A 37-Year-Old Man With Multiple Somatic Complaints

Arthur J. Barsky, MD, Discussant

**Dr Delbanco:** Mr H is a 37-year-old man who has had multiple physical complaints for years without a clear medical diagnosis. An immigrant from Colombia to the United States, he is self-employed, and works as an educator for the young in the inner city. He is covered by a commercial managed care insurance plan and is cared for by a medical resident in primary care practice at the Beth Israel Deaconess Medical Center.

His multiple physical complaints began during adolescence with nausea and vomiting without weight change. In recent years, he has suffered from periodic pruritus ani, legs that become “weak” at times, and allergic symptoms including hay fever, allergy to cats, and recurrent itchiness around the eyes. He notes a frequent rectal discharge and had 1 episode of bleeding, evaluated by colonoscopy, which was normal. Liver function tests were mildly elevated in the past. He has experienced pain and numbness in his shoulder, and more recently had intermittent nausea and diarrhea. He also complains of a swollen tongue and swelling around the neck. He has had recurrent, depressive symptoms since adolescence, for which he has periodically sought counseling. He has never taken psychoactive medications, and there is no history of suicidal ideation or gestures. He almost constantly feels anxious, with his anxiety focusing on his multiple somatic symptoms.

Multiple medical evaluations have not revealed significant findings. During a trip to France he experienced some improvement with homeopathy. He also has had acupuncture, tried different approaches to self-assessment and self-help, and had some success with counseling from a social worker.

His father died at a young age of unclear cause. He is separated from his wife and has a 4-year-old child. He does not smoke or abuse alcohol or other drugs. Physical examination, stool for occult blood, and liver function tests were normal.

**Mr H: His Understanding and Perceptions**

Mr H: I moved to the United States 16 years ago, and I haven’t felt well since. My legs are shaky all the time. My anal area is always itching. I feel swollen in my eyes and in my face sometimes. I have a lot of gas and I feel tired all the time. I have gone to doctors many times and explained the symptoms to them. I have seen specialists many times, and they said I look fine. But I have never found an answer to why I have these problems. I have to live with it every day and I don’t feel well. I could communicate with people better if I know what I have. I know for doctors it’s very tough, but sometimes the first thing that I perceive when I go to see a doctor is that they think maybe this guy just needs to go to a psychiatrist.

I have a psychosomatic problem that is showing itself in a very strong way physically, because I do have constant problems like itching anus and swollen eyes, shaky legs, and heat rashes. I feel bad for any human being who has to live with that. I don’t think it’s very comfortable even though the doctor might say, well, you look pretty healthy, or you’re just stressed out, or it’s modern society that is making you feel that way. But when you look at a patient that way, you’re basically denying the person the right to feel better.

I went to France twice and saw a doctor who went to medical school in Boston and was practicing homeopathic medicine, and he helped me. In that field the communication is totally different. He told me to describe everything that you feel. If you want to talk about your symptoms, talk about symptoms. If you don’t, just talk about whatever is important to you. At that very moment the United States had invaded Panama and I said to him, this is making me so stressed out. I feel so sick. I explained to him how I felt, and he made me feel really good. I think he was able to see more or less where I was psychologically, and I think that he helped me a lot.

Just because I’m not dying doesn’t mean that those symptoms are not important. If there are symptoms that bother you every single day, it’s like torture and you don’t want people to live in torture. If you’re a good physician, you shouldn’t be just saying, oh well, who knows what it is? Sometimes you just need to look carefully to find the roots of the problems. I know that the human body is pretty complex and there are many things that you won’t be able to find out right away. But I know that a lot of the things that you don’t find are because of the approach you’re using. Even if things cannot be fixed, maybe they can be alleviated somewhat.

**Dr Y: Her Understanding and Perceptions**

Dr Y: The biggest issues Mr H faces are dealing with his physical complaints, and trying to see them as based in psychological issues rather than actual physical problems. He is beginning to do that now, but I think he still has a way to go. In my limited experience with people who somatize, you have...
to address the problem as they present it. You have to acknowledge that they may be feeling this physical complaint and by doing that, examine the area that they're complaining about. Putting your hands on the patient is very important, and then investigating that complaint as fully as possible to come up with evidence either that there is a physical basis or that there actually is no physical basis for that complaint.

In explaining this to Mr H, I acknowledge that he is feeling this complaint, but that in my medical experience there is no physical reason for this complaint, and I think it's probably psychological. I reaffirm that he is feeling what he's complaining of, but that there is no medical way I can help him, and that I think psychological help would be better.

I add the part that I think is in a patient's head by saying, 'we've examined you. I've drawn tests or studied you in this way and haven't been able to come up with any physical basis for your complaints. I'm wondering if there is some stress in your life, and I'm wondering to what extent stress is playing a role in your physical complaints.

It's crucial that the physician addresses the physical complaint, examines the patient, works with the patient, but also draws a limit to the tests they are going to do if they feel convinced this is not a medical problem. It's also important that the physician and the patient have an open communication line and that the physician is willing to listen to the patient talk about their problems over and over again.

**AT THE CROSSROADS: QUESTIONS TO DR BARSKY**

What are the epidemiology, etiology, natural history, and clinical features of patients who have multiple somatic symptoms? What are the social and economic implications of their difficulties? How should the primary care physician evaluate and manage patients with these problems? What are your recommendations for this patient? How helpful are psychoactive medications, education, and alternative therapies? What should the interface be between the primary physician and the mental health professional?

**DR BARSKY:** Mr H's case illustrates several important points about somatization. The first is the chronicity and multiplicity of his symptoms: he has a long history of many different complaints involving many different organ systems. The second point is that he describes 2 distinct sources of discomfort and suffering: his physical suffering and the sense of illegitimacy that results from not having a diagnosis. The absence of a medical explanation for his problem makes it seem invalid. The suspicion and disbelief surrounding the patient with medically unexplained symptoms is in itself a major source of distress. Finally, Mr H is not satisfied with his medical care. The somatizing patient feels sick, but also senses that his physicians dismiss and negate that experience.

**The Dimensions of the Problem**

Somatization is defined as experiencing and reporting bodily symptoms that have no pathological basis, attributing them to disease, and seeking medical attention for them. The phenomenon is ubiquitous. It is estimated that in 25% to 50% of all primary care visits, no serious medical cause is found to explain the patient's presenting symptom. Another way, 38% to 60% of the patients in primary care practice complain of symptoms that have no serious medical basis. And if we focus not on patients or visits, but rather on symptoms, a similar picture emerges: of all the symptoms patients report, 30% to 75% remain medically unexplained after adequate evaluation. Even among symptoms that have "bothered [the patient] a lot" in the past month, 16% to 33% have no medical explanation. The burden such symptoms impose is no less than that of the symptoms of serious medical disease; functional symptoms without organic cause are as disabling, more chronic, and more refractory to treatment than organically based symptoms.

Somatizing patients are disproportionately high utilizers of medical services, laboratory investigations, and surgical procedures. When compared with nonsomatizing patients, they have elevated rates of ambulatory medical visits, hospitalization, and total health care costs. Studies have shown that patients with somatization disorder (a severe and chronic form of somatizing that is considered a psychiatric disorder) use 3 times the ambulatory medical services of nonsomatization disorder patients, 10 times the mean inpatient and outpatient services of the general population, and have 3 times as many hospitalizations and surgical procedures as patients with major depression. Predictably, patients with somatization disorder also have unusually high rates of iatrogenic illness.

Although somatization is a serious, prevalent, and significant problem in almost all branches of clinical medicine, far too little is known about the phenomenon. In particular, epidemiological and phenomenological studies are needed to subdivide this large, heterogeneous group of patients into smaller, more homogeneous subgroups for whom specific therapeutic strategies can be developed and tested. It is also important to begin to probe the actual mechanisms of symptom formation and modulation with cognitive and perceptual testing, and eventually with functional brain imaging as well.

**The Spectrum of Severity**

The specific nature of a patient's complaint may or may not help to identify it as the product of somatization. Multiplicity of symptoms, as seen with Mr H, is generally more indicative of somatization than is the specific nature of the particular symptoms. However, complaints that are highly personalized and idiosyncratic and are sensations generally not indicative of demonstrable disease (eg, a "tired heart," "aching veins") are more likely to indicate somatization. Clinical experience suggests that somatization is also more likely when the symptom begins with a psychologically meaningful or stressful event; when the patient adamantly denies any role for psychological or psychosocial factors in his or her distress; when there is a history of prior, medically unexplained complaints; and when major, psychiatric disorder is present.

Somatization varies along a spectrum of seriousness. At one extreme are mild, transient, functional symptoms that occur often in daily life (eg, noticing palpitations following an argument with one's landlord). Somewhat more disturbing, impairing, and persistent symptoms may arise in the context of taxing life stresses or demanding life changes that require adaptation (such as the complaint of "tired feet" from the recently widowed mother of 2 young children who has had to begin working 2 jobs). At the most serious end of the somatizing spectrum are severe, disabling, and persistent symptoms that result in invalidism, undue utilization of medical care over a prolonged period, and preoccupying health concerns. Severe somatization is characterized by (1) chronicity of symptoms (at least 3 months duration); (2) multiplicity of symptoms (at least 3 different complaints); (3) refractoriness to appropriate reassurance and somatologic management (severe somatizers characteristically re-
spond to palliative attempts with a paradoxical exacerbation of symptoms and health concerns); (4) the absence of a single, discrete, stressful precipitant; (5) disproportionate disability and role impairment; and (6) a growing preoccupation with health, symptoms, and the pursuit of medical care. This severe form of somatization can be termed chronic, major somatization, and seems to be Mr H’s difficulty.

The Differential Diagnosis of Chronic, Major Somatization

As the severity, chronicity, and invalidism of somatization increase, so does the likelihood of a major psychiatric disorder. In particular, the multiplicity of functional somatic symptoms is a reliable indicator of psychiatric disorder so that when the number of medically unexplained complaints exceeds 3 in men or 5 in women, the likelihood of a diagnosable psychiatric disorder increases dramatically. The most common disorders in this regard are depression (major depressive disorder and dysthymia), anxiety disorders (panic disorder, generalized anxiety disorder, and obsessive compulsive disorder), the somatoform disorders (hypocondriasis, somatization disorder), and alcohol or substance abuse. It is important to remember that psychiatric disorder typically presents to physicians in a somatized form. Of primary care patients who ultimately receive a psychiatric diagnosis, 50% to 70% presented initially with a somatic complaint, and 75% of primary care patients with major depression or panic disorder on a structured diagnostic interview came to their physician with exclusively somatic symptoms. Primary care physicians underdiagnose psychiatric disorder most when it presents in this somatized fashion. Thus, several studies have documented that major psychiatric disorders are far more likely to go unrecognized in primary care practice when obscured behind a veil of functional symptoms.

It is beyond the scope of this brief review to discuss these psychiatric entities or their differential diagnosis. We can only point out their high prevalence and emphasize that many are eminently treatable with pharmacotherapy and/or cognitive and behavioral therapy. In addition, failure to recognize and treat them has been shown to lead to further disability and increased utilization of medical care.

Mechanisms of Symptom Formation

A phenomenon as complex as somatization obviously results from many different psychiatric, psychological, interpersonal, and situational forces. However, 2 specific mechanisms of symptom formation stand out because of their implications for medical management.

The Amplification of Bodily Sensation.—Somatization can result from a self-perpetuating cycle of cognitive and perceptual distortion, in which beliefs about health and disease cause the patient to amplify benign bodily discomfort so that it becomes unusually intense, noxious, and disturbing. Amplification has been studied most in relationship to hypochondriasis, but it is thought to be important in other forms of somatization as well. This process begins when an individual like Mr H misinterprets normal physiology, a benign and transient medical disorder, or the somatic and autonomic comorbidities of emotional distress as evidence of a serious medical disease. This misattribution to disease amplifies the original symptom, and also causes the individual to note additional symptoms previously overlooked, ignored, or dismissed as insignificant. This occurs through several mechanisms: by heightening bodily scrutiny and attention, by creating a set of expectations about future sensations through the process of suggestion, and by arousing anxiety and alarm. Suspecting that he is sick, Mr H, the somatizer, begins to select from his perceptual experience evidence to confirm his suspicions, and he ignores contrary evidence that he is not sick. This sifting of one’s perceptions for confirmatory evidence of one’s preconceptions appears to be a general, psychological principle. Ambiguous evidence of disease is always at hand, in the newly amplified bodily sensations that seem increasingly intense and noxious, in the information obtained through discussion with others and from the mass media’s health reports, in the somatic concomitants of one’s mounting anxiety, and in the medical encounter itself. A vicious circle is thereby created in which the belief one is sick amplifies symptoms, which then further heighten disease conviction.

Interpersonal and Situational Forces.—Somatization also occurs in response to stressful and trying life situations. Mr H has acknowledged this to some degree. He says that he has not felt well since emigrating, and that he has separated from his wife. When people find themselves faced with insurmountable difficulties, or confronted by seemingly insoluble problems, they try to tell others about their dilemma and ask for their help. Somatizing patients do this in a nonverbal language, calling attention to their plight with a bodily pantomime. Their symptoms are a metaphor, a request for help and special attention, a way of calling for time-out when in dire straits. This is not malingering and is an unconscious process shaped by prior learning and experience. The malingerer consciously attempts to deceive others by feigning illness and, in contrast to the somatizer, does not have the symptoms he or she describes.

But most physicians, viewing symptoms only as guideposts to underlying organ pathology, do not hear this interpersonal communication. Finding no structural disease, the physician informs the patient that “nothing is wrong,” noting “you are fine,” and that there is no “problem.” This negates the patient’s assertion of distress and invalidates the symptoms, as Mr H noted. In taking the patient’s symptoms too literally, the physician misses the real communication and the patient leaves the office feeling misunderstood, slighted, and unheard. These patients sense that their suffering has been refuted or dismissed, and may come to feel that only more serious, numerous or intense symptoms will compel the physician to notice their distress. An escalating cycle ensues in which the physician’s attempts to dismiss the patient’s symptoms (either by saying explicitly that nothing is wrong, or by treating the symptoms with the expectation that they will resolve) result in growing somatic distress and escalating requests for clinical attention. It is no surprise, therefore, that Mr H has sought help from many different physicians and changed physicians when he felt they were not taking his complaints seriously.

Clinical Management of the Patient With Chronic, Major Somatization

There are several principles of management for Mr H and others like him with chronic, major somatization. These guidelines (Table) apply only to the care of the patient whose somatization is prolonged, refractory, and disabling, and not to patients whose somatization is milder, more transient, or is clearly stress-related.

Care Rather Than Cure.—The objective of medical management is not to eliminate Mr H’s symptoms, but to improve
his ability to cope with them. In short, the goal is care rather than cure. The physician's role is akin to his or her role in the management of a chronic medical illness: helping the patient live successfully with, adapt to, and minimize chronic symptoms and residual disability. Since no structural disease is present, physicians expect to eliminate the somatizer's symptoms, forgetting that "no pill can cure, and no surgery can excise the need to be sick." Because the patient's symptoms arise from cognitive, situational, and psychiatric factors, biomedical interventions cannot ablate them. Allowing Mr H to retain his symptoms and focusing instead on coping with them avoid the vicious circle in which therapeutic attempts lead only to worsening symptoms and heightened demands. In accepting the patient's complaints rather than trying to eliminate them, the physician is acknowledging the reality of the patient's distress. Much of the anger and frustration that physicians experience in caring for somatizing patients comes from the physician's sense of being thwarted or foiled by the patient. Once the physician has stopped trying to eliminate the symptoms, then the patient no longer seems to be contravening and defeating his therapeutic efforts. As a result, the physician feels less exasperated and angry. It also helps to remember that the patient is not deliberately trying to foil the physician or to consciously defeat his or her efforts.

In the physician's view, the goal of medical care is to definitively diagnose each symptom and to institute a specific therapy accordingly. But given the pervasiveness, chronicity, and persistence of Mr H's distress, this may not be a feasible short-term goal. Such an approach works well with symptoms resulting from demonstrable disease, but is less successful with medically unexplained symptoms. It may be more productive to consider the alternative with Mr H—namely, that some degree of distress will probably persist into the foreseeable future. The goal of medical management then becomes helping him to minimize his symptoms, adapt them, and cope with them better. This is a major shift in perspective for both Mr H and Dr Y, and the transition cannot be made rapidly.

Diagnosis and Therapeutic Conservatism.—Because occult medical disease may always be present, the physician must first fulfill his or her medical mandate to evaluate every symptom completely. The dilemma, however, is that somatizing patients are often subjected to excessive diagnostic procedures and therapeutic interventions. Overly aggressive diagnostic testing and the elective treatment of incidental or equivocal findings too often result in complications, adverse effects, iatrogenic disorders, and new symptoms to replace the old ones. Before ordering an invasive study, question the patient carefully and check the record to make sure it has not already been performed. A rule of thumb in ordering laboratory studies is to do exactly what the physician would do for the patient were he or she not a somatizer. If the patient requests a series of tests that are not indicated, the physician may decide with the patient that further testing for that symptom will not be conducted if the results from the initial test are negative (eg, "if your ambulatory electrocardiogram is normal, let's agree not to go on a stress test").

The most powerful therapeutic tool is the physician: his or her attention, concern, interest, and careful listening; don't just do something, stand there. Frequent physician visits, a laying on of hands, and careful physical examinations are beneficial. Simple and benign remedies such as lotions, vitamins, ace bandages, and heating pads are helpful. They provide tangible evidence of the patient's distress and an acknowledgment of the physician's ongoing interest.

Validating the Patient's Distress.—When somatization is viewed as an interpersonal communication, the patient is understood to be seeking out recognition of his distress and an ongoing relationship with a physician. The patient needs to be assured that this relationship is legitimate and that access to the physician is not predicated only on symptoms and somatic distress. This message can be conveyed in several ways. First, the physician makes it clear that psychosocial issues are subjects as legitimate for clinical discourse as physical health, and shows a gradually increasing interest in the social history and in the patient as a person. Mr H describes how important it is that his physician "gets to know" him first, to build a relationship. Some of this can transpire during the physical examination, which both saves time and also amalgamates the physical and psychosocial realms. Second, access to the physician is divorced from the patient's clinical status, and ongoing contact is not made contingent on continued symptoms and suffering. This is done by scheduling visits on a regular basis, rather than as needed. Physician and patient agree on a satisfactory frequency of appointments and then try not to vary this with changes in the patient's symptom status. (This may not always be possible, of course, if the patient develops more emergent symptoms.) When practical, the physician can also offer a regular call-in time. This too guarantees access to the physician without requiring that the patient have an alarming change in clinical status. The net effect of uncoupling medical attention and somatic distress is to reduce the latter. A few patients may continue to make excessive and unreasonable requests and demands for time, attention, support, and information. Clear, firm, nonpunitive limit setting is then necessary in these cases.

Provide an Etiological Explanation.—Somatizing patients often say, as did Mr H, "I'd feel better if I just knew what I had." Many chronic, somatizing patients suffer not only from their symptoms, but from their seeming inauthenticity or illegitimacy as well, since they have no medical diagnosis. Telling them only that serious disease has been ruled out is insufficient: they require an alternative explanation for their symptoms. Such an explanation should attempt to move the patient from a structural model of a her localized, discrete, occult lesion, to a model of dysfunction. It is helpful to explain the cognitive and perceptual process of symptom amplification described above. The
physician can then suggest that the problem lies in the nervous system's processing of bodily sensation, and that the patient has an extraordinarily sensitive sensory nervous system that amplifies benign symptoms that others experience as less intense. An analogy can be made to a radio whose volume has been turned up so high that background static has become disturbing and noxious. Any such explanation must be coupled with the explicit assurance that this means that the patient's symptoms are "real" and not "made up" or "all in your mind."

Reassurance should be given cautiously and with circum¬ception. Although Mr H should be reassured that he does not have a grave disease that will progress or worsen, his physi¬cian should also begin to discuss the caveat that symptoms like these tend to be difficult to treat and are often refractory.

The Psychiatric Referral.—Somatizing patients are especially dubious about psychiatric consultation; it seems to be irrelevant, or even an accusation that their symptoms are "imaginary" or inauthentic. If the patient is very resistant to a psychiatric referral, little is gained by forcing him or her, since an unwilling patient will render the psychiatric encoun¬ter unproductive. It is better to wait and then gradually re¬introduce the idea again in the future. However, if the patient is willing to see a psychiatrist, consultation can be helpful in the following ways: (1) diagnosing psychiatric comorbidity behind the veil of somatic complaints and concerns, (2) considering the use of psychotropic medications, and (3) engaging some patients in ongoing psychiatric treatment.

When a pharmacologically responsive psychiatric disorder (eg, depressive disorder, panic disorder, obsessive-compulsive disorder) is present, the appropriate psychotropic agents should be prescribed. Since somatizing patients tend to react to medications with bothersome adverse effects or new symp¬toms to replace the old ones, they are best prescribed with a note of caution, even pessimism, avoiding any suggestion that they will be curative. The patient may be told that it is uncertain whether the medication will help, and although it is unlikely that it will be markedly beneficial, it may still be worth a try. If the patient is skeptical or pessimistic, little is gained in disputing the patient's reluctance in taking medication. Doses should be initially low and gradually increased.

Since somatizing patients believe they are medically ill, psychologi¬cal treatment seems profoundly misguided to them. It may be acceptable, however, if treatment is aimed at improved coping with somatic symptoms, or if the clinician can identify an (apparently unrelated) source of emotional distress. Some pa¬tients will accept psychological treatment as long as it targets physical symptoms and somatic distress. Many accept the premise that their health is adversely affected by "stress," and are therefore willing to undertake therapy under the rubric of "stress reduction" or "stress management." Some patients ac¬knowledge emotional distress for which they will accept treat¬ment (admitting, for example, to marital discord, difficulties at work, or to feeling depressed), although they generally deny it has any causal relationship to their somatic symptoms. The pa¬tient need not acknowledge a link between his emotional and his somatic distress; traditional psychological insight does not appear to be particularly helpful. Mr H speaks to this point. He has seen a therapist and found it productive, and he understands that his symptoms result from a combination of psychosocial and medical factors. This insight, however, has not diminished his bodily distress or his health concerns. This does not mean that his psychotherapy has been unproductive, but merely that the goal of psychotherapy need not be insight into the genesis of his somatic symptoms. Rather, psychotherapy can proceed with 2 distinctly different aims: to work on Mr H's psychological problems, and to acquire cognitive and behavioral techniques to help him to cope better with his somatic symptoms.

Recently, significant strides have been made in developing standardized, cognitive, and behavioral treatments for various forms of chronic somatization. These programs are more edu¬cational than psychotherapeutic in tone. They are often con¬ducted in a classroom format, meet for 6 to 16 sessions lasting 1½ to 2 hours each, and are highly interactive. Instruction is sup¬ported with workbooks, reading materials, and audiotapes. The therapy includes experiential class exercises, didactic informa¬tion, and group discussion. The aim is to identify and restructure dysfunctional beliefs and assumptions about health; modify mal¬adaptive behaviors that sustain disability such as avoiding usual activities, seeking reassurance from others, and physician shopping; initiate a program of progressive exercise and carefully graduated physical conditioning; and learn relaxation or medita¬tion techniques. There is growing literature on the efficacy of this approach in treating hypochondriasis, somatization disor¬der, and single isolated, medically unexplained symptoms such as atypical chest pain, irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, headache, and other forms of chronic idiopathic pain. Some interventions have included control groups receiving a nonspecific relaxation or education program. Follow-up has been conducted for up to 4 years, and attrition rates are low. These cognitive and behavioral treatments have been shown to reduce somatic symptoms, generalized distress, and impairment of role function. Some interventions have also reduced utilization and costs of medical care.

Alternative Therapies.—Very little is known about the utili¬zation or effectiveness of alternative and nontraditional therapies in chronic somatization. These approaches might offer some benefit when they empower patients by providing them with an array of self-treatments, such as yoga, hydro¬therapy, and dietary supplements, which they can regulate, adjust, and combine to treat their own symptoms. Although this enhanced sense of self-efficacy and control over one's symptoms seems to be helpful to some, there are no empirical data to substantiate the impression. Patients must also be cautioned against alternative therapies that may actually be harmful, are unscrupulous, or which take the place of traditional medicine for demonstrable disease.

In summary, Mr H and Dr Y have established a solid rela¬tionship with very good communication. Dr Y correctly rec¬ognizes that their relationship is founded on her taking Mr H's complaints seriously, evaluating them thoroughly, and acknowl¬edging their existence despite the absence of a demonstrable cause. She is able to tolerate the frustration of being unable to definitively cure Mr H. And she realizes that progress with chronically somatizing patients is painstaking, slow, and re¬quires time. This is particularly difficult in this instance because she is a house officer and Mr H may therefore have to change primary care physicians in a relatively short time.

QUESTIONS AND DISCUSSION

Mr H: This is interesting. I think the more insight you have, the better you'll be able to understand. Therefore, as Dr Barsky said, I perhaps can realize that doctors will never find an answer to my problems, but that perhaps I can find a way myself to learn to live with what I have in a better way.
DR DELBANCO: If your doctor gave you the article with Dr Barsky's discussion and said, "read this, it will help you in managing your illness," do you think that would be helpful?

DR Y: I thought that Mr H and I had done many of the things that were spoken about. We set up an appointment for him to come back in 2 weeks. So it was very helpful for me to hear this. I think it helps me formulate an approach. Having Mr H here, we hear it together, so that at our next meeting we can make some more progress.

AN INTERNIST: When I think of an analogy like chronic obstructive pulmonary disease or diabetes, I have a fairly clear sense about what successful management looks like or how I can help a patient succeed. For Mr H, or for patients like him, how do we know what successful management or realistic goals are? One of the real problems could be that we set high goals for the outcome of the process you articulated, and then we find that we still are in an unending cycle. Then we feel we failed. So what would successful management look like in the months and years ahead?

DR BARSKY: You do need some reference points against which to measure your treatment. I want the patient to be able to say, "I can tolerate my symptoms. They're not interfering with my work, my family life, or my activities." So that you hear your patient is functioning reasonably well. The symptoms are bothersome but bearable. And from your perspective as a health care provider, the relationship with the patient should feel productive and more than merely tolerable. You feel as if you're on the same wavelength, and that the patient's medical care is under control. You don't feel as if you're just chasing after a multitude of symptoms, and engaging in a series of interactions that are unproductive, frustrating, or adversarial.

DR DELBANCO: What about the cultural determinants of illness? I don't know much about Colombia. How do you take into account the patterns of health care, and the patterns of symptoms in someone from another country?

DR BARSKY: Often we as providers really aren't aware and don't know enough about the patient's culture to see how it factors in. In general, ethnic and cultural issues are very important influences on somatic symptom reporting. They influence the kinds of symptoms people report, their threshold for reporting them, and their threshold for seeking medical attention. So these are major issues. If the patient's culture is unfamiliar to you, you may have to rely on the patient to tell you what the norm is.

A RESIDENT: Do you find that there's a name or a label that you can put on this type of condition that helps patients deal with it, in a way that putting a name on something like irritable bowel syndrome or chronic fatigue syndrome seems to help patients relate to or accept their condition?

DR BARSKY: I tend to be more descriptive rather than apply a diagnostic label or term. I might say, "You have chronic, medically unexplained symptoms and a preoccupation with your health, with prominent fears about disease, and difficulty feeling reassured." The diagnostic labels we use are pejorative and stigmatizing and don't convey much. It is better to describe what the patient's problems are in straightforward, everyday language. I would do the same in the medical records, rather than using diagnostic terms and labels.

AN INTERNIST: Can you comment on managed care aspects of dealing with this kind of problem?

DR BARSKY: Managed care will probably have a number of contradictory effects on somatizing patients. On the one hand, I think there are some reasons to worry, and I think that the pressure that managed care will put on physicians' time and their resources is probably going to distress somatizing patients even more. The doctor is going to have less time to spend with the patient, and will have a higher threshold for ordering tests and obtaining referrals and consultations. Somatizers may therefore feel even more ignored, overlooked, and dismissed. They may feel as if the only way they will get attention is to "up the ante"—to present symptoms which are more severe, more ominous, or more alarming. So I worry that capitulation and managed care may make things worse.

On the plus side, managed care may force us to develop new services and new delivery mechanisms. Once we are responsible not just for illness episodes, but for the patient's overall health status, it will become cost-effective to treat somatization and to make the somatizer's utilization of care more appropriate and more adaptive. We will also have an increased incentive to implement cognitive and behavioral treatments and to institute programs to teach people about symptom appraisal and reporting. At present we don't do enough of this.

MR H: I want to stress something I've noticed here. Physicians should really look at the way they communicate with their patients, because although I'm pretty outspoken, a lot of people don't explain their symptoms or don't describe many things because they're embarrassed. I was embarrassed at some point in my life. If you make people feel comfortable, you'll get to the nitty-gritty of things. It's like love. If you love somebody, you go and do the best you can. You open your heart. You go and give flowers or whatever. And that allows something to develop that makes sense. Even if you are a good doctor, you won't be able to identify the symptoms if you don't communicate well. The stress has to be placed first on communication, so that doctors will be able to communicate among themselves in a good way, as well with their patients, and I think that is very important.

Clinical Crossroads is made possible by a grant from the Robert Wood Johnson Foundation. We thank the patient and his doctor for sharing their stories in person and in print.

References
An 89-Year-Old Woman With Urinary Incontinence, 1 Year Later

In September 1996, at Medicine Grand Rounds, Dr Neil Resnick discussed an 89-year-old woman who had multiple urinary incontinence for 14 years and had tried multiple approaches to improve it.1 Dr Resnick discussed the prevalence and causes of female geriatric urinary incontinence along with the diagnostic and management approach. For Mrs S, he recommended that treatment address her nocturia, arthritis, and detrusor overactivity.

MRS S, THE PATIENT

I turned 90 a few weeks ago. I wish I could say I was doing well, but I’m not. I’ve developed problems with my neck and spine and I’m uncomfortable and all bent over; it’s affecting my spinal cord. My neurologist says I’m healthy enough to consider surgery, so I have an appointment to see a neurosurgeon next week. This problem has only made my incontinence worse. Now I’m losing control during the day as well as at night. I have to empty my bladder every hour. I just came out of the bathroom. But my general health is good. Wish me luck!

DR B, THE PRIMARY PHYSICIAN

Mrs S had a difficult year. She has marked cerebral spondylosis with cord compression that has resulted in a gait disturbance and increasing urinary incontinence. She’s now incontinent during the daytime. She is about to see a neurosurgeon because of the marked degree of cord compression noted on her MR scan. Despite all these medical problems, she continues to live at home with her son and enjoys watching television and visiting with friends.

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