotions could result in somatization.

Within most Asian American cultures (Uba, 1994), including Chinese American and Japanese American cultures (Marsalla, Kinzie, & Gordon, 1973), it is considered appropriate to be passive, unassertive, deferent (Marsalla, Kinzie, & Gordon, 1973), receptive, and nonconfrontational when communicating (Uba, 1994). The resulting subtle, indirect style of communication is accompanied by "high levels of empathy and receptivity to others and considerable sensitivity to nonverbal communication" (Nilchaikovit, Hill, & Holland, 1993, p. 42) and is thought to preserve interpersonal harmony (Uba, 1994). An example of this style, called *enryo* in Japanese "involves a particular type of reserve, reticence, deference, and humility" (Uba, 1994, p. 17). Asian and Asian American persons often utilize indirect, passive and passive aggressive communications, such as guilt, to modify the behavior of others (Uba, 1994). Asian Americans and Malaysians were found to have higher levels of alexithymia when compared to European Americans (Le, Berenbaum, & Raghavan, 2002), which indicates that the ability to directly express emotions as well as the ability to recognize specific emotions is more difficult for people of Asian descent than Caucasians. Interactions with helping professionals are impacted by communication styles. The desire to show respect and deference according to hierarchical power structures influences some people of Asian heritage to take a very passive role in their relationship with helping professionals, which is expressed by never disagreeing with or questioning the professional and occasionally passive aggressive noncompliance (Nilchaikovit, Hill, & Holland, 1993). It is not uncommon for differing styles of communication between Asian patients and American

physicians to lead to frustration in both parties, with the doctors feeling that not enough factual information is being conveyed in a timely manner and the patients feeling that the physician is uncaring, untrustworthy, and rude (Nilchaikovit, Hill, & Holland, 1993).

Emotional self-control was found to be one of five components of the Asian American Values Scale and a predictor of a negative attitude toward seeking professional psychological help (Kim, Li, & Ng, 2005). Open, direct, verbal expression of emotional distress is disapproved of in Asian and Asian American cultures, including Chinese culture (Cheung & Lau, 1982; Nilchaikovit, Hill, & Holland, 1993; Parker, Gladstone, & Chee, 2001; Tseng, 1975), because it can threaten social harmony (Chun, Enomoto, & Sue, 1996; Uba, 1994). For example, even expressing sadness that is unrelated to the actions of family members is thought to burden others with concern for the unhappy individual (Yeh, Inman, Kim, & Okubo, 2006). Instead stoicism, indirect expressions of positive emotions, and suppression of negative emotions are endorsed, and emotional control is considered a highly valued trait (Kleinman, 1986; Nilchaikovit, Hill, & Holland, 1993; Uba, 1994) and indicative of social and psychological maturity (Chen & Swartzman, 2001). Additionally, expression of strong emotions is shunned, because Chinese traditional medicine acknowledges that extreme affect can produce illness-causing disharmonies (Chen & Swartzman, 2001).

Conformity to norms was confirmed as one of five components of the Asian American Values Scale (Kim, Li, & Ng, 2005), demonstrating that adherence to societal norms is highly valued by most Asian American cultures, including Japanese and Chinese Americans (Marsalla, Kinzie, & Gordon, 1973). Rebellion is strongly disapproved of in traditional Asian cultures (Sue, Wagner, Ja, Marcullis, & Lew, 1976).

As in other collectivistic societies, many Asian people feel fitting in to be tremendously important, and in the Japanese culture "in order to belong, the individual must conform to the group" (Fujii, Fukushima, & Yamamoto, 1993, p. 316). It is believed that mental illness is considered to be so stigmatizing in Japanese culture, because it is a deviation from the norm (Fujii, Fukushima, & Yamamoto, 1993). Conformity to social and moral standards also is considered very important, because Confucianism dictates that it is necessary to obtain good health according to Confucianism (Chen & Swartzman, 2001).

Many Asian cultures are fatalistic, especially those that have been strongly influenced by Buddhism (Nilchaikovit, Hill, & Holland, 1993) and Taoism. Feeling that forces outside of one's control regulate one's life may make one feel helpless, more prone to simply accept symptoms, and less likely to seek help for physical or psychological problems (Nilchaikovit, Hill, & Holland, 1993). Fatalism is a frequently used coping mechanism within Asian American cultures (Yeh, Inman, Kim, & Okubo, 2006), and in Chinese culture, it is thought to be protective and helpful for accepting a life anticipated to be full of difficulties (Parker, Gladstone, Chee, 2001).

Immigrant/minority status of Asian Americans also influences somatization. It is thought that the disruption in patterns of communication and interactions with significant others that are consequences of the immigration process reinforces somatization in elderly Korean Americans (Pang, 2000). Similarly, Westermeyer, Bouafuely, Neider, and Callies (1989) posit that "social isolation and cultural alienation" (p. 42) of Hmong refugees in America may result in somatization, and therefore the authors suggest attempting to acculturate refugees quickly in order to prevent somatization.

Asian American culture affects help-seeking behavior for physical and psychological symptoms, including somatization, by influencing if help is sought and from whom help is sought. It is hypothesized that the stigma associated with mental illness acts a barrier to seeking professional psychological services for Asians and Asian Americans (Chen & Armstrong, 2001; Fujii, Fukushima, & Yamamoto, 1993; Gaw, 1993; Kim, 1999; Narikiyo & Kameoka, 1992; Uba, 1994; Yeh, Inman, Kim, & Okubo, 2006). Belief that one should have emotional self-control was negatively correlated with positive opinions of professional mental health treatment (Kim, Li, & Ng, 2005). Most Koreans will not seek help for minor symptoms in an attempt to overcome them through self-control (Kim, 1999). Japanese American will attempt to "endure and adjust to the situation" Narikiyo & Kameoka, 1992, p. 367) before consulting a professional. Koreans often seek medical advice from laypersons instead of physicians (Kim, 1999). Southeast Asian Americans tend to seek the help of family members and friends for life difficulties rather than professional mental health services, which do not even exist in their nation of origin (Nishio & Bilmes, 1987). Similarly, Japanese American students considered talking to and spending time with friends and family and resolving interpersonal problems as more helpful for combating psychological distress than meeting with a mental health professional (Narikiyo & Kameoka, 1992). Cheung and Lau (1982) found that help-seeking behavior of Chinese patients and their symptom presentation varied according to the context of treatment, and they theorize that where one's goes for help depends upon one's understanding of the problem. In medical settings, patients focused on somatic symptoms and in psychiatric settings, somatic symptoms were concomitants to psychological symptoms (Cheung & Lau, 1982).

Latino/Hispanic Americans

Hispanic is used by many researchers to refer to a heterogeneous group of people from various racial, ethnic, cultural, and national backgrounds all of whom are of Spanish decent and most of whom speak Spanish (Altarriba & Santiago-Rivera, 1994). Put more colorfully, Montilla and Smith (2006) state "Hispanic refers to a multicultural multiethnic, mariachi, salsa, and tutti-frutti mosaic of people that sounds good, looks exotic, tastes great, moves quickly, and is found everywhere" (p. 30). *Latino* and *Latina* are terms that refer to "a Latin American; a person of Hispanic, especially Latin American descent, often one living in the United States; an American whose first language was Spanish" (Smith & Montillo, 2006, p. 235). The terms are used synonymously and interchangeably by many (Perez-Stable & Napoles-Springer, 2006; Lopez & Katz, 2006; Sue & Sue, 1999) or no distinction in made between terms (La Roche, 2002; Romero, 2000). I too will use these terms interchangeably or jointly.

As mentioned above, though Latino culture may encompass a wide variety of people, the Spanish language is often shared amongst them and is a unifying feature of this minority group. Though bilingual clients will have varying degrees of fluency in each language, emotional words and experience are typically more clearly and spontaneously expressed in one's dominant language (Altarriba & Santiago-Rivera, 1994), and clients may instinctively revert to their native tongue when discussing strong emotions (La Roche, 2002). Utilizing a second language in which he or she does not have complete fluency could result in the client focusing on how to say what he or she needs to express instead of what to say in a treatment session. For those Latinos whose preferred language is Spanish but live in an environment in which they must speak

English, such as with most available mental health professionals, no opportunity to completely communicate their emotional experiences may exist. The result of this prohibition could be somatization. Additionally, Falicov (2006) hypothesizes that "the *amabilidad* (amiability), gentility, and civility of the Spanish language no doubt contribute to a politeness of demeanor, deportment, and address" (p. 57). The focus on politeness references the highly valued concept of *respeto*, which is simply translated to mean respect, but also involves the expectation of hierarchy (Falicov, 2006) and deference to authority figures (Southern, 2006), with men and older individuals being given greater authority (Falicov, 2006). In order to demonstrate *respeto*, individuals may sometimes feel that free, direct expression is prohibited. The possible resulting inhibition of emotional expression could lead to somatization. The emphasis on courtesy and graciousness in the Spanish language also indirectly implies the importance of others to the individual and the collectivism that is crucial in Hispanic culture.

Latino/Hispanic cultures are considered collectivistic (Dobkin de Rios, 2001; Falicov, 2006; Janoff-Bulman & Leggatt, 2002; Montilla & Smith, 2006; Romero, 2000; Smith & Montilla, 2006) or allocentric (La Roche, 2002). Hispanic culture is particularly relationship (Montilla & Smith, 2006) and community focused, and it posits that life can only be fully experienced in the connection with others with the entire community sharing one member's distress (Falicov, 2006). However, Latino culture also respects and values the uniqueness and dignity of each individual, while highlighting the common good and responsibility to the rest of the group (Falicov, 2006; Montilla & Smith, 2006). An emphasis on interdependence (Montilla & Smith, 2006; Romero, 2000), especially that of family members (Dobkin de Rios, 2001; La Roche, 2002),

naturally accompanies the collectivistic nature of the Hispanic/Latino culture. This familial interdependence usually continues through all stages of life (La Roche, 2002) and is reflected in the greater desire and greater sense of obligation to help distant family and friends in Latino Americans when compared to Anglo Americans (Janoff-Bulman & Leggatt, 2002). A group sense of self (Romero, 2000) and more specifically a familial self (Falicov, 2006; Koss, 1990) stem from the collectivism and interdependence seen in this cultural group.

A strong sense of family, also known as *familismo* (familism), is "at the heart of the Latino community" (Montilla & Smith, 2006, p. 30). *Familismo* is core to Latino/Hispanic Americans (Arrendondo, 2006; Dobkin de Rios, 2001; Falicov, 2006; La Roche, 2002; Lopez & Katz, 2001) regardless of nation of origin or language preference, implying that this value is common to all Latinos and not affected by acculturation level (Villarreal, Blozis, & Widaman, 2005). Familism in Latino/Hispanic cultures includes an attitudinal aspect that includes feelings of solidarity, reciprocity, and loyalty to family, a behavioral component that involves frequent contact with family members (Villarreal, Blozis, & Widaman, 2005), and large, multigenerational households, which is demographic familism (Luna, Torres de Ardon, Lim, Cromwell, Phillips, & Russell, as cited in Villarreal, Blozis, & Widaman, 2005). The importance of family also is demonstrated in the flexible, inclusive definition of family in which extended family members, padrinos (godparents) (Romero, 2000; Villarreal, Blozis, & Widaman, 2005), and neighbors (La Roche, 2002) may be considered family. The intense devotion of family engenders a loyalty that makes many hesitate to divulge negative information about the family to others (Carrillo, 2001; Montilla & Smith, 2006), such as

psychotherapists, which decreases the likelihood of seeking professional help for emotional or psychological problems (La Roche, 2002).

Mental illness is considered socially stigmatizing by most Hispanic cultures (Alarcon, 2001). One is expected to be able to overcome stress and stay in control of one's emotions in Latino culture (Dana as cited in Romero, 2000). Failure to do so indicates weakness that can be stigmatizing (Romero, 2000) and shaming (Carillo, 2001). In addition to the being affixed with the stigma associated with mental illness, some Latino clients could be stigmatized for disrespecting and betraying their family by sharing private, familial information when they fully engaging in therapy. Lopez and Katz (2001) hypothesize that Hispanics somatize with greater frequency in an attempt to avoid the stigma associated with mental illness.

Hispanic/Latino culture influences the experience and definition of symptoms. Health and illness of an individual is considered a family matter (Montilla & Smith, 2006; Romero, 2000). Therefore it may be best to focus on the family's symptoms (La Roche, 2002) and include the Latino family in treatment. Additionally, this culture considers physical symptoms to be more legitimate than emotional ones (Arrendondo, 2006), which reinforces somatized symptoms.

Like many collectivistic societies, the Latino culture generally desires "to live in harmony with nature, the universe and self" (Montilla & Smith, 2006, p. 33). This way of being can be expanded to include interpersonal harmony, which is also highly valued in Hispanic culture. *Simpatia* is the desire for good interactions (Perez-Stable & Napoles-Springer, 2001) and incorporates the avoidance of direct confrontation or expression of anger, which helps to prevent interpersonal disharmony (Lopez & Katz,

2001). Even if they disagree with or don't understand a treatment recommendation, Latino clients may always nod and appear to agree with the helping professional, because *simpatia* and *respeto* (Carillo, 2001; Perez-Stable & Napoles-Springer, 2001) prevent the clients from doing anything that could jeopardize the interpersonal relationship. Demonstrations of reciprocity and appreciation commonly are found in Hispanic cultures (Carillo, 2001), because they encourage strong social relationships. Koss (1990) goes further to say that physicalized symptoms are often an attempt to remedy an imbalance in the interpersonal realm, such as creating a firmer boundary between an individual and her family or bringing family closer together following a loss or trauma.

Holism is a part of the common Hispanic culture's conception of illness, which incorporates a connection of the mind, body (Angel & Guarnnaccia, 1989) and spirit (Koss, 1990; Montilla & Smith, 2006). Within this framework, it is accepted that affective disruptions can find a physical expression through somatic symptoms (Canino & Canino Stolberg, 2001; Koss, 1990). Additionally, from this health model it is possible for spiritual problems to be manifest as bodily complaints.

External attributions of illness are common in the Hispanic culture and somewhat reflect the belief in fatalism common in this group of peoples (Carillo, 2001; Villarreal, Blozis, & Widaman, 2005). Supernatural sources are believed to be the source of physical and mental illness, such as a *mal de ojo* (magic spell) in many Mexican Americans or Puerto Rican Americans (La Roche, 2002), magical influences in Andean villages (Alarcon, 2001), witchcraft hexes in many Spanish speaking immigrants (Dobkins de Rios, 2001) and Mexican Americans (Martinez, 2001), illness-causing spirits in followers of Spiritism (Arrendondo, 2006) from Puerto Rico, Argentina,

Venezuela, Brazil or Spiritualism in those from Mexico and Central American countries (Koss, 1990), and punishment from God or devils in Peru (Alarcon, 2001). Interpersonal problems also may result in physical symptoms, which are a metaphorical expression of one's psychosocial distress and can be considered indirect, external sources of bodily illness (Koss, 1990). Feelings of intrusion secondary to the collectivism, familial self, and familism widespread within the cultural group are expressed through somatic symptoms, which allow for a reinforcement of personal, individual boundaries while avoiding potential interpersonal difficulties (Koss, 1990). Reflecting the collectivistic nature of the Latino community is the belief that acts of deception or betrayal can result in mental illness (Alarcon 2001).

The communication style of the Hispanic culture is shaped by the Spanish language, *respeto, familismo,* and *personalismo* (Falicov, 2006). *Respeto* and *familismo* dictate a hierarchy of expectations of how one is to act with different members of the community. "Indirect, implicit, and covert" (Falicov, 2006, p. 57) communication or *indirectas* are valued as means by which interpersonal harmony can be maintained, especially when anger is involved (Falicov, 2006). The opposite style of communication that includes assertiveness, direct demands for clarification, and open differences of opinion often is viewed as rude (Falicov, 2006). *Personalismo* is a term that references respect for relationships, an unspoken expectation of reciprocity (Arrendondo, 2006), and the ability to create smooth and positive social interactions. This value sometimes finds expression in a preference for indirect communication and to warming up in a conversation before getting to business with professionals. For example, Latino clients may wish to inquire about the well being of family members before discussing medical

matters with a physician, whereas many physicians have little time to spend with each patient and would prefer to get straight to medical issues (Perez-Stable & Napoles-Springer, 2001). What may appear to be small talk is of great importance to members of this culture. Often emotions are expressed more openly when they are subtly approached opposed to asked about directly (Falicov, 2006).

The degree of open emotional expression in Latino culture is unclear. On one hand, emotional control is valued and expected from those in the Hispanic/Latino community (Dana as cited in Romero, 2000). S*imaptia* often requires the individual to control and indirectly express their anger so as to maintain interpersonal harmony (Falicov, 2006; Perez-Stable & Napoles-Springer, 2001). However on the other hand, according to Montilla and Smith (2006) "most Hispanics would not refrain from expressing negative or positive emotions in public because the idea of privacy seems to be of lesser importance than to be transparent" (p. 36). From this perspective, collectivism is demonstrated by preferring to share one's feelings with others, rather than restrict affective expression and therefore keep one's emotions to oneself.

Latinos strictly conform to some key norms within their culture, such as *respeto* (Dobkin de Rios, 2001; La Roche, 2002; Villarreal, Blozis, & Widaman, 2005), which requires that respect be given to those in authority typically according to gender, age, and social class. Gender role norms are often followed more strictly in Latino and Latino American cultures than in European American cultures (Lopez & Katz, 2006). The term *machismo*, a belief that men should be strong, powerful, and responsible for providing for their family (Rodriguez, Bauer, Flores-Ortiz, 2006), is not unfamiliar to most Americans, but the reciprocal feminine term, *marianismo*, may be less well known. It references the

"self-sacrificing, long-suffering woman who receives a certain satisfaction from her life circumstances because she is assured of a 'cloud in heaven' for her self-abnegation or martyrdom" (Dobkin de Rios, 2001, p.30) and also refers to feminine moral superiority and greater spiritual strength (Dobkin de Rios, 2001). The cultural expectation of this submissive and sacrificial behavior creates a situation that lends itself to somatized symptoms as the only socially acceptable expression of women's negative feelings and a protest against their oppression and powerlessness.

The Latino/Hispanic culture has a fatalistic component referred to as *fatalismo* or fatalism (Carillo, 2001; Villarreal, Blozis, & Widaman, 2005). This is exhibited as God being given complete control over the individual's life, which promotes a passive attitude toward life and health. Consequently, many Hispanics are dissuaded from seeking help for psychological or emotional symptoms, which could possibly increase or intensify somatization, or for physical symptoms, some of which may be psychosomatic in origin, and hence this could no longer be defined as somatization.

A large percentage of the Latino/Hispanic population is immigrants or sojourners in this country. Dobkins de Rios (2001) states that these populations are especially vulnerable to become nostalgic for their nation of origin to the point of developing gastrointestinal problems or other somatized symptoms. Additionally, minorities and Hispanic immigrants, in particular, "commonly experience racism, discrimination, prejudice, and stereotyping...[that results in] severe emotional strain" (Dobkins de Rios, 2006, p.24). This stress of being a minority in America could result in somatization.

Hispanic culture influences help seeking behaviors. Based on familismo, Latinos usually first seek psychological help from family members rather than from mental health

professionals (Romero, 2000), and they may be reluctant to discuss family problems with outsiders (Montilla & Smith, 2006). Requiring outside help may be viewed as the family's failure to take care of their own (Carrillo, 2001). Instead treatment may be sought for cultural idioms of distress or culture bound syndromes that often entail a somatization component, such as *nervios, ataque de nervios,* (Angel & Guarnaccia, 1989), *mal de ojo,* and *susto,* which are not as stigmatized and are viewed as a culturally appropriate and legitimate (Lopez & Katz, 2001) method of expressing "strong emotions due to stressful life events; [they are] an outlet for anger grief, and family disruptions" (Romero, 2000, p.218). Overall, the stigma and assumption of weakness associated with requiring help with emotions or coping with stress is likely to inhibit Hispanics from seeking mental health services (Romero, 2000), but they may instead seek help for somatic expressions of their emotional distress.

Summary

The following is a brief list of some of the influential shared beliefs of African American, Asian American, and Latino/Hispanic American cultures that increase the likelihood of somatization. Collectivism commonly propagates a group or familial sense of self, encourages of interdependence, and builds a foundation of familism. By placing greater import on others than on the individual self, less energy or consent is available to strive for individual goals, including an individual's physical or mental well-being; this could breed contempt; and the emphasis on "we-ness" may be compensated for by defining individual boundaries through somatic symptoms. Via lack of self-care, unconscious intolerable conflicts, or somatized self-boundaries these cultural attitudes can lead to or reinforce somatization. In these cultures, mental illness commonly is

viewed as stigmatizing for individuals and their families and emotional problems are invalidated because of they are experienced only by individuals, both of which reinforce the somatic expression of distress and inhibits psychological or emotional expressions of distress. Generally, these three cultures strive for harmony and balance interpersonally, spiritually, emotionally, and physically, which impacts one's definition of pathology and conceptualization of somatized symptoms and their remediation. All three cultures have traditions of holistic medical models that accept the physicalizing of distress making somatization more likely to occur. All of the above interact to have some bearing on the attribution of illness and somatized symptoms, which in turn impacts help-seeking behavior and attitudes about mental health care. Cultural sanctions against direct communication and emotional expression leave the body to "voice" one's distress through somatization in these cultures. The urge to conform, low self-efficacy, and passivity encourages a silent resignation to somatized symptoms and a disinclination to seek help for them. Based on the above cultural beliefs, African Americans, Asian Americans, and Hispanic/Latino Americans are more likely to seek help from family members, traditional healers, spiritual leaders, or physicians than mental health professionals. Lastly, the general stress brought about by being a collectivistic, ethnic minority living in an individualistic, European American majority culture is an experience jointly felt by members of all three cultural groups that contributes to somatization.

Some cultural beliefs common to African Americans, Asian Americans, and Hispanic/Latino Americans can safeguard against somatization. The tightly woven interpersonal support network created by collectivism, interdependency, and familism

can act as a partial buffer against somatization. The need to conform to norms and blend in may drive some people of these cultures not to express extreme somatization, because disabling somatization would draw attention to the individual. The fatalism found in these cultures could make them reluctant to seek professional help for their somatized symptoms and hence no longer meet the requirements of the somatization definition.

In addition to the similar ways in which African American, Asian American, and Hispanic/Latino American cultures influence somatization, there are several differences. Each of the three cultural groups is associated with a unique language, if not numerous languages, that shapes one's understanding of the universe and can potentially spawn somatization symptoms. People in these cultures tend to follow different organized religions as well as numerous, local spiritual systems, which then affect somatization in different ways. Some of the religions more popular in Asian Americans, such as Buddhism, Taoism, and Confucianism, have very strong ramifications on somatization, whereas the religions followed by most African Americans and Hispanic Americans impact somatization less directly, in my opinion. Traditional Chinese and Ayurvedic medicines, primarily believed by Asian Americans, are two extremely longstanding, well organized, and frequently utilized health models that appear to have a greater impact on somatization than the traditional health models of African Americans and Latino Americans, which are less organized and less utilized in this country. African Americans tend to value indirect communication less than Hispanic Americans and Asian Americans, which increases the likelihood of somatization in these two groups. Asian American cultures are inclined to value emotional control more highly than Latino

American or African American cultures do, meaning those of Asian descent may be more prone to somatize secondary to unexpressed affect.

In conclusion, there are numerous ways in which parallel cultural beliefs of African Americans, Asian Americans, and Hispanic/Latino Americans propagate somatization, and there are some shared cultural values that shelter the peoples of these cultures from somatization. There are a large number of congruent attitudes within these three cultural groups, because they all have collectivism as their base. Despite their common foundation, each culture is distinct and influences somatization in unique ways.

Summary

Epidemiological studies of somatization prevalence were reviewed with the primary focus given to the conflicting information about the rates of ethnic minorities as compared to Caucasians. Though data exists indicating all three of the principal minority groups in the United States (African Americans, Asian Americans, and Latino/Hispanic Americans) somatize more than European Americans, research also has been published supporting the opposite position that there are no significant differences in somatization rates between ethnic groups. After considering the disparate information, I concluded that severe forms of somatization, such as somatization disorder, vary little amongst ethnic groups, but that there are ethnic variations of the prevalence of less debilitating somatic expressions of distress that do not meet the criteria for somatization as I have defined it. Belief in various cultural values is chiefly responsible for these differences in low-level somatization.

In this analysis of the influence of culture on somatization, collectivism or individualism were the primary characteristics through which culture was evaluated. I

examined how language and cultural beliefs influence people's concepts and definitions of health and illness, their interpretation of experiences as symptoms of pathology or normality, and their judgments of the acceptability of behavior, including how to remediate illness. These and other aspects of culture affect the process, progress, and most importantly, the meaning of somatization for individuals and groups.

The cultural values of African Americans, Asian Americans, and Latino/Hispanic Americans that have the most influence on somatization were discussed next. Because these three cultures typically are collectivistic, they have many cultural beliefs in common, and hence the influence of those cultures on somatization is alike in many ways. When compared to the individualistic United States, there are more similarities than differences among these three minority cultures in how they affect somatization. Though my analysis of African American, Asian American, and Latino/Hispanic American cultures emphasizes similarities, the expression of analogous values or beliefs is unique in each culture. Lastly, it is important to remember that ethnic labels, such as Latino American, are applied uniformly to very heterogeneous groups of people and that one's acculturation level and ethnic identity dramatically affect how strongly cultural beliefs influence somatization in that individual.

Additional Treatment Models and Proposed Treatment Recommendations

Having scrutinized its definition, compared the major psychological theories and treatments, reviewed the epidemiology literature, and analyzed the influence of culture on it, I now discuss the treatment of somatization. This section starts with a review of treatment recommendations often given to physicians and other medical providers. The biomedical, biopsychosocial, biofeedback, and pharmacotherapy approaches are included

here. Next, culture-based treatments are presented. These include yoga, acupuncture, Kampo herbal medicine, and Japanese psychotherapies. This section proceeds to a review of three key treatment controversies. Lastly, my treatment recommendations are presented.

Medical and Culture-based Treatments for Somatization

Medical Treatments

The biomedical approach.

By definition, people who somatize seek help from those who attempt to alleviate somatic symptoms. In the United States, those professional service providers are usually primary care physicians or nurses. As a result, much has been written for medical audiences about the "management" of those with somatization, and the bulk of this literature is written from a biomedical standpoint, which is the standard paradigm in Western medicine. Biomedicine is based on reductionistic thought and holds that disease is both functional, due to physiological or chemical processes, and ontological, exists independent of the patient (Fabrega, 1991). Mind-body dualism is closely related to these principles, and as a result, biomedicine does not easily allow for the incorporation of emotional, spiritual, or social problems into the conceptualization of illness. In fact, to defy the tenets of functional and ontological disease by reporting illness in the absence of evidence of disease is "crazy" and may contribute to some of the negative affect felt by physicians when treating somatizing patients.

A predominant theme in somatization treatment literature for medical professionals is the frustration, anger, and dread somatizers evoke in physicians and nurses. Frustration stems from the lack of improvement and occasional increase in

somatized symptoms despite extensive efforts made by medical professionals (Holloway & Zerbe, 2000). Physicians often are accustomed to the satisfaction that comes with solving their patients' problems and alleviating their suffering. When unable to do so because the source of the problem is not biological, patient complaints can "erode the physician's feelings of effectiveness" (Holloway & Zerbe, 2000, p. 90). Conceptualizing somatization as a chronic disorder alleviates the need for the medical provider to find a "cure" and can relieve many of the negative feelings evoked by these patients (Maynard, 2000). Somatizers are often viewed as being very demanding by insisting on the severity of their physical complaints but also help-rejecting and reluctant to get better by being noncompliant with prescribed treatments and unwilling to follow through on psychological referrals (Holloway & Zerbe, 2000). Understandably, an all too common response is then to blame the patient for his or her situation. This all can take its toll on physicians, lead them to doubt their abilities, and possibly even result in burnout (Holloway & Zerbe, 2000). Sometimes, if the negative feelings of the physician become such a hindrance that they prevent the patient from receiving adequate care, it is best to refer the patient to another doctor (Smith, 1990). Maynard (2003) goes so far as to consider the irritation felt by the clinician to be a diagnostic cue for somatization.

Generally, this literature considers somatization to be a chronic condition that is to be managed rather than cured. If the patient and/or physician aim to completely eliminate symptoms, disappointment as well as possible iatrogenic complications could result. Instead, it is recommended that the focus of treatment be on improved function, learning to cope with symptoms, and tolerating an ambiguous explanation for symptoms (Servan-Schrieber, Tabas, & Kolb, 2000). Though this comes from traditional Western

medicine, it encompasses Buddhist principles that might appeal to some Asian Americans. Somatization management was found to be effective at stabilizing patients' health status, decreasing their use of health care, and improving their satisfaction with the care they received (Smith, Monson, & Ray as cited in Smith, 1990).

Somatization management recommendations geared toward physicians or other medical professionals have several common suggestions. It is often recommended that one primary care physician become the principle or only physician for the patient (Holloway & Zerbe, 2000; Servan-Schrieber, Tabas, & Kolb, 2000; Smith, 1990). Because in their desperation to find relief from their symptoms, many people who somatize seek help from multiple physicians and/or medical facilities, which puts them at risk of receiving prescriptions that have negative interactions, conflicting information about their illness, and repetitive, unnecessary diagnostic procedures. Additionally, this behavior will increase the cost of their medical care, perpetuate their focus on their body, possibly delay the diagnosis of somatization, and hence delay appropriate treatment. However if consultation or treatment with a specialist is deemed necessary, the primary physician must inform the professional being consulted of the patient's pattern of somatization so as to avoid as much as possible a disruption of the conservative management plan (Smith, 1990).

Brief appointments scheduled approximately regularly (Holloway & Zerbe, 2000; Lipowski, 1988; Maynard, 2003; Servan-Schrieber, Tabas, & Kolb, 2000; Smith, 1990) are also advised. It is thought that regular appointments decrease the need for patients to develop new symptoms in order to receive attention and care from the physician (Holloway & Zerbe, 2000; Servan-Schrieber, Tabas, & Kolb, 2000; Smith, 1990). Over a

substantial length of time, perhaps a year or more, patients hopefully will realize that they will have consistent, caring contact with their doctor regardless of their health status. This suggestion will likely appeal to minority clients, especially Latino/Hispanic patients, who tend to desire an amicable and more personal relationship with their physician. Maynard (2000) also suggests creating a physician/patient partnership in which the patient is told that he or she is a part of the treatment team, can have control over his or her health and symptoms, and will not be abandoned by the physician who is dedicated to working with the patient. While this approach will likely be helpful for many patients, it could be unappealing for those whose cultures are fatalistic and have a passive approach to health or whose cultural backgrounds highly value hierarchical authority to the well educated, such as physicians. For these people, to think that an individual has more power over their health than God, the spirits, or the universe would be blasphemous, and to consider themselves to have the same amount of power and status as a medical doctor would be arrogant and inappropriate.

Medical management often advises the physician to physically exam the symptomatic body part or organ system during each visit (Smith, 1990). This simple procedure can make the patients feel that their symptoms and complaints are being taken seriously, and the "laying of hands" (Smith, 1990, p. 47) has a ritualistic symbolism of caring that can be healing by itself. Additionally, a quick physical examination can assure the physician that no organic disease is being missed (Smith, 1990). It is important to remember that somatizers often have substantiated co-morbid conditions, both physical and psychiatric, that require care (Servan-Schrieber, Tabas, & Kolb, 2000; Smith, 1990). Just because some symptoms are psychological in origin does not mean

that the patient cannot have organic diseases. However, once a diagnosis of somatization has been reached, it is best to avoid unwarranted interventions (Servan-Schrieber, Tabas, & Kolb, 2000) and diagnostic procedures (Smith, 1990) beyond the brief physical examination unless clearly indicated, as these can have negative, iatrogenic side effects and perpetuate or intensify somatic anxiety.

It is important that physicians assess for underlying or co-morbid psychiatric disorders, such as major depressive disorder, generalized anxiety disorder, and panic disorder (Smith, 1990). It is possible that appropriate treatment of a co-occurring mental illness will alleviate the somatic symptoms as well. The usefulness of mental health professionals for this aspect of treatment is mentioned in the medical management literature, in which making a gentle referral to a support group or psychological treatment after a strong doctor/patient relationship has been established is supported (Smith, 1990). Servan-Schrieber, Tabas, and Kolb (2000) suggest that physicians label individual or group psychotherapy as "stress management for chronic disease" (p. 1424) as a way to avoid the stigma associated with psychiatric care. However, regardless of how compassionately and gently the referral is made, many people who somatize reject mental health care. To many, their physician suggesting that they seek psychotherapy is equivalent to their doctor proclaiming that the patient is crazy and has feigned all of his or her physical symptoms, and being willing to receive psychotherapy is the same as admitting that he or she is insane and malingering. It is important that the physician use empathetic phrases to validate the patient's discomfort (Maynard, 2000), explore psychosocial issues with the patient (Servan-Schreiber, Tabas, & Kolb, 2000), and

provide emotional support (Smith, 1990), especially for those who are not willing to utilize psychological services.

Medical management of somatization often includes setting reasonable, short-term goals (Maynard, 2000) that can be measured behaviorally, such as walking around the block three times a week or enjoying a pleasurable activity once a week. Servan-Schrieber, Tabas, and Kolb (2000) specifically recommend regular exercise and pleasurable activities. Goals like these emphasize the patient's ability to function and ability to enjoy life instead of focusing on the presence or absence of symptoms and disability. Having specific, measurable, behavioral goals makes the patient's progress easy to track, which can be very affirming and reassuring for patients and their medical providers.

Providing an acceptable diagnosis and explanation of symptoms to the patient that acknowledges the patient's distress while avoiding the implication that the symptoms are purely psychological in origin has been emphasized by Servan-Schrieber, Tabas, and Kolb (2000). These researchers are sure to acknowledge the suffering and disability caused by the patient's "condition" by informing the patient that he or she has a serious, non-life-threatening, chronic, common condition that has no known cure but can be managed in a manner that will allow the patient better deal with the symptoms. Though Servan-Schrieber, Tabas, and Kolb (2000) do not recommend using a specific diagnostic label, they are not opposed to terms such as *somatoform disorder, pain disorder,* or *irritable bowel syndrome* if the patient insists on a name for their condition. Providing a diagnosis is perhaps the most delicate part of somatization treatment, and failure to

deliver a tolerable diagnosis can damage the doctor/patient relationship in an irrevocable way that sabotages treatment before it has even begun.

Several other recommendations for medical management of somatization have been made. Some physicians (Servan-Schrieber, Tabas, & Kolb, 2000) may consider all forms of treatment that are not traditionally part Western medicine, such as biofeedback, acupuncture, and herbal medicine, to be ineffective but benign, and so they will neither support or advise against their use. On the subject of coping with the demands of somatizers, some clinicians take a rather infantilizing position and insist that the medical professional set limits and stick to them (Maynard, 2000). Others (Servan-Schrieber, Tabas, & Kolb, 2000) recognize that doing so can appear to be arbitrary rule setting to the patient and instead recommend emphasizing the impact that the patient's demands have on the clinician's emotions and needs, which cannot be disputed. Lastly, Holloway and Zerbe (2000) suggest that medical practitioners who have frequent contact with people with somatization make sure they prevent burnout by striving for balance in their own lives.

The biopsychosocial approach.

An alternative to the biomedical foundation traditional to Western medicine is the more holistic biopsychosocial approach, which is becoming increasingly popular in Western medicine. This viewpoint considers the spheres of "bodily functioning, emotions, and social relationships" (Epstein, Quill, & McWhinney, 1999) all to be possible sources of illness, and all significant illnesses will affect the patient on those levels; treatment should address problems in any of these realms. Not surprisingly, somatization, a disorder that by definition encompasses the biological and psychological,

has been addressed from the biopsychosocial perspective. Within this model, some degree of somatization of psychological or emotional distress and emotional consequences of physical illness are normalized (Epstein, Quill, & McWhinney, 1999). However, that does not mean that severe somatization does not warrant treatment.

The biopsychosocial model supports many of the management techniques advocated by the biomedicine orientation discussed above. However, there are some differences and additions put forward by this more holistic medical model. The biopsychosocial paradigm advocates finding a name for the patient's illness that has meaning for the patient but also for the physician, (Epstein, Quill, & McWhinney, 1999); this way the patient's illness experience is validated, and the physician can apply accurate diagnostic labels. Epstein, Quill, and McWhinney (1999) recommend avoiding the term *somatization*, because so often it is interpreted in a demeaning way by patients. This model places much emphasis on patient care rather than finding a cure or cause of the illness (Epstein, Quill, & McWhinney, 1999). Utilizing adjunctive therapies, such as diet, meditation, physiotherapy, relaxation techniques, biofeedback, massage, and regular exercise are recommended in this model; as are collaboration and consultation with mental health specialists, preferably on-site in the primary care setting (Epstein, Quill, & McWhinney, 1999). Involving the family in treatment is advocated by many (Epstein, Quill, & McWhinney, 1999) and is the key component to medical family therapy or family systems medicine, one manifestation of the biopsychosocial approach.

Major proponents of medical family therapy and co-editors of *Families, Systems, and Health*, a journal formerly known as *Family Systems Medicine*, Susan McDaniel (1995) and Thomas Campbell (McDaniel & Campbell, 2006) have discussed a

component of somatization called somatic fixation (McDaniel, Campbell, & Seaburn, 1989). They explain that somatic fixation results when the biomedical component of illness is the exclusive focus of either the patient or physician and the psychological and social aspects of the physical symptoms are ignored. When this occurs in patients, they tend to present with somatization. When physicians become somatically fixated, which is common when they come from a biomedical orientation, this too can perpetuate somatization in the patient (McDaniel, Campbell, & Seaburn, 1989). Though McDaniel, Campbell, and Seaburn (1989) provide treatment recommendations for somatic fixation, I feel that these suggestions can be applied to somatization in general. They are: 1) explore biomedical and psychosocial components to every problem the patient presents from the beginning; 2) requesting a symptom diary that includes somatic as well as psychosocial information can be helpful; 3) work collaboratively with patients in a way that avoids presenting medicine as the only possible panacea for their problems; 4) schedule regular appointments and encourage the patient to not see any other physicians; 5) elicit the discussion of stressful events from the past and present and how they impact the somatic problem; 6) involve the patient's family in treatment; 7) focus on strengths, competencies, and abilities; 8) measure progress through level of functioning instead of symptoms; 9) reduce the intensity of treatment gradually and not too soon and anticipate relapse; and lastly 10) find a way to enjoy working with these patients (McDaniel, Campbell, & Seaburn, 1989). Again, many of these management techniques are reiterations of those proposed from the biomedical model; however, the additional focus on the psychosocial aspects of illness comes through.

Another incarnation of biopsychosocial medicine is behavioral medicine, which is defined as "a set of disciplines that address the health of individuals by teaching new behaviors, which in turn alter mood and affect body processes" (McLeod, Budd, & McClelland, 1997, p.251). In a six-session course of weekly classes that included daily homework, reading, in class exercises, and out of class discussions, participants learned, through the use of meditation, how to become more aware of how their relationships and activities affected their bodies and moods (McLeod, Budd, & McClelland, 1997). This relatively brief and inexpensive treatment program called Ways to Wellness resulted in significantly lower somatization scores immediately after the course and six months later when compared to a wait-list control group (McLeod, Budd, & McClelland, 1997). As a result, behavioral medicine techniques, such as those utilized in this study, are considered to be promising tools to somatization.

Biofeedback.

Biofeedback, or applied psychophysiology, has been utilized as an effective somatization treatment that bridges the gap between biomedical and biopsychosocial medicine (Wickramasekera, Davies, & Davies, 1996). Applied psychophysiology, with its use of high technology and attention to physiological responses, has more face validity than psychotherapy for somatizing patients who are convinced of the somatic nature of their symptoms. Biofeedback can be used to demonstrate the mind-body connection in skeptical patients by inducing mild psychological stress via a mental arithmetic test and observation of the consequential physiological changes in temperature, muscle tension, skin conductance, blood volume pulse, and heart rate (Dreher, 1996; Wickramasekera, Davies, & Davies, 1996). By acknowledging the interaction of the cognitive and

emotional (Wickramasekera, Davies, & Davies, 1996) this treatment has a holistic foundation that people from collectivistic, holistic cultures may consider more appealing than traditional Western biomedicine. Treatment involves using self-hypnosis and temperature biofeedback techniques to teach self-soothing skills that can be applied both to the body and the mind (Wickramasekera, Davies, & Davies, 1996). In a case study, biofeedback skills were combined with cognitive behavioral therapy (CBT) to help the patient find insight (Wickramasekera, Davies, & Davies, 1996) into the source of the repressed perception of threats that had been somatized (Dreher, 1996). The experience of stress is decreased by utilizing self-soothing skills, the origins of stressors are dealt with through CBT, and together biofeedback and psychotherapy effectively reduce somatized symptoms.

Pharmacotherapy.

Surprisingly, relatively few empirical studies investigating the use of pharmacotherapy to treat somatization exist in the literature. Several factors support the use of psychotropics for somatization: blood serum levels of tryptophan, a precursor of serotonin, are significantly decreased in patients with multiple unexplained symptoms (Rief, Pilger Ihle, Verkerk, Scharpe, & Maes, 2004), a multitude of psychopharmacological medications are considered to be effective and popular in the public eye since the development of selective serotonin reuptake inhibitors, and there is a commonly held belief in the link between somatization and depression and anxiety. In a meta-analysis of the use of pharmacotherapy to treat all somatoform disorders, Fallon (2004) found only one study that included participants with medically unexplained somatic symptoms. That small, uncontrolled study by Noyes, Happel, Muller, Holt,

Kathol, and Sieren, et al. (as cited in Fallon, 2004) indicated that fluvoxamine effectively treated somatized symptoms. In other studies it has been reported that paroxetine is effective for those with somatization disorder (Okugawa, Yagi, Kusaka, and Kinoshita, 2002) and antidepressants are effective for those with medically unexplained physical symptoms (O'Malley, Jackson, Santoro, Tomkins, Balden, & Kroenke, 1999). Several researchers (Holloway & Zerbe, 2000; Lipowski, 1988; Maynard, 2003; Servan-Schrieber, Tabas, & Kolb, 2000; Smith, 1990) recommend the use of antidepressants or anxiolytics for those with somatized symptoms if the patient shows signs of depression or chronic anxiety. The use of psychotropics should not be used alone but rather as a part of an overall management plan in conjunction with other forms of treatment. Should pharmacotherapy be indicated, the prescribing physician should also keep in mind that many minority clients respond to lower doses of psychotropic medication than the average Caucasian patient.

Culture-based Treatments

Yoga.

Though yoga has been used therapeutically to treat psychosomatic disorders for centuries, it has rarely been used as such outside of the subcontinent. Yoga is a life philosophy and practice that has origins in spirituality and whose physical or psychological effects are secondary (Goyeche, 1979). Compared to the layperson's understanding of yoga, Goyeche (1979) defines yoga more broadly to be a methodology that brings about the restraint of the self that allows for awareness of the present moment and a calm detachment or objectification of experience. This altered state of consciousness provides a "cushion against stress" (p. 60), induces relaxation, promotes

empathy, and increases tolerance for anxiety, all of which prepares the individual for counseling (Nagakawa & Ikemi, 1979) and could reduce somatization. The precise method by which this state is achieved varies according to the different schools of yoga, but often involves practice of postures, meditations, and breathing techniques (Goyeche, 1979). Goyeche (1979) posits that the "holistic somatopsychic approach of the yoga system" (p. 376) makes it naturally applicable to psychosomatic disorders. He further explains that yoga can redress hyper-self-consciousness, muscle tension, poor posture, irregular gross motor activity, irregular breathing and blood flow, all of which are common aspects of psychosomatic illnesses.

Acupuncture.

Acupuncture is a treatment technique based upon traditional Chinese medicine that has been successfully applied to most physical and many mental illnesses for centuries. However, its application to somatization has only begun to be empirically investigated. Equal numbers of Chinese participants with somatoform disorders were sampled from an outpatient clinic and the inpatient ward of the Department of Acupuncture in China and placed in one of two treatment groups: psychotherapy plus acupuncture or psychotherapy alone (Hou & Song, 1999). For eight weeks, each group received cognitive behavioral therapy twice a week and the psychotherapy plus acupuncture group also received acupuncture treatment five times a week. Both treatment groups made improvements, but 73.3% of the psychotherapy plus acupuncture group responded to treatment whereas only 46.6% responded to psychotherapy alone. On a whole, the psychotherapy plus acupuncture group had greater reductions in their depression and anxiety scores than did the psychotherapy alone group. Though this study

indicates acupuncture may be an effective adjunctive treatment for somatoform disorders, it also has several flaws. The most pronounced of which is the ambiguous somatoform diagnoses of the participants; greater detail about their diagnoses is not provided. Additionally, there is no control for treatment time exposure; the treatment groups were exposed to two versus seven treatment sessions per week. It is unclear how applicable these findings are to American patients who may not already be familiar with acupuncture or the traditional Chinese medical model of health. Though this study contains some methodological problems, it still suggests that acupuncture could be a promising treatment addition for somatization.

Kampo (Japanese herbal medicine).

Originally based upon traditional Chinese medicine, *Kampo* or Japanese herbal medicine has been practiced in Japan since the sixth century (Mizushima & Kanba, 1999). It remains a very popular form of medical care in Japan and has been used to treat several somatoform disorders (Mizushima & Kanba, 1999) and somatized symptoms. As with most holistic health models, *Kampo* considers every disease to have psychological components, so patients with symptoms that are unexplained by Western medicine are neither judged nor treated any differently from any other patient (Mizushima & Kanba, 1999); this removes much of the stigma associated with somatization or other mental illnesses, making this form of treatment more attractive and comfortable for many. Again the applicability of this form of herbal medicine to those not immersed in this health model is questionable. Kim (1993) does not encourage the practice of acupuncture or herbal medicine in conjunction with Western psychopharmacological interventions but does not discourage it if the patient expresses a strong desire to utilize the more

traditional treatment methods as well. Although no empirical studies yet exist, Mizushima and Kanba are currently executing a formal study on the efficacy of *Kampo* medicine as a treatment for somatoform disorders.

Japanese psychotherapies.

Morita therapy is a Japanese psychotherapy that is steeped in cultural beliefs valued in the East, such as collectivism, group self, interpersonal harmony, emotional control (Hedstrom, 1994), Zen Buddhism (Fujii, Fukushima, & Yamamoto, 1993; Murase & Johnson, 1974), and Taoism (Kim, 1993). This therapy was first developed in Japan as treatment for *shinkeishitsu* (Fujii, Fukushima, & Yamamoto, 1993), a Japanese syndrome, with three primary components: 1) neurasthenic, which includes fatigue, poor concentration, and tension, 2) obsessive-phobic, which includes social fears, such as blushing or body odor, and 3) anxiety, which includes somatic symptoms such as palpitations, dizziness, and vomiting (Hedstrom, 1994). It appears that *shinkeishitsu* closely resembles what is also known as *taijin kyofusho*, a Japanese culture-bound syndrome in which there is an intense fear or phobia that one's body or its functions displeases or disgusts others (DSM-IV-TR, 2000). Traditionally, it was a residential therapy that has the patient progress from complete bed rest and social isolation to increasingly physically taxing chores and social interaction (Fujii, Fukushima, & Yamamoto, 1993; Hedstrom, 1994; Murase & Johnson, 1974); an outpatient variant has been developed as well (Hedstrom, 1994). During the course of therapy, the individual is guided to accept their own thoughts, feelings, and selves as they are, so as to stop over attending to the self (Hedstrom, 1994), live with suffering (Fujii, Fukushima, & Yamamoto, 1993), and dismiss their perceived social failings. According to Hedstrom

(1994), the goal of this treatment is to direct attention outward to one's social roles, duty, and obligations. Adding to this, Fujii, Fukushima, and Yamamoto (1993) highlight that awareness of obligations to others allows the patient to recognize that they are needed and useful to others. However, Murase and Johnson (1974) state that the goals of Morita therapy are to eliminate destructive self-doubt and "neurasthenic and/or psychophysiologic symptoms" (p. 122) and to enhance self-acceptance. Though I know not of any controlled studies that support the efficacy of Morita therapy as treatment for somatization specifically, it was designed to help those with somatization symptoms that are part of the larger syndrome of *shinkeishitsu.*

Naikan therapy is another Japanese psychotherapy based on Buddhist philosophy (Hedstrom, 1994; Murase & Johnson, 1974). During week-long retreats, individuals are instructed to meditate on their relationships with significant others, especially their mothers, with the hope that they will become aware of the sacrifices made on their behalf and their obligations to others (Fujii, Fukushima, & Yamamoto, 1993; Hedstrom, 1994; Murase & Johnson, 1974). Ryback, Ikemi, Kuno, and Miki (2001) emphasize the use of "Rogerian empathy" (p. 133) during this process. The goal of treatment is to foster "a healthy existential guilt" (Hedstrom, 1994, p. 156) that allows for an appreciation of others (Murase & Johnson, 1974) and a commitment to remediate any emotional debts (Fujii, Fukushima, & Yamamoto, 1993). Though the Naikan counselor's primary function is to facilitate adherence to the Naikan procedure (Ryback, Ikemi, Kuno, & Miki, 2001), they also verify that the patient has some sort of emotional reaction and connection to the memories upon which they meditate (Murase & Johnson, 1974).

However, it is not required that memories or thoughts be shared with the counselor (Murase & Johnson, 1974).

Though there are some similarities to Western behaviorism (Hedstrom, 1994) and cognitive restructuring techniques, these Japanese therapies are the antithesis of most European-based psychotherapies in many ways. Unlike many Western psychotherapies that aim for individuation from family, assertive confrontation to address unresolved problems, or personal self-disclosure to others, Morita and Naikan therapies cultivate interdependence, obligations to others, and conformity, emphasize behavior and duty rather than feelings, do not require confrontation or even disclosure of interpersonal problems. Perhaps for these reasons, Morita and Naikon therapies have not been strongly embraced in the United States, but those same reasons might support their effectiveness with collectivistic, minority clients, including those with somatization. The stigma associated with most mental health treatment in the Japanese culture is avoided by the connotation that Morita and Naikan therapies are religious retreats (Murase & Johnson, 1974). Both of these Asian therapies have a holistic nature in which the mind is used to affect change in the body through spiritual acts that also have a social theme. Rather than attempting to adjust treatments developed within Western, individualistic worldviews for minority patients, it might be better to utilize a therapy that was constructed on a collectivistic foundation.

Treatment Controversies

As with every disorder that does not have an etiological paradigm, there are points of contention about somatization treatment. I discuss three of the most significant controversies here and offer my opinion on these topics. The first debate centers on the

possibility that no treatment may be the best treatment. Next, the question of whether to focus treatment on somatization behavior itself or to concentrate on the underlying sources of distress that then lead to somatization is discussed. Lastly, the importance of clients accepting that their symptoms are psychological and not organic in origin is questioned.

Is it possible that the best remedy for somatization is to do nothing? There are several reasons for many medical and mental health professionals to answer yes. "*Primum non nocere*" Latin for "First, do no harm" is one of the most basic principles of medical ethics taught to physicians. Fear that trial runs of medications, invasive diagnostic procedures, or exploratory surgery will cause more harm than good leads most physicians to believe that no medical treatment for somatized symptoms should be given. Their fear of iatrogenic harm is reasonable as it is possible that addiction can result from unnecessary use of pain medications, tolerance to other medications can arise, painful scar tissue can develop at incision sites, medication side effects or interactions with other prescriptions can induce new symptoms, and infection or anesthetic complications can even threaten the lives of surgical patients. Furthermore, in our current overly litigious society, it is not uncommon for physicians to take a conservative approach to medical interventions out of fear of being sued for malpractice. Of course, a thorough medical exam should be performed before the decision to cease medical interventions is made, though it need not be exhaustive if somatization is suspected. Additionally, the decision to not provide treatment for somatized symptoms does not preclude providing medical care for other substantiated symptoms or diseases. In fact, many people who somatize

also have documented organic disorders (Epstein, Quill, & McWhinney, 1999) or psychiatric disorders (Brown, Golding, & Smith, 1990).

Another reason for medical doctors to decide that they should not treat somatization is that it is considered a psychological disorder, not a medical problem and therefore beyond the scope of their practice, with the exception of psychiatrists. The concept that physicians should not practice outside of their area of expertise is a fundamental ethic that is even part of the modern Hippocratic oath: "I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery" (Lasagna as cited in Association of American Physicians and Surgeons, n.d.). Based on this pledge, many physicians refer a patient with somatization to a mental health professional (Sharpe & Carson, 2001).

The natural and timely resolution of numerous ailments suggests that treatment may not always be necessary. Many psychiatric symptoms, such as insomnia, anxiety, and depressive affect resolve themselves without any interventions. Some somatizing patients have "recovered" without any treatment (Thomas, as cited in Kellner, 1991), and many somatized symptoms last a few weeks to a few months untreated (Kellner, 1963 as cited in Kellner, 1991). However, it is unlikely that somatization disorder will be cured just with time, because by definition a broad array of symptoms must be in effect for a number of years for this disorder to be diagnosed. If somatization is likely to resolve on its own in a relatively short period of time, many patients might prefer to wait it out than seek a form of treatment that could expose them to risk of iatrogenic harm and be a financial burden.

Lastly, if one considers that somatization can be a culturally sanctioned idiom of distress, as many do (Keyes & Ryff, 2003; Kirmayer, Groleau, Looper, & Dao, 2004; Kirmayer & Santhanam, 2001; Kirmayer & Young, 1998), a radical culturally relativist position would indicate that this behavioral expression should simply be respected and not cured. Through the lens of cultural relativism, somatization would make sense as a communicative behavior and not be pathological in the context of some cultures. However, only if taken to an extreme would cultural relativism indicate no action. Most who acknowledge somatization as idiom of distress also recognize that somatizers are requesting aid for their distress, even if they do so in a surreptitious way, and therefore choose to offer some form of treatment.

The opposite answer to the issue of no treatment as the best treatment for somatization is that people who somatize should receive aid. This is the position I support. Though some argue about the "reality" of a somatizer's disease, the reality of their illness is not contested. People with somatization subjectively experience pain and discomfort due to their symptoms, whether those symptoms are organic or psychosocial in origin. Ethically, they should receive some sort of treatment for their suffering, and the psychological or sociological origin of somatization symptoms influences the nature of that treatment. Whether conducted by a physician or a mental health professional, the majority of treatment likely is going to address behavioral or mental components opposed to physical complaints.

Once one accepts that somatization should be addressed by a helping professional, the next controversy to be debated here is whether the focus of treatment should be on somatization behavior alone or the underlying distress of which somatization is an

expression. In this discussion somatization behavior refers to the help-seeking component to a broader definition of somatization that is often measured by health care utilization in number of medical appointments or cost (Reid, Wessely, Crayford, & Hotopf, 2002; Fink, Sorensen, Engberg, Holm, & Munk-Jorgensen, 1999). Those that define somatization as a pathological behavior (Slavney, 1990) or are rooted in the behaviorism orientation (Speed, 1998) naturally are likely to posit that treatment should correspondingly solely address behavior. According to the definitions of somatization that include help-seeking behavior components, such as Lipowski (1988), DSM-IV-TR, and my definition created above, an individual would no longer meet criteria for somatization or somatization disorder if that behavioral condition is not met. Based on those definitions and the opinion that a behavioral focus is best, one could consider somatization successfully treated if excessive help seeking was extinguished.

The alternative point of view that treatment should hone in on the cause of somatization instead of somatization itself conceptualizes somatization as a sign, a communication, or a side effect of the real problem. Once the deeper problem is dealt with directly, somatization will be indirectly treated and decrease in frequency and/or intensity. As Chun, Enomoto, and Sue (1996) recommend, "If the patient's problem is identified as somatization illness behavior, the treatment should target the underlying psychological distress or psychiatric disorder" (p. 361). This side of the argument is likely to be supported by those that define somatized symptoms as expressions of masked depression (Katon, Kleinman, & Rosen, 1982), anxiety disorders (Beidel, Christ, Long, 1991), or both (Escobar, Rubio-Stipec, Canino, & Karno, 1989; Katon, Lin, Von Korff, Russo, Lipsomb, & Bush, 1991; Kirmayer, Robbins, Dworkind, & Yaffe, 1993; Smith,

Gardiner, Lyles, Sirbu, Dwamena, Hodges, et al, 2005). Focusing treatment on the underlying distress of somatization does not necessitate labeling somatization behavior as pathological. Somatization can still be respected as a culturally sanctioned idiom of distress while the source of the distress is addressed. Additionally, this position does not exclude attending to behavioral components in treatment, which are significant features of somatization, but they are not made the focal point of therapy.

While point of view that somatization behavior should be the heart of treatment has a simplistic sort of logic, I feel that it drastically over simplifies an individual's experience of somatization. Can one consider the patient's needs met if that individual still experiences all other facets of the definition even though they do not seek help for those other aspects? I do not feel that one can. Though a somatizer who doesn't seek help for their symptoms would no longer trouble the medical profession, the patient's troubles would not be over. Additionally, I feel that concentrating on the underlying sources of distress allows for a treatment that is more attuned to the client and more respectful of their culture. For these reasons I am of the opinion that somatization treatment should endeavor to address the underlying distress that brings about somatized symptoms.

That the somatizing client accepts the psychogenic nature of their physical symptoms is last controversial treatment topic mentioned here. Followers of some CBT treatment modalities posit that it is crucial somatizers recognize that their somatic symptoms are not organic but in fact psychological in origin. The totality of reattribution therapy is designed to do just this (Goldberg, Gask, & O'Dowd, 1989). It is purported that once patients correct their misinterpretations of somatic sensations, they will no

longer have any symptoms (Goldberg, Gask, & O'Dowd, 1989; Kellner, 1982; Warwick, Clarks, Cobb, and Salkovskis, 1996).

Most other therapeutic models do not feel that clients must recognize that their symptoms are psychosomatic. In fact, many researchers (Chalder, 2001; Epstein, Quill, & McWhinney, 1999; McDaniel, Hepworth, &Doherty, 1995; Smith, 1990) advise against making this an issue in treatment. In fact, McDaniel, Hepworth, and Doherty (1995) and Epstein, Quill, and McWhinney (1999) state that distinguishing between the physical and the mental aspects of illness is unnecessary, and may in fact be detrimental for the patient. This either-or mentality about the origin of symptoms only emphasizes the mind-body dualism in Western society. By effectively forcing the patient to choose between a physiological and a psychological etiology, the therapist negates the biopsychosocial approach that acknowledges the influence of biological, psychological, and social factors on all forms of physical and mental illness. If the client believes in a health model that is holistic, a clinician's insistence in a dualistic mentality can also come across as culturally insensitive or oppressive. Furthermore, insisting the patients' symptoms are purely psychological implies that the symptoms are "all in their head" making the patients feel "blamed, coerced, devalued, ... misunderstood" (Epstein, Quill, & McWhinney, 1999), invalidated, and stigmatized. As a result, the therapeutic relationship could be threatened (Smith, 1990) or impregnated with an absence of trust that could prove a long-term obstacle to successful treatment. Finally, early termination could result from the irreparably damage to the therapeutic relationship.

I agree with these points and conclude that clinicians should not resolutely try to convince somatizers of the psychogenic nature of their symptoms. Further, I assert that

trying to get patients to assent that their symptoms are psychosomatic can degrade into a power struggle between the client and clinician, either medial or psychological. Additionally, when people with somatization interpret that the validity of their symptoms is being called into question, their symptoms may intensify for reasons that will be discussed further below.

In summary, my positions on these three somatization treatment controversies are as follows. I feel that at the core somatization is experienced as distressing, and therefore one should attempt to alleviate that distress instead of deciding that no treatment is the best treatment. In my opinion, focusing therapy on the underlying sources of somatized symptoms in preferred, because it allows for a more client centered and culturally respectful treatment, opposed to a therapy that centers on the help-seeking behavioral component of the disorder. Finally, I believe that clients deciding that their symptoms have a psychological and not biological etiology should not be a focus of somatization treatment, but would in fact be detrimental to the therapy and for the client.

Culturally Sensitive Recommendations for the Treatment of Somatization by Mental Health Practitioners

Having now examined somatization treatment from different theoretical psychological, medical, and culture-based orientations, presented here is an amalgamation of that information that forms my somatization treatment recommendations for mental health professionals. I hope to provide a collection of suggestions that are culturally sensitive, effective, and applicable to clients from all ethnic backgrounds. Provided below are details on seven generalized recommendations,

several tables of additional recommendations, an example of these recommendations applied to a fictional case, and suggestions for future research.

Work From a Biopsychosocial Foundation

There are several reasons why it is important that all members of a somatizing client's treatment team work from a biopsychosocial foundation. Using this approach helps medical providers from becoming somatically fixated and mental health providers from becoming psychosocially fixated (McDaniel, Campbell & Seaburn, 1989), both of which are a disservice to the client. It can provide a common ground for the members of the treatment team with different area of expertise to discuss the case. This outlook should be applied to all of the client's symptoms, not just those that are thought to be somatized. If this approach is uniformly applied to all somatic complaints, it normalizes the interaction between biological, psychological, and social components. By destigmatizing the concept that the client's somatic symptoms are not organic in origin, it may make the client more receptive to psychological treatment. The biopsychosocial model is compatible with all psychological orientations, especially cognitive behavioral therapy, and so does not interfere with other conceptualizations of a case. Many minority clients may readily accept the biopsychosocial model, because it is holistic and therefore akin to many African American, Asian American, and Hispanic American cultural health models.

Although having a biopsychosocial foundation may not impact every interaction with the client, it is most influential during the beginning stages of therapy when the groundwork is being constructed for the rest of treatment. After the assessment has been performed and the treatment phase has begun, the biopsychosocial model should be

introduced to the client. It may be best to start by discussing how somatic diseases that are generally believed to have a purely biological basis, such as diabetes or the common cold, are strongly influenced by psychological factors and how having a "biological" disease can impact one's mental state. Then provide everyday examples of the physicalizing of stress, such as headaches or backaches resulting from anxiety related muscle tension or insomnia and fatigue secondary to anxiety or sadness, and examples of how physical illness has emotional consequences, such as depression resulting from a chronic illness diagnosis or anxiety during an asthma attack. Next the clinician can proceed to explain how more extreme symptoms are simply extensions of the same process, and eventually, this framework can be tentatively applied to the client's own symptoms. This does not lay blame or pathology in the client's lap, but it does create a vocabulary and an opportunity for discussing these interactions. This process hopefully helps ease the client into the therapeutic relationship by first beginning almost as a teaching relationship and only slowly delving into more personal and emotion-laden topics. It is nonconfrontational, nonjudgmental, and doesn't demand the client abandon their previously held beliefs about their illness.

Collaborate with Physicians

A close collaborative relationship should be developed with the primary physician of a client with somatization. It seems natural that somatization, as a problem of the blending of the body and mind, would be best treated by a blend of medical and mental health professionals. A collaboration in which physician and psychotherapist frequently and freely communicate helps prevent potential power struggles between these helping professionals. Additionally, presenting a unified front in which therapist and physician

are viewed as collaborating members of a treatment team reduces the likelihood that somatizing clients will attempt to form a coalition with the therapist against the medical doctor. This kind of splitting is not uncommon when ill individuals become frustrated with the absence of a medical explanation for their symptoms and can be an obstacle in treatment.

This collaborative relationship benefits the mental health professional in many ways. Somatization cases are very medically complicated, and the mixture of multiple organic and psychosomatic symptoms, which a mental health professional cannot be expected to differentiate, can be confusing, overwhelming, and intimidating for most therapists. These individuals usually have extensive medical histories that are not easy for a non-medical professional to decipher from a chart. However, in a good relationship with the medical practitioner, one can ask for clarification of these complex issues. Additionally, physicians often have known the patients they refer for an extended period of time and are good sources of non-medical information on the client as well.

Physicians also profit from the collaboration. Typically physicians request mental health services for the patient, because the physician feels like she or he lacks either the time or training to fully address the emotional problems of this patient. One of the goals of the collaboration can be to address the needs of the physician (Epstein, Quill, & MnWhinney, 1999). Many will ask for advise about managing the patient and be relieved to share responsibility of a patient with difficult problems with another professional (McDaniel, 1995). Offering a validating, empathetic ear to their complaints about a somatizing patient and recognition for their efforts to care for the client can help alleviate some of the negative emotions physicians often associate with somatization

patients. The client's overall quality of care can improve with the physician's outlook about the client (McDaniel, 1995).

Ideally medical and psychological treatment would be conducted in the same clinic by professionals who already have a working relationship. However that is rarely possible, so collaboration often begins at the time of referral, before the mental health professional even meets the client. It is nice to get as much information from the referring party, usually a physician, before meeting the client, because discrepancies between what the physician and the client report are often key bits of information. Table 5 lists the most important information to obtain from the physician at the time of referral. This list mostly focuses on the medical history of client, but also includes psychosocial information on the client and the physician's expectations of the referral and of the mental health practitioner. Table 6 lists the most important information to convey to the referring physician at the time of referral, such as the use of a biopsychosocial foundation in therapy, the best method of future communication, and desire for regular updates and communication with the physician. For good and for ill, the "cultural milieu" (Schilling & Stoller, 1995) of medicine is very different from that of mental health services. This difference influences the expectations one establishes about the other party in potentially unanticipated ways, which is why discussing some of these expectations at the very beginning of the collaboration is recommended.

Collaboration continues after the mental health professional accepts the referral. Meeting the client for the first time during a medical appointment with their physician can make the client more likely to follow through with the referral for psychological treatment (McDaniel, 1995) and their transition into mental health care much easier.

Table 5 *Information to Get From the Referring Physician or Medical Provider at the Time of Referral*

1. The client's medical history, including current and former 1) major physical disorders/diseases, 2) psychiatric disorders/diseases, and 3) substance use/abuse as well as the symptoms, current and former, the physician feels are/were somatized.
2. The current medical treatment plan, including medications, interventions currently in action or planned, dietary or activity restrictions, and the physician's plans on how to deal with somatization symptoms in the future.
3. Any other Western medicine or alternative medicine practitioners that are treating the client. (This is an important question to ask of minority and majority culture individuals, as many alternative forms of health care are becoming increasing popular with all peoples in the United States.)
4. Any known psychosocial factors the physician feels could be impacting the client's health. (Not only does this give you information about the client, but also it gives you some insight in to the doctor/patient relationship and how important gathering psychosocial information is to the physician.)
5. The physician's frustration level and feelings about the client.
6. Most importantly, the physician's expectations of you, the mental health clinician.

Table 6 *Information to Convey to the Referring Physician or Medical Provider at the Time of Referral*

1. You will be working with the client and all of their symptoms from a biopsychosocial orientation, and that this might result in attitudinal changes in the client that are observable in their medical appointments.
2. When they can expect to hear from you next.
3. That you are always open to consulting with the physician and the best way to communicate with you (e.g., when you return phone calls).
4. What you would like from the physician, such as regular consultations in which the medical and mental health provider can present each other with updates on progress and treatment plans.

Putting forth the effort to join the patient and physician in the medical setting signifies your dedication to the client, which may be especially important to clients who feel that their physician is abandoning them by referring them to psychological treatment or who have felt their symptoms dismissed by the physician. Initially meeting in a medical setting also can validate and destigmatize psychological treatment for those clients who are skeptical of mental health care. If a therapist does collaborate with another professional, this information must be disclosed to the client when confidentiality is discussed prior to them consenting to treatment. Collaboration continues with the regularly scheduled updates. The nature of the case will influence the frequency of the scheduled updates and they may not need to be as frequent as therapy progresses. Many physicians are extremely pressed for time and may be hesitant to agree to these consultations if they think they will be very time-consuming. However, taking responsibility for initiating the consultations and agreeing that some of the consultations can be simple phone messages, whereas others will need to be phone conversations, may make the physician more willing to consent to this request. Keeping all members of the client's treatment team informed of all aspects of treatment the duration of treatment, decreases confusion among the helping professionals, decreases the dissemination of conflicting information to the client, and allows for more cohesive, well organized, and complete care for the client.

Seek Appropriate Consultation When Necessary

As educated and knowledgeable as mental health professionals are, they are going to have at least one gap in their knowledge about one of the many disparate factors that come to play in most cases of somatization. Additional reading and continuing education

can go far to shorten those gaps, but consultation with experts allows for investigative interaction that can not be found on one's own. In addition to the medical consultation or collaboration, the mental health clinician should not hesitate to consult with experts about cultural factors, such as language, cultural health models, and spiritual elements, or social work factors, such as job training, applications for disability, or public housing.

Regardless of which language is being spoken in treatment, if the client's primary language is different from the primary language of the therapist, it would be helpful to consult with a fluent speaker of the client's native language to determine if there are any linguistic tropes or particular phrases that associate body parts with emotions, akin to "got under my skin" or "twist my arm." What could be translated simply and accurately as annoyance or manipulation might actually have a symbolic connection to the body or somatized symptoms. These subtleties of language may appear insignificant to a translator or go unrecognized by a non-native speaker of the client's language, but may hold significant meaning and offer key insight into the case. Both psychodynamic (Deutsch, as cited in Ammon, 1979; House & Andrews, 1988; Wolman, 1988) and feminist psychology literature (Cushman, 1995; Showalter, 1997) propose that somatic symptoms can have symbolic meaning. Hinton and Hinton (2002) go further to state "tropes may generate symptoms as a somatization of distress, amplify certain symptoms, and profoundly affect the personal and interpersonal meaning of the … sufferer's complaint" (p. 165).

This recommendation is applicable to those situations in which 1) a translator is being utilized, in which case the translator can be consulted out of session, 2) the therapist is speaking, as a second language, the client's preferred language, or 3)

treatment is being conducted in English and either the therapist, the client, or both are not native English speakers. Unless the clinician is a native, fluent speaker of the client's primary language, this type of consultation is advised. A linguistic consultation also might be considered if the therapist and client speak the same language, but were raised in different countries. Just as some Australian phrases are nearly meaningless to American ears, the nuances of colloquial Spanish from a Honduran client might be lost on a Mexican American therapist whose first language was Spanish.

Culture-based health models are other aspects of culture that are filled with nuance and are difficult to understand for those not immersed in them. Many health models, especially holistic ones that encompass human biology, natural elements, emotions, and spiritual forces, are wildly complex, interactive, and influential on an individual's understanding of their symptoms. While literature on some popular health models, such as traditional Chinese medicine, is available, literature is not available for many other health models believed by small ethnic groups. For these reasons, gathering this crucial information via expert consultation is preferred over merely reading about the topic. Additionally, if the client regularly utilizes non-Western medicine, the therapist should consider collaborating with that medical practitioner much in the same way she or he would collaborate with a Western medicine physician.

Spiritual and religious matters also are factors that might warrant consultation with experts. They can strongly influence the client's illness experience, be difficult to fully understand for those outside of the faith, and be uncomfortable to discuss for many therapists. For a variety of reasons, not the least of which is fear of unintentionally offending the client, psychotherapists often avoid discussing aspects of religion with

clients. Lack of background information on the client's religion may intensify that avoidance, which could be corrected with consultation. If the client worships or practices their form of spirituality with others, then the mental health provider may want to collaborate specifically with the client's spiritual/religious leader. For some clients, their religious leader is a very important figure in their lives, as influential as their family members, and should be consulted much like a therapist might meet with the spouse of the client.

There are many reasons for consultation. It is not necessary for every aspect of the client's life with which the therapist is not an expert. However, if the client's symptoms to seem to be tied to a particular aspect of culture that is unfamiliar to the therapist, consultation should be sought to fill the void in the clinician's knowledge. Consultation can also be used to exemplify the therapist's willingness to understand and respect the client's culture, which can be very meaningful for some clients who have experienced racism or culturally insensitive treatment in the past. The time taken to perform the consultation also demonstrates the clinician's dedication to helping the client. When figures in the client's life are consulted, the consultation potentially can become collaboration, which may be appealing to many clients who come from a collectivistic culture that often relies upon interpersonal networks for support.

Supplement Standard Psychological Assessment with Appraisal of Key Cultural Beliefs and Acculturation Level

In addition to a thorough physical examination by a physician and a standard psychological intake interview, the initial stage of treatment should incorporate an assessment of the client's language proficiency, acculturation level, and those cultural

traits that are particularly likely to be influential on somatization. The manner in which these factors influence somatization has been discussed in previous sections and will not be reiterated here. However, all of these factors will be incorporated into treatment a myriad of ways so as to tailor therapy to the client as much as possible.

If the client and therapist do not have a language in common, language proficiency obviously can dramatically impact treatment by requiring the use of an interpreter. Interpreters may be used in less obvious situations, as well. (In this discussion, I will proceed assuming that the therapist is a mono-lingual English speaker; however, I recognize that many clinicians are fluent in multiple languages and in no way intend to imply that English is the preferred language for psychotherapy.) Even if the client has sufficient English skills to hold a light conversation, this may not indicate that English is the appropriate language for psychotherapy. As mentioned before, an individual's emotional language skills likely will advance more slowly than their typical conversational language skills. In some circumstances, an interpreter should be incorporated into treatment of individual who is proficient in English in a number of other situations.

The use of formal writing, reading, and oral tests of language proficiency available through organizations that provide English as a Second Language services are suggested by Altarriba & Santiago-Rivera (1994). Though this would inarguably provide the most accurate assessment of the client's language skills, it may not be practical or possible to apply to many clients. In those situations when a formal assessment is not available, the therapist must base their decision to utilize an interpreter on the client's opinion about the use of an interpreter, his or her basic conversation skills, and their

response to assessment questions about affect. Language proficiency assessment is a recommendation primarily intended to be applied to client's who do not consider English their primary language. However, it may also be usefully applied to clients whose first and primary language is English but who may have learning disabilities, cognitive impairments, or a limited education. In cases of illiteracy in all languages, one can alter the amount of reading material, written homework, and one's vocabulary level to match that of the client.

Acculturation level and/or degree of ethnic identity should be assessed as well. There are multiple measures of acculturation and ethnic identity that are short questionnaires, such as the African American Acculturation Scale (Landrine & Klonoff, 1994), Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987), and the Short Acculturation Scale for Hispanics (Marin, Sabogal, & Marin, 1987). Acculturation reflects a general estimation of the influence of cultural beliefs on somatization behavior, whereas interview questions specifically about key cultural beliefs provide more accurate information.

The key cultural factors discussed in the previous sections should be assessed. As of yet, no formal measure incorporates all of those concepts, so this information must be gathered via interview during the initial stages of therapy. Table 7 lists examples of questions that probe for information on the some of these key factors. These questions explore linguistic preference, group/familial self of self (which tends to reflect collectivism and value of interdependence as well), stigma of mental illness, religiosity (which influences recognition of symptoms, meaning of symptoms, and fatalism), health

Table 7 *Intake Interview Questions to Elicit Information on Key Cultural Beliefs*

1. Which language do you speak at home? What was your first language? Which language do you primarily speak?
2. How much time do you spend with your family? Are you happy with the quality and amount of time you spend with them?
3. How did you feel when your doctor suggested you meet with someone to talk about your health problems?
4. Do you engage in a religious or spiritual practice? How often do you worship?
5. How do you understand your health problems? What do you think is the cause of your illness?
6. What do your symptoms mean to you?
7. How do you usually deal with anger?
8. Besides your doctor, have you gone to anyone else for help with your health problems?

model (which includes holism and importance of balance and harmony), meaning of symptoms, emotional expression (which reflects communication style), and help-seeking behavior. The entire interview can also reflect the client's preferred style of communication. Many other questions could illicit the same information, and those listed do not comprehensively address all of the important cultural beliefs that influence somatization, but they are a good beginning that can be augmented with additional follow-up questions.

Involve the Client's Family in Treatment if Possible

For many somatization clients, involving their family into treatment as the identified patient in the case of family therapy, as occasional guest participants in the client's individual therapy, or as contacts for additional sources of information about client is advised. Family systems (Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1975; Wood, 2001) and medical family therapy (McDaniel, Hepworth, & Doherty, 1992; McDaniel, Hepworth, & Doherty, 1995) advise utilizing a family therapy modality in the treatment of somatization. The importance of familism in African American, Asian American, and Latino American cultures also supports incorporating family members in somatization treatment in some way. For many clients this culturally sensitive decision will be much appreciated, making the identified client feel more comfortable and respected by the clinician. Depending on the practicality of family member involvement and the nature of the treatment issues, the degree of involvement of family members can be flexibly determined. While weekly joint sessions will be appropriate for some, brief phone conversations may be best suited to other families. Asian American and Latino American families often have taboos against publicly

revealing familial problems, and this can become an obstacle in therapy at times. However, it is possible that having family members present in therapy implies consent to discuss family issues that are often kept private within many families. Of course, it is also possible that having other members of the family present may make it more difficult for some minorities to discuss problematic family issues.

There will be some clients who will find the inclusion of family unwanted. They may feel that 1) such involvement would shame their family by having them involved in any kind of mental health treatment; 2) requesting the involvement of children, grown or not, may violate hierarchical positions of power and privacy; 3) asking their family to make time for sessions feels too burdensome, or 4) psychotherapy should be a personal experience for them, and they are already struggling with an individual identity. Additionally, the involvement of some family members in therapy is counter-indicated if there a history of abuse or neglect, unless the therapy intends to adequately address those family issues.

Identify and Address Social/Interpersonal Sources of Distress

By identifying and addressing social and interpersonal sources of distress, psychotherapy can tackle many of the underlying sources of somatization. Some clients may initially be confused and uncertain of a therapy to treat their somatic symptoms that focuses on non-biological issues. However, first explaining the biopsychosocial model and not rushing to focus on their social and interpersonal problems will decrease this skepticism. Additionally, if the somatization client presents with prominent concern about relationships or social needs, the treatment can address these issues without necessarily drawing a direct line between them and the physical ailments, especially at

the beginning of the therapy. As always, a point should be made to determine if client is exposed to a dangerous social/interpersonal stressor, such as intimate partner violence or prostitution, that could be threatening the client's life as well as actively be contributing to the somatization symptoms. If the client is in such a situation, safety issues should be addressed before the somatization. There are numerous sources of distress that come from the interpersonal and social spheres that go unrecognized by individuals. If one does not recognize the true source of the problem, one cannot adequately ameliorate the problem. There are far too many types of social and interpersonal problems to discuss them comprehensively here. However, three categories of social distress are discussed here: discrimination, trauma, and poverty.

Feminist psychology indicates that the diagnosis of somatization, or hysteria in years past, was used as a tool of patriarchal oppression. Women were labeled insane, blamed for their mental disorders, and the true oppressive sources of their symptoms were dismissed. These same concepts can be applied to discrimination against ethnic minorities, gay, lesbian, bisexual, and transgendered, populations, persons with disabilities, etc. Clinicians should ward against making the same mistake as Victorian physicians and not focus on the emotional and psychological nature of problems to the point of ignoring the "social problems and inequities that are signaled by the emotion" (Kirmayer & Young, 1998, p. 427) or symptom.

Perceived discrimination in all of its various forms is a universally stressful experience, and heightened stress levels, whatever their exact cause, may be expressed as somatization. Experiences of sexism are correlated with somatization rates (Landrine, Klonoff, Gibbs, Manning, & Lund, 1995; Klonoff, Landrine, & Campbell, 2000), and

racial discrimination is correlated with psychological and physical stress responses (Clark, Anderson, Clark, & Williams, 1999) and likely somatization rates. Other factors influenced by discrimination, such as socially enforced anger suppression (Koh, Kim, Kim, & Park, 2005) in women (Cox, Van Velsor, & Hulges, 2004) and many minorities and women pursuing "masculine" careers (Silverstein & Perlick, 1995), also increase somatization. Based on these correlations and peripheral factors, treatment for somatization should address discrimination.

Somatization treatment can attend to matters of oppression by acknowledging the discrimination, cultivating empowerment, enhancing coping skills, and encourage social/political action to help eliminate the oppression. It is possible that recognizing the social origins of the patient's symptoms can be a healing process on its own. Locating the "blame" for the problem outside of the patient and labeling it as a societal problem and not the patient's fault has the potential to be very freeing. If somatized symptoms are unspeakable communications, as some (Griffith & Griffith, 1994; Griffith, Polles, & Griffith, 1998) have theorized, then knowing that their messages are being heard may bring much relief to the patient. Acknowledging and validating this grievance against their oppression could help their bodies stop shouting in protest. Though it is important to bring to light oppressive stressors related to the client's gender or ethnic group, their group status should not overshadow their unique identity or individual needs (Ussher, 1992). Enhancing the client's sense of empowerment can be an effective way to battle the stress of oppression. According to Jackson and Sears (1992), "empowerment of self serves as a mediator of stress" (p. 186) and for African American women, "an Africentric worldview has the potential to counter the negative images that African American women

experiences through racism and sexism" (p. 186). By this rationale, helping minority clients view themselves, their behavior, and their decisions in the context of their culture, sexual orientation, and/or disability instead of the context of the majority will increase their empowerment, decrease their stress, and correspondingly decrease their somatization. Similarly, La Roche (2002) recommends fostering empowerment in all Latino psychotherapy clients by identifying social injustices and that they do not have to acquiesce to the "marginalizing and oppressive status quo" (p.119). In addition to validating the patient's feelings about their oppression, the therapist can help the patient to cope with those forms of social oppression in more adaptive ways, such as assertiveness training, relaxation training, and stress management skill building. Supporting involvement in political or community action can help clients address the sources of oppression in productive ways.

Several studies have linked trauma experiences to somatization. Specifically, a history of sexual abuse (Creed, Guthrie, Ratcliffe, Fernandes, Rigby, Tomenson, Read, & Thompson, 2005; Modestin, Furrer, & Malti, 2005; Stein, Lang, Laffaye, Satz, Lenox, & Dresselhaus, 2004; Walker, Katon, Roy-Byrne, Jemelka, & Russo, 1993), exposure to violence (Hilker, Murphy, & Kelley, 2005), intimate partner violence (Lown & Vega, 2001), torture (Daud, Skolund, & Rydelius, 2005), and surviving the Holocaust (Amir & Lev-Wiesel, 2003) have all been associated with high somatization rates. PTSD has been found to be a mediating factor between trauma and somatization (Engel, 2004; Escalon, Achilles, Waitzkin, & Yager, 2004). Based on these correlations, trauma therapy or treatment that targets PTSD may be warranted for some clients with somatization. A discussion of trauma-focused therapy is beyond the scope of this dissertation. Please see

Horowitz (2003) or Foa, Keane, and Friedman (2000) for more information on these therapies.

Poverty and factors related to poverty can expose clients to additional stressors that then contribute to somatization, and hence should be addressed during the course of treatment. For a variety of reasons, poverty is associated with poor overall health (Sapolsky, 1998). People living in poverty were found to have poorer neighborhood quality than those not living in poverty, and poor neighborhood quality was indirectly correlated with physical complaints in adolescents (Chapman, 2005). Unemployed men developed significantly higher somatization rates than a matched group of men who remained employed (Linn, Sandifer, & Stein, 1985). Though traditional psychotherapy can do little to dramatically improve a client's financial situation, social workers can help clients gain access to a variety of social services that can improve the clients' financial state. If the therapist is not a Licensed Clinical Social Worker (LCSW) experienced in case management, collaboration with a social worker is recommended. If that is not possible, the psychotherapist should fulfill this role as best she or he can and provide referrals to appropriate social services. In addition to facilitating access to practical assistance, therapists can aid their impoverished clients by helping them identify which factors that contribute to their poverty they have control over and which ones are beyond their control. A balanced outlook that alleviates some possible guilt for elements that aren't within their control and empowers clients to take action to change those factors that are malleable will help those in poverty as well.

Create Client-centered, Culturally Sensitive Therapeutic Goals

Short and long-term therapeutic goals should be congruent with the client's particular cultural beliefs but should not 1) merely correspond to general beliefs typical of his or her ethnic group, 2) be a generic list of goals based solely upon the diagnosis determined by the clinician, or 3) be constructed to address only behavior deemed problematic by his or her physician. This recommendation is very broad and imprecise. However, the actual goals should be narrowly defined, measurable, and focus on ability and activity. Precise, detectable goals make it easier to track small, incremental changes. Objectives that highlight ability and activity level de-emphasizes disability and inactivity, on which many chronically ill individuals become fixated. With attention drawn to what they can do, clients with somatization may not ruminate on and hence exacerbate their disabling symptoms. Lastly, treatment goals should not aim for the complete elimination of symptoms or cure, as this is often unrealistic. Instead, aspiring for greater quality of life is both realistic and hopeful.

Tuning goals to the client and taking their cultural beliefs into account should begin in the first meeting with a client and continue throughout treatment. Most clients who are referred to psychological services for somatization treatment are skeptical that mental health services can make their problems better. For that reason, it is very important that at their first meeting, the clinician and client find a goal, no matter how small, that both agree upon. This is especially true for ethnic minority clients, because minority groups tend to underutilize mental health services. If client and clinician don't at least explore mutually agreed upon goals at the first meeting, the client may not return for a second meeting. Questions about how the client's symptoms have interfered with

her life or inhibited her from doing some things she did before these symptoms developed and what the client would like to get out of their time with mental health professional can help clinicians elicit information to form client-centered goals. For example, a 48-year-old African American woman is referred for medically unexplained asthma that is unrelated to her hyperlipidemia or type-II diabetes. During the first intake session, she states that psychotherapy is a selfish indulgence that takes time, energy, and money away from her large family, which she considers to be far more important than anything she is going to get from a psychologist. Obviously, this client is at risk of not returning to psychological treatment unless an effort is made at that first meeting to create a treatment goal that appeals to her. Being able to take regular walks to the playground with her 3-year-old grandson twice a week is a goal that might please her. It facilitates the client being able to fulfill her family role as caretaker/grandmother, which prioritizes her culture-based familism, and also promotes regular exercise and engaging in a pleasant activity that the mental health professional is likely to encourage. Perhaps even more importantly, creating a goal like this demonstrates to the client that the mental health provider and mental health treatment is going to respect the client's culture and individual wishes.

Fictional Case Example

Xiao-Ming is a 27-year-old man recently emigrated from China, who has been referred by his primary care doctor for insomnia, fatigue, and poor concentration all of which were believed to stem from medically unexplained neck and back pain. During the conversation with Xiao-Ming's physician about this referral, the clinician asked the questions listed in Table 5 and learned that Xiao-Ming has no other medical, psychiatric,

or substance related diagnoses other than lactose intolerance and mild allergies. His medical doctor has prescribed pain medication that Xiao-Ming takes occasionally but generally avoids because of unpleasant side effects. There are no other medical interventions in play, and the doctor feels that she can do nothing else for future symptoms than what she is already doing. She is referring Xiao-Ming to psychotherapy out of desperation, because she feels there are no other treatment options available. When discussing her feelings about this case, the physician exasperatedly said, "I just don't know why he doesn't get better!" and admitted being frustrated by her patient's unrelenting symptoms and irritated by his frequent visits following back spasms. The physician knows that Xiao-Ming had gone to a traditional Chinese medicine practitioner for acupuncture and herbal medicine, but she has not made any attempts to contact that practitioner and seems somewhat dismissive of alternative medicine. The doctor acknowledges that unemployment has been stressful for Xiao-Ming. The doctor initially stated she would like Xiao-Ming to be symptom-free in six months and to reduce his visits to four a year, but agreed that it was unreasonable to expect this patient to be without any symptoms. After imparting the information found in Table 6, the physician agreed to bimonthly phone consultations with the mental health clinician, to implement regular monthly appointments with Xiao-Ming for the time being, to introduce the patient to the clinician at the his next appointment, and to supply a room in which the clinician and patient could meet privately for half an hour.

When introduced to the clinician, Xiao-Ming appeared unenthusiastic about the referral but politely agreed to meet privately with the clinician. During that first half hour meeting, the clinician focused on connecting with the client by validating his physical

pain and letting him know she believed his illness experience. The clinician also briefly introduced the biopsychosocial model, to which the patient seemed to respond. Together they agreed that practicing meditation, a former habit he had fallen out of, for 10 minutes a day probably would not exacerbate his neck and back pain and could help him find balance and a little respite from his worry about health issues. He agreed to attend weekly sessions at the clinician's office.

During the assessment/intake meeting, Xiao-Ming presented with significant concern and worry about his inability to find employment, the stresses of poverty, and intense loneliness since leaving his family in China three years ago, in addition to his somatic symptoms. Despite holding an accounting degree from a Chinese university, the client feels that his poor English skills, strong accent, and passive demeanor have led American businesses to be unwilling to hire him, because they to assume that he is stupid and uneducated. As a result, the only employment he had been able to find was repetitive manual labor in a factory, but he had to quit that job when his pain became unbearable four months ago. Now in nearly constant pain, plagued by chronic exhaustion, isolated in his studio apartment for days at a time, and unable to pay his bills, this client considers himself a complete failure and a disgrace on his family's honor. He felt he was failing to fulfill his familial duties by having selfishly left his aging parents without a child to tend to their needs (Xiao-Ming is an only child.) and for having prioritized his career above finding a wife; a career that has yet to develop and seems like it never will. He reported that the excitement he originally felt about living in America, has dissipated and he no longer finds much pleasure in his life. His pain keeps him from being very active, and

for this reason he feels he has to move very slowly and gingerly. He denied any additional psychiatric symptoms.

Continuing with the questions listed in Table 7, Xiao-Ming considered Mandarin his primary language. Though the clinician feels that Xiao-Ming's strong accent didn't impede his ability to be understood, the client's concern and the likelihood that his ability to communicate affective topics was less developed, led them to utilize a translator. When asked about his family, Xiao-Ming focused on how he was unable to fulfill his duties as a son rather than saying he missed home. He was reported to be grateful for the doctor's referral, and though he didn't know how it would help, he trusted his doctor's decision. Having grown up in Communist China, Xiao-Ming has never followed a formal religion, but followed Confucianism and would frequently engage in meditative practice when he lived in China. Since emigrating, he had not continued that practice. The client felt that he has *shenjing shuairuo*, or neurasthenia, and his symptoms are the result of a decrease in *qi*, vital energy, and related to his failure as a son. To him, his symptoms mean he is unable to work and therefore cannot justify his decision to move to America, and they serve to remind him of his loneliness, as there is no one in his life to take care of him. Xiao-Ming reported that he usually does nothing when angry other than try not to be angry any more. He also discussed seeking traditional Chinese medical care for his symptoms, but he had to stop this treatment because he can no longer afford to pay out of pocket for it and the free medical care he receives through the county does not cover "alternative" medicine.

Given this information, the clinician developed the hypothesis that several factors were contributing to Xiao-Ming's symptoms: 1) previously undiagnosed Major

Depressive Disorder, Single episode, mild, 2) neurasthenia that was unacknowledged by his medical doctor, 3) unexpressed anger at being discriminated against in job interviews, 4) stress of immigrating alone, 5) guilt at being separated from his family related to collectivism, group self, and Confucianism, 6) belief in a holistic health model, and 7) his nonconfrontational, indirect communication style. The clinician consulted with the referring physician about Xiao-Ming's intake assessment, and they agreed that antidepressants should be prescribed. Xiao-Ming's former Chinese medicine practitioner was contacted, with the patient's permission of course, as a consultant.

Based on the client's presentation, treatment began with a discussion of his unemployment status and included the acknowledgment of the discrimination the client experienced and the anger it triggered. However, the client was not strongly encouraged to express his anger outwardly, as that would likely feel very uncomfortable for him. The additional consequences of the discrimination, such as unemployment, poverty, and the client's view of himself, were placed in the context of that oppressive, social experience, which helped the client improve his opinion of himself and his decision to move to America. A short-term goal was to learn assertive communication skills to be applied in select circumstances. Xiao-Ming's more passive communication style was not pathologized nor was he held responsible for the discrimination he experienced, but the inability of most Americans to accurately read subtle, indirect communications and their need to have things directly and plainly stated was discussed. Though he reported that speaking assertively would feel uncomfortable in most situations, he was glad to have that skill so he would be better prepared to stand against possible future discrimination. The relationship that sleep has with fatigue, pain, concentration, emotions, and his vital

energy, *qi,* was discussed. A short-term goal was to develop and put a regular sleep schedule into practice, which was presented so as to match his health model. Continuation of regular meditation for increasingly longer periods of time was another short-term goal that was congruent with the client's cultural beliefs and served the clinician's desire to implement a relaxation technique. A long-term goal of treatment was to control his symptoms well enough to find employment that would allow him to save money to put toward a trip home to visit his parents.

Xiao-Ming also was given several referrals. The first was to a support group for recent Chinese immigrants to help him with the stress of immigration, to connect him with a local network of people who likely have experienced similar discriminatory events, and to decrease his isolation. Additionally, Xiao-Ming was able to work within this group to support other immigrants through discrimination and take political action against such discrimination as a group. With the help of the clinician and a social worker at a community agency, the client applied for temporary disability to decrease the gravity of his financial situation. Xiao-Ming was referred to free services at a local Chinese medical school so he could pursue the treatment of his choice. He agreed to continue to attend his regular appointments with the referring physician as well. Based on the client's continued discomfort with his English skills, he was referred to free English as a Second Language classes.

With the use of pharmacotherapy and psychotherapy Xiao-Ming's depressive symptoms, such as anhedonia, psychomotor retardation, excessive guilt and feelings of worthlessness, slowly began to improve. As his sleep schedule improved, so did his insomnia and fatigue. His neck and back pain also improved but did not completely

dissipate. However, his symptoms decreased enough to allow him to find employment as an entry level billing clerk, and his financial situation improved. Though Xiao-Ming felt that his education should have gotten him a job at a higher level, he was pleased to find work in his preferred field and did not mind working his way up. Periodically, when experiencing high levels of stress, Xiao-Ming continued to experience intense back and neck pain, but he felt this pain was manageable. Though he still was working towards visiting his parents, he no longer regretted immigrating and was able to enjoy living in his new country again.

Future Research

Despite centuries of study, more research is needed on somatization. The following are just a few directions I foresee future research headed. The diagnostic usefulness of the overly narrow Somatization Disorder and the overly broad Undifferentiated Somatoform Disorder have been called into question. The DSM and ICD systems would profit from the addition of an intermediary diagnosis, like abridged somatization, but further research is needed before that change takes place. The field of somatization would benefit from the development of a measure based upon cultural beliefs that promote somatization, such as collectivism, stigma of mental illness, emphasis on preserving interpersonal harmony, holistic health models, indirect communication style, emotional self-control, conformity to norms, and fatalism, etc. This measure could be especially helpful during the diagnostic stage as well as treatment. Additionally, a study investigating the efficacy of a somatization treatment model that focuses on empowerment of women and minorities would be useful.

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