

# Understanding and Caring for the Distressed Patient With Multiple Medically Unexplained Symptoms

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**Background:** Although physicians commonly encounter patients with complicated medical problems, some have a mix of unexplained medical symptoms and distress that can seem overwhelming to patient and physician alike.

**Methods:** We describe a model for thinking about and helping these complex patients. The model was developed from our personal clinical experience as primary care psychiatric consultants, as well as from a review of the literature using such key words as "difficult," "frustrating," and "somatization."

**Results:** The model involves understanding predisposing factors that render the patient vulnerable to the development of a disabling condition, precipitating factors that initiate an episode of illness, and perpetuating factors that maintain maladaptive illness behaviors with time.

**Conclusions:** Awareness of these factors allows the clinician not only to tolerate and gradually unravel the complicated interactions that create and sustain distress in patients with multiple medically unexplained symptoms, but also devise practical and effective management strategies for these complex patients. (J Am Board Fam Pract 1998;11:347-56.)

Primary care providers and specialists routinely encounter patients whom they find frustrating. Some of these frustrating patients have been characterized as difficult or hateful patients<sup>1-10</sup> because they frequently evoke strong negative feelings in medical practitioners, stemming mostly from an inability to establish and maintain an effective physician-patient relationship. Other patients, however, frustrate the physician as a result of their complicated medical problems. Interestingly, physicians find caring for some complex patients challenging and rewarding, whereas other patients can arouse feelings of disappointment and helplessness. We examine how medically unexplained physical complaints can cause physician frustration and offer a model clinicians can use to understand and care for patients who have complicated physical symptoms that appear unresponsive to treatment.

Traditional biomedical training has emphasized detecting physical disease in a manner similar to puzzling out a murder mystery. Clinicians often derive intellectual satisfaction from the diagnosis

of occult diseases. Yet for some patients no cause is found for their symptoms, and the clinician, gradually fatigued and defeated, can lose interest in the patient's condition.

Recent studies have shown that no organic cause can be found for more than three quarters of such physical complaints as fatigue, chest pain, or dizziness.<sup>11</sup> In the search to rule out physical disease, many patients receive extensive workups for their illness complaints, while psychosocial evaluations are frequently deferred or incompletely accomplished. When psychosocial evaluations are accomplished, the most common findings include complicated mixes of current stressful life events, chronic social stressors, psychiatric disorders, childhood and adult sexual and physical victimization, chronic somatization, high health care utilization, and comorbid medical disease.<sup>12,13</sup> These studies have also shown that patients and physicians differ markedly in their perception of how medically ill and disabled the patient is. Patients not only are likely to perceive themselves as considerably more ill and disabled than their physicians do, but they often perceive a lack of empathy and understanding on the part of their physicians.

We attempt to answer several questions: What are the best ways to approach complicated patients with multiple medically unexplained symptoms? What factors should be assessed, and what is the most efficient way to do so? Is there a useful clinical

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cal model that ties together these findings? How should the practicing clinician incorporate these findings? When is specialty consultation helpful?

## Methods

We have more than a decade of experience practicing in primary care clinics. Drawing from that experience, we searched the literature using such key words as "difficult," "frustrating," and "somatization," and prepared a model that synthesizes the current data on complicated, high-utilizing patients with our own experience of providing consultative advice or management.

## Understanding Illness and Disease

One of the most helpful starting points is the ability to differentiate between illness and disease. Although these terms are frequently used interchangeably, medical sociologists have made useful distinctions between the two concepts.<sup>14</sup> Disease describes the objective, physiologic changes that are associated with organic abnormalities and physical signs. Thus, high blood pressure, heart murmurs, and abnormal laboratory and physical examination findings are characteristic signs of disease. Illness, on the other hand, refers to subjective physical or psychologic symptoms that are perceived by the patient and can be associated with decrements in emotional, role, social, and occupational functioning.

Patients can have relatively severe diseases, such as myocardial infarctions, yet adapt well and refuse to give up their work or social roles; thus, they have disease with little illness. Often these patients are admired for being brave and stoical, for getting on with their lives despite their disease. When hospitalized, these patients can minimize or deny they have a serious disorder and might attempt to leave against medical advice. Alternatively, physicians also encounter patients who appear to be highly disabled physically, emotionally, or occupationally out of proportion to the degree of suffering or despite the absence of any discoverable disease. These patients are often perceived as whiners and crocks, and when hospitalized, might attempt to stay against medical advice.

Thus, although many patients have disease and illness episodes simultaneously, some might have disease without illness, and others might have illness without disease. In our culture we have far more difficulty dealing with the latter; it can pro-

voke strong negative feelings in health care providers, which, in turn, can cause patients to persist in demanding that they get their medical needs met.

## A Model of Illness and Disease Interaction

To deal with the many biologic, psychologic, and social factors that can affect clinical outcomes in patients, it is sometimes useful to use a three-stage model in which factors are grouped according to their role in the development and maintenance of a set of symptoms.<sup>15</sup> In this model particular events that occur during a patient's life can lay the groundwork for, initiate, or maintain the process of illness. The three stages of the model are (1) predisposing factors, (2) precipitating factors, and (3) perpetuating factors (the P-P-P model).

*Predisposing factors* are patient characteristics that provide a basis for developing a disabling condition. Certain patient attributes contribute to the potential for a symptom to develop, like fuel waiting to be ignited. They can include such factors as biologic diatheses (eg, increased intestinal motility in patients with irritable bowel syndrome or autonomic nervous system instability in patients with panic disorder), chronic childhood medical illnesses, childhood maltreatment, low resilience, poor coping ability, low social support, chronic social stress, comorbid medical disease, and low psychological mindedness.

*Precipitating factors* are those elements of the patient's life that precipitate an illness event. They can include medical disease; a psychiatric disorder; social, fiscal, or occupational stress; a car accident; changes in social support; reexperienced trauma; or something as simple as change in routine or diet. These factors ignite the potential energy of the predisposing factors and precipitate a crisis that pushes the patient into a distress state and increases the use of health care.

Finally, *perpetuating factors* are features of the patient's life that maintain the illness process and are akin to additional fuel for the fire. These features can include financial reinforcers of disability for a patient who dislikes his job, decreased self-confidence, decreased activation and weight gain, social isolation, and personal gain from the symptoms. Perpetuating factors often involve coping skills learned by the patient that at one time might have been adaptive solutions but have now become maladaptive and counterproductive.

When predisposing factors are ignited by a precipitating stressor, the patient can begin a period of increased health care utilization and symptomatic distress. If allowed to continue, perpetuating factors can gradually reinforce and strengthen illness conviction and disability, thereby increasing health care utilization and the likelihood that the process will become difficult to reverse.

### Case 1

A 42-year-old woman wants to establish care at your practice. Currently she is in no distress and comes to the office for her yearly gynecologic examination. The visit is pleasant and unremarkable.

*Predisposing factors:* During the review of systems she reports a history of persistent diarrhea and joint pain, currently inactive. Her family medical history is remarkable for alcoholism in both father and mother, which sometimes led to occasional emotional and physical abuse. You get the sense that the patient's self-esteem is low, and you realize that you had some difficulty establishing a warm physician-patient relationship. She leaves the visit with no follow-up plans.

*Precipitating factors:* Two months later she complains of trouble sleeping and symptoms of diarrhea and joint pain. You begin evaluating her symptoms and set up a follow-up appointment. At the next visit she is greatly distressed, and you learn that she and her husband had a major fight. He had abstained from alcohol for 5 years but came home drunk 2 weeks ago after receiving a pay cut at work. He has continued to drink and has become increasingly emotionally abusive. Last night he struck her. As you continue to work up her physical complaints, you suggest to her that her physical problems might be related to her marital distress. You find her somewhat defensive and angry, and she fails to appear for several appointments.

*Perpetuating factors:* During the next few months, she sees several specialists on her own, who confirm her physical symptoms as colitis and fibromyalgia. The specialists confirm her belief in the organic foundation of her symptoms. She now is being seen on a regular basis by a gastroenterologist, a gynecologist, and a rheumatologist. By the end of the year, although findings from diagnostic laparoscopy and colonoscopy are normal, she reports increasing fatigue and functional disability and is applying for Social Secu-

rity disability assistance for her chronic medical problems. Her marriage has failed. She avidly follows the Internet self-help groups on fibromyalgia and chronic fatigue. You find yourself increasingly unable to influence this vicious cycle of disability and somatization.

This clinical example shows the power of psychosocial factors in the shaping of patient behavior and illness conviction. Notice the interaction of the various aspects of the model and the gradual worsening with time. While the model shows how chronic somatization and disability develop, it also illustrates opportunities to interrupt the process at various stages and reduce the likelihood of chronicity. The next step is to understand how awareness of the model can be useful in reversing the process of disability and somatization.

### Patient Care Using the Model

Management of this complex set of factors involves three steps: (1) controlling perpetuating factors (minimizing further damage, or tertiary prevention), (2) limiting precipitating factors (avoiding new flare-ups of the symptoms, or secondary prevention), and (3) decreasing the power of predisposing factors (attempting to remove or inhibit predisposing factors from resulting in more damage, or primary prevention).

#### Controlling Perpetuating Factors

It is often useful to begin with the perpetuating factors. These factors reinforce the sick role and illness conviction. It is unlikely that patients will be able to change without attention to these factors, because they continually reinforce beliefs about illness and maladaptive behavior.

#### Reduce Functional Disability

Many patients with chronic symptoms expect to become completely symptom-free. Because symptoms can accomplish something positive for a patient (ie, a woman with abdominal pain might [unconsciously] find her husband less physically abusive when she is ill), it is unlikely that such a patient would be willing to give up the positive benefits of such a symptom. By understanding the importance of the symptom to the patient, it is possible to find alternative ways to provide the desired outcome independent of the symptom (eg, suggesting marital therapy). Patients need to see their symptoms as annoyances to be overcome, not



as deterministic limits on their lives. The main goal is improving functioning as much as possible.

Let patients know that their symptoms might be long-lasting and that learning to live with the symptoms will help them regardless of whether the symptoms completely resolve. Emphasize that you can collaborate with the patient to help reduce distress from symptoms, but you might not be able to eliminate the symptoms entirely. Because physical deconditioning is common in patients with benign, nonmalignant pain, gradual, stepwise increments in physical exercise are usually necessary to build physical tolerance. For example, a patient with chronic low-back pain might be directed to a physical therapy program designed to increase mobility and conditioning and to prepare the patient to return to work, and the workplace might be modified to decrease the opportunities for back strain. You might not be able to cure the symptom completely, but you might be able to reduce its impact on the patient's daily functioning.

#### *Treat Underlying Major Depression or Anxiety Disorders*

Most chronic somatization syndromes have been found to be highly associated with major depression as well as with such anxiety disorders as generalized anxiety disorder and panic disorder,<sup>16</sup> and a somatoform illness frequently delays the timely physician recognition of any mood or anxiety disorder.<sup>17</sup> Antidepressant medications can often reduce the disability-maintaining effects of both major depression and anxiety.<sup>13</sup> Screen patients for major depression, dysthymia, panic disorder, and generalized anxiety disorder, and be aware that even if the patient does not meet criteria for a major depression, these patients are at high risk for relapse from previous episodes of depression. In general, benzodiazepines are not appropriate for long-term management of anxiety except in selected patients who have severe, incapacitating anxiety. These patients might best be treated in collaboration with a psychiatrist.

Instruments such as the Beck Depression Inventory<sup>18</sup> and the PRIME-MD<sup>19</sup> have been used successfully in primary care to help the clinician estimate the risk for depression and anxiety disorders. Becoming educated about the patient's vulnerability to these disorders and establishing relapse prevention plans can help detect early stages of recurrence. If patients meet diagnostic criteria for major depression, dysthymia (chronic low-

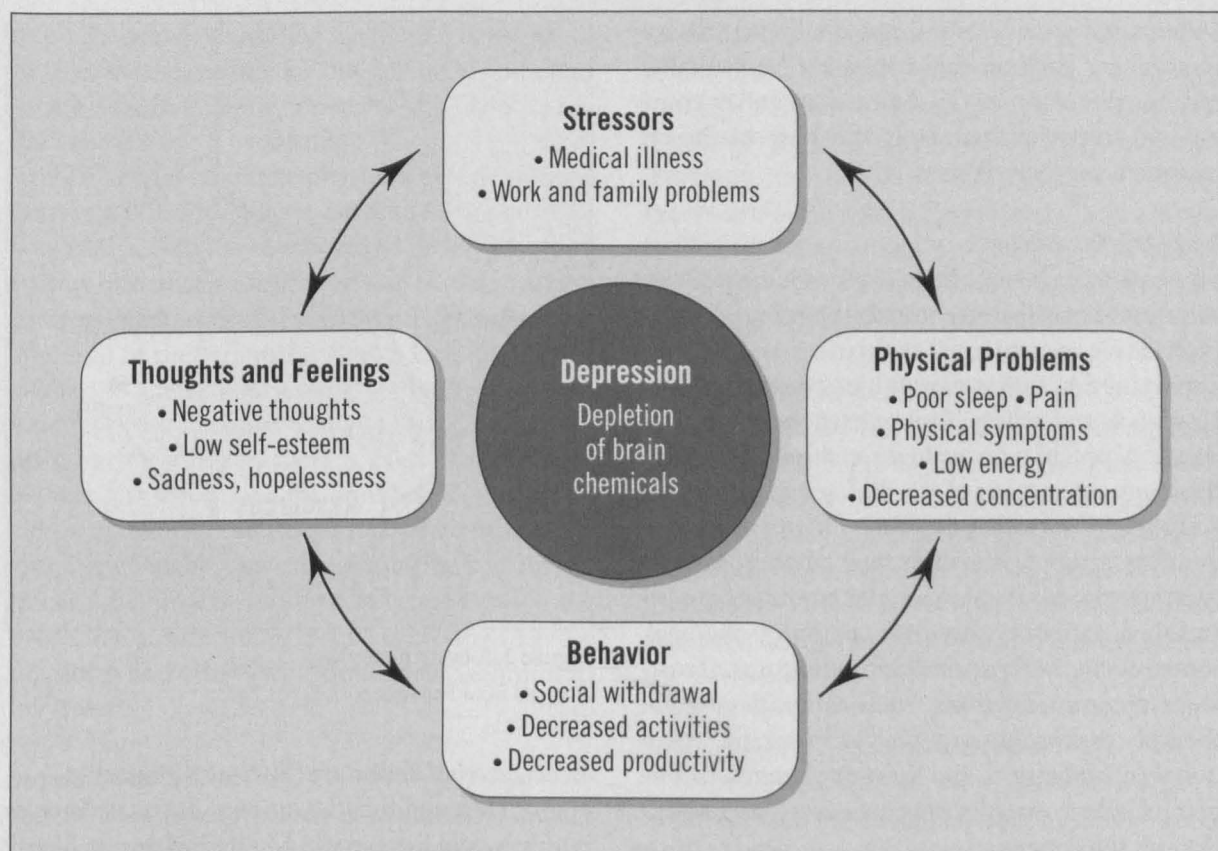
grade depression), or panic disorder, a trial of antidepressant medications at full therapeutic doses should be considered for at least 8 weeks, with a referral for psychiatric consultation if the patient responds poorly.

#### *Work on Changing Illness Beliefs*

Whereas some patients feel well most of the time and occasionally get sick, somatizing patients can feel as though they are ill most of the time and only occasionally experience good health. Reversing this distorted perception might require regular medical visits to reduce the patient's need to develop new complaints to gain access to and the attention of physicians.<sup>20-24</sup> Determine how many times the patient has appeared for treatment in the last 2 months, and schedule regular appointments accordingly. Regularly scheduled appointments decrease the patient's need for a physical complaint to obtain an appointment. Somatic fixation will often abate as patients realize the physician will see them regardless of whether they have a symptom. Replace the attention and caregiving that accompany symptomatic visits with reinforcement of patient's attempts at increasing positive activities and social contacts.

Restoring a sense of control over symptoms and learning how stress and symptoms interact can benefit patients. Patients sometimes have the attitude of "your job is to fix me." A successful physician-patient collaboration requires that the clinician and patient both view healing as a cooperative venture and recognize that not every aspect is within the control of either the physician or the patient. A useful strategy is to explain that there might be no cure for the chronic symptoms, but that you and the patient can work together to improve functioning to the highest degree possible.

The cycle of depression (Figure 1) explains how physical symptoms interact with depression. Part of the vicious-cycle model is consistent with the patient's perception that depression is a result of physical symptoms, but patients might find it less intuitive that depression and anxiety have a role in producing and exacerbating physical symptoms. Help the patient understand the circular causality shown by this model and how this vicious cycle is self-maintaining. Awareness can open the door to negotiation about how treatment of stress and depression is a goal in its own right as well as a means



**Figure 1. The vicious cycle of depression.**

to decreasing the stress and disability related to the symptoms. It will also help a patient realize that the symptoms are not "all in my head" and that your perspective is more biopsychosocial.

#### *Deal With Own Feelings About the Patient*

Clinicians can benefit from talking about complicated patients with other physicians and from understanding that the difficulties posed by the patient are not personally directed at the clinician. These patients often use the same dysfunctional coping mechanisms in all their interpersonal relationships and can generate strong negative reactions in others, also. Such feelings of anger and resentment are common when dealing with complicated patients, and physicians can benefit from being aware of these feelings by preventing them from interfering with compassionate care. Balint groups in family practice training<sup>25</sup> are an example of physician support groups that help physicians deal with frustrations arising from specific patients. By being empathic and supportive, the group helps the members understand their own feelings about a particular patient and develop more adaptive solutions to the patients' problems.

#### *Refer to Specialists With Caution*

Patients can unwittingly recreate the traumatic events that led to their symptoms as they attempt to find cures for their disease. Some specialists who are unaware of the process of somatization might lend credibility to the patient's belief that occult organic forces are responsible for their distress. Medical approaches appropriate in inpatient medical settings are often destructive when caring for patients with chronic, medically unexplained symptoms. Inappropriate approaches can include prescribing opiates for patients with chronic pain syndromes, performing repeated medical procedures and surgeries in patients with histories of sexual and physical maltreatment, and referring patients to new specialists to search for the elusive diagnosis. Patients are more likely to do well when they have a single provider who coordinates their care and who judges the appropriateness of consultation referrals and maintains the role of the principal physician who writes prescriptions.

#### *Educate Patients To Be Smart, Proactive Health Care Consumers*

Present the vicious cycle of depression model to



patients and provide your diagnosis. Share with patients the guidelines that constitute high-quality care for this disorder (ie, depression) and encourage and empower them to ask for state-of-the-art treatment for their distress.

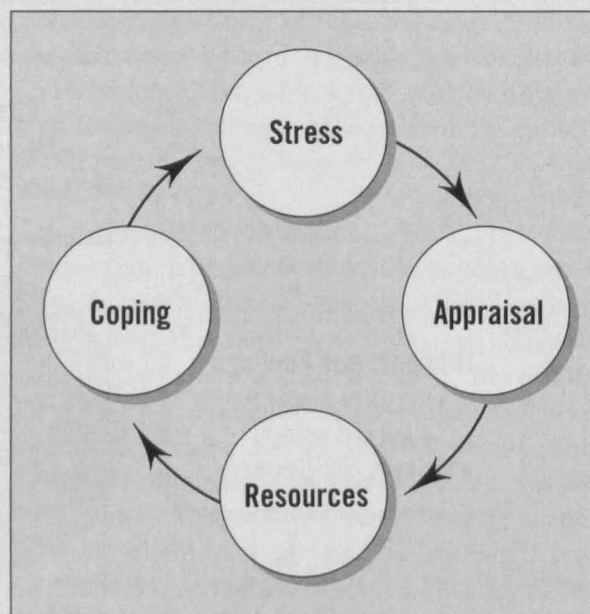
#### *Psychiatric Consultation*

Some patients benefit from early psychiatric consultation to assist in treatment planning. A comprehensive psychiatric evaluation is often an important first step in establishing treatment-planning goals and ruling out important medical diagnoses. A psychiatric evaluation should include a thorough assessment of the biologic, psychologic, and social forces that could be factors in the patient's symptoms. It is important to choose a psychiatrist who has experience and confidence in examining patients who have complex medical, somatoform, and psychologic symptoms. Treatment recommendations, such as antidepressant therapy, psychotherapy, physical therapy, vocational rehabilitation, and lifestyle changes, can be helpful when establishing an overall treatment plan for the patient.

A request for a psychiatric consultation should be the same as for a cardiology or orthopedic consultation. State what you would like to know and how the consultant might help you. Are you troubled by not understanding the diagnosis? Would you like recommendations on medication management or the suitability of the patient for psychotherapy? Ask for a consultation summary after the initial visit, so that you can share the recommendations with the patient. Because of the stigma of mental illness, referral to a psychiatrist can be more intimidating to the patient than referrals to other specialists. You should help your patient understand the nature of the consultation and how it will help you provide specific medical treatments that will assist in resolving the symptoms. A follow-up appointment should be scheduled after the consultation to review the recommendations and to reassure the patient, who might interpret the consultation as abandonment by the primary care physician.

#### *Limiting Precipitating Factors*

After beginning the process of limiting perpetuating factors, the next approach is to understand triggers that can activate preexisting conditions and initiate new illness episodes and then to minimize the potency of these stressors on the patient.



**Figure 2. A cycle of coping.**

Adapted from Folkman et al.<sup>26</sup>

#### *Treat Comorbid Medical and Psychiatric Diseases*

It is often found that the onset of distress coincides with stressful life events and physical or psychiatric illness. These disease processes disrupt normal coping mechanisms and life schedules and can overwhelm a patient's precariously balanced solutions to chronic stressors. Prophylaxis against new episodes of physical and psychiatric disease can decrease the patient's vulnerability to relapse.

#### *Help Patients Learn New Stress Management Skills*

Patients often have complex maladaptive behavior patterns that have been present for years and can seem impossible to influence. Although the many major changes that challenging patients need to make will require such specialty treatments as long-term psychotherapy, physicians should not overlook the opportunity to help them make minor lifestyle and coping changes that can reduce frustration in the physician-patient relationship or increase their quality of life.

It is sometimes helpful to review with patients a commonsense approach to problem solving. Such an approach involves isolating the components of a problem that cannot be changed and supporting acceptance while looking for opportunities for change and developing methods for methodical implementation. Folkman et al<sup>26</sup> have formulated a coping cycle model that is useful (Figure 2). Problem solving involves the three-

step process of appraising the problem, using resources that can influence the outcome, and instituting adaptive coping mechanisms that can reduce the stress.

This model offers the physician several options even in a brief, 15-minute encounter. Some stressors can be dealt with directly (eg, removing an anxiety-provoking skin lesion and thus the source of stress). Others can be improved by changing the appraisal of the symptoms from a highly negative valence to a neutral or even positive one (eg, "the lesion on your shoulder that you thought was cancer is harmless beauty mark"). New resources can be brought to bear on the problem (eg, giving a victim of domestic abuse the telephone number of a shelter). Finally, new coping mechanisms can be learned that provide more adaptive solutions to the problem (eg, substituting problem solving with the physician and others for drinking as a solution to job stress).

#### *Increase Social Support*

Several decades of research document the impact of increased stress and isolation on the incidence of physical and emotional diseases.<sup>27</sup> Social support buffers the effects of transitory stress and can be an important barrier to development of chronicity. Even in the face of a complex, stressful event, patients with good social support are less likely to move on to perpetuating their distress. A strong physician-patient relationship can provide increased support, as can more formal psychotherapy. For some patients, support groups, such as Alanon or Overeaters Anonymous, can be helpful.

#### *Health Promotion*

Health care maintenance is usually the first entry in a problem-focused medical record, yet maladaptive habits are often the most difficult for the patient to change. It is important to have the patient focus on wellness issues, particularly exercise, healthful diet, and smoking cessation.

#### *Decreasing the Power of Predisposing Factors*

This approach is the most difficult. Many predisposing factors are relatively immutable biologic properties of the patient (eg, bowel hypermotility) or are long-standing personality characteristics that might have both biologic and learned components, either of which could be difficult to modify.

#### *Accepting Physical Limitations*

Here efforts might be directed toward accepting biologic diatheses, framing them as potentially useful indicators of emotional state (eg, "you have a twitchy gut, which may be normal for you and serves as a barometer of your stress"). It can also help to develop a common language to discuss stress-induced exacerbations of underlying biologic vulnerability.

#### *Understanding Previous Illness Experiences*

Another approach involves assessing previous reactions to illness. Some patients have been previously exposed to illness or disease either personally or in family members and expect to deal with it again in the future. Such expectations can create anticipatory anxiety based on recollections of treatment regimens or memories of family members receiving treatment.

#### *Assessing Effects of Childhood Maltreatment*

It helps to be aware of any childhood maltreatment, because emotional abuse, physical abuse or neglect, or sexual abuse can have profound effects on how adult physical symptoms are produced and how caregivers are perceived.<sup>28</sup> Children who experience bad things (abuse) or the absence of good things (neglect) can find it difficult to accept care in medical settings. The vulnerable state created when a patient relinquishes control of his or her body to a medical caregiver might unconsciously recreate many anxieties of childhood, when the caregiver might have been untrustworthy, or worse, abusive. This association can seriously impede the formation of a healthy physician-patient relationship. Trust might build more slowly with time but to a lesser degree than expected.

Many patients who appear to be very controlling are unable to allow themselves to be taken care of properly, because to do so would make them too vulnerable or anxious. This independence often leads to requests for great amounts of information about the symptoms so the patient can retain control of medical care. Physicians can better serve these patients by acting as consultants who give the patients a series of choices and allow the patients to make as many treatment decisions as possible.

Often physicians are unsure whether they should inquire about childhood maltreatment when it is suspected to play a role in a patient's dis-



stress. In general, patients tolerate well a sensitive inquiry focused on understanding how previous stressful experiences might affect current functioning. Normalization ("many of my patients have these experiences and it's common for us to discuss them") can be a reassuring technique for approaching the patient. Deeper levels of inquiry would be more appropriate for formal mental health settings, since some patients can become distressed discussing these experiences for the first time or with a new provider. Physicians should also gauge how comfortable they are discussing these matters and whether they want to obtain mental health consultation to assist in further evaluation.

#### *Help the Patient Learn New Coping Skills*

While personality or biologic traits might seem insurmountable obstacles to learning new solutions, offering new coping skills to circumvent these factors can increase the patient's feelings of self-efficacy. Physicians can help patients develop practical, one-day-at-a-time plans to cope with their unchangeable traits and to increase their social support. Coping skills can be arranged hierarchically from least helpful (eg, denial or alcoholism) to more helpful (eg, problem solving or humor). Helping a patient replace lower order coping skills with skills that increase the ability to deal with personal and biologic attributes can restore his or her ability to function.

#### *Psychotherapy Can Help*

Although predisposing factors are resistant to change, psychotherapy and medication can help patients gradually modify biologic or personality characteristics that seem to underlie the current difficulty. Psychotherapy can be provided by such qualified professionals as psychiatrists, psychologists, or clinical social workers.

Patients can gain better insight into the patterns of response that spontaneously arise in the face of stress and learn alternative actions that are more adaptive solutions to problems. As with any referral, you should communicate with the treating therapist and schedule the patient for follow-up to be sure that the patient is getting help and improving.

#### **Case 2**

A 54-year-old married male patient has made very few visits to your practice in the 20 years you have

known him. He comes to your office today with a 2-week history of gradually worsening chest pain and shortness of breath. You recall that he is an otherwise healthy nonsmoker who has no family or personal history of heart or lung disease. You begin your evaluation with the P-P-P model in mind. He has very few cardiac risk factors, but because of his age you order an electrocardiogram. While you are waiting for the test to be set up by your nurse, you continue your history.

*Precipitating factors:* You begin by looking for events during the last month that could have been precipitating factors. Your patient tells you that about 2 weeks ago he was told he will be laid off from his job. He has worked for 34 years as a loading dock foreman; his company has recently come under new management, and a planned down-sizing will eliminate his job in 2 months. He is also worried that his retirement fund might have been mishandled by the previous owners.

You sympathetically point out that anyone who found himself about to be unemployed with 2 kids in college would be understandably distressed. You express regret for his bad news and review the normal-looking electrocardiogram. As you perform a physical examination, you point out how you commonly encounter these symptoms in patients undergoing stressful experiences and discuss the possibility that his symptoms might be due, not to heart disease, but to a stress reaction known as panic disorder. He does not seem fully convinced but accepts your prescription of an antidepressant.

After seeing him three more times during the next 6 weeks, he does not appear to be getting any better. You are more convinced than ever that his pain is not caused by ischemia; nevertheless, you order a treadmill test, which is normal. As you reconsider about the efficacy of the medication, your mind drifts back to the P-P-P model, wondering about predisposing factors that might blunt the antidepressant response. You schedule a special visit and ask him to bring his wife.

*Predisposing factors:* After asking about his early family experiences, you learn that he was the oldest son of a poor, depression era family from the rural Midwest. He left school in 7th grade to work to help the family finances. His father was a short-tempered, physically abusive man who took out his frustrations on his spouse. As the patient grew older he assumed the role of protecting his mother while attempting to avoid his father's abusiveness.



You realize how the actions of the company (an authority structure) mimic the patient's childhood family problems. You recommend a single consultation with a psychiatric colleague for an estimate of whether psychotherapy might augment your medication approach and advice on increasing medication compliance. The patient is uncertain about this approach, and although he states that he will make an appointment, he does not.

*Perpetuating factors:* In the week before his layoff date, he has an injury on the loading dock. He comes to you for evaluation and is sheepish about his failure to keep the appointment with the psychiatrist. While it appears that the injury is a superficial low-back strain, his physical disability is steadily increasing. The patient has been to an emergency department and obtained narcotic analgesics. He would like more and requests a larger dose because the effect is declining. You again consider the P-P-P model and realize that several perpetuating factors are emerging that could become chronic management problems. You decide that you must aggressively prevent any increased functional disability.

You discuss with the patient how concerned you are that this injury is gradually robbing him of his independence and that it will be important for him to learn to live with his injury regardless of whether it resolves. You reassure him you are relieved to find no worrisome muscular or skeletal damage, and tell him you have many patients whose pain sometimes persists even though the physical damage has healed. You ask how he has been coping with the stress of this discomfort. After sensing that he understands the stress model, you point out how alleviating stress from the injury is a treatment goal in itself and discuss the cycle of depression model. You once again request that he make a single visit to your psychiatric colleague for an opinion. You also order daily physical therapy.

He returns in 2 weeks somewhat better. The psychiatrist prescribed paroxetine 20 mg/d. The consultation note states that he had a Beck Depression Inventory score of 23 (severe depression) 10 days ago and suggests following his progress with this instrument. Today he has a score of 12. He reports only a minor decrease in his pain but has more energy and is sleeping better. You express your satisfaction with his progress and remind him that treating the stress itself often re-

sults in great improvement and that he should continue to keep up his social contacts and pleasant activities. You also begin to focus the patient on the importance of beginning to think about a strategy for a job search as soon as possible. You plan to see him in 2 weeks to be certain that he continues to improve.

### Summary

Patients with multiple medically unexplained physical symptoms can challenge the busy family physician. Several recently published books expand on the ideas presented in this article.<sup>29,30</sup> Becoming aware of the factors that set up, initiate, and maintain these unexplained symptoms is an important first step in controlling unnecessary health care utilization and provides the clinician with opportunities to help the distressed patient with effective social and psychologic interventions.

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