

Article

What do patients with medically unexplained physical symptoms (MUPS) think? A qualitative study

José Nunes MD MSc

Department of Family Medicine, Faculty of Medical Sciences, New University of Lisbon, Lisbon, Portugal

Teresa Ventura MD

Department of Family Medicine, Faculty of Medical Sciences, New University of Lisbon, Lisbon, Portugal

Ricardo Encarnação MD

Department of Mental Health, Faculty of Medical Sciences, New University of Lisbon, Lisbon, Portugal

Patrícia Rosado Pinto PhD

Head of Medical Education Department, Faculty of Medical Sciences, New University of Lisbon, Lisbon, Portugal

Isabel Santos MD PhD

Department of Family Medicine, Faculty of Medical Sciences, New University of Lisbon, Lisbon, Portugal

ABSTRACT

Context Medically unexplained physical symptoms (MUPS) are frequently encountered in family medicine, and lead to disability, discomfort, medicalisation, iatrogenesis and economic costs. They cause professionals to feel insecure and frustrated and patients to feel dissatisfied and misunderstood. Doctors seek answers for rather than with the patient.

Objectives This study aimed to explore patients' explanations of the medically unexplained physical symptoms that they were experiencing by eliciting their own explanations for their complaints, their associated fears, their expectations of the consultation, changes in their ideas of causality, and the therapeutic approach that they considered would be useful.

Methodology A qualitative analysis was undertaken of interviews with 15 patients with MUPS in a family medicine unit, 6 months after diagnosis.

Results Experience is crucial in construction of the meaning of symptoms and illness behaviour. Many patients identify psychosocial causes underlying their suffering. These patients received more medication and fewer requests for diagnostic examinations than they had expected. Normalisation is a common behaviour in the clinical

approach. Normalisation without explanation can be effective if an effective therapeutic relationship exists that may dispense with the need for words. Listening is the procedure most valued by patients. Diagnostic tests may denote interest in patients' problems. The clinician's flexibility should allow adaptation to the patient's phases of acceptance of the significance of their physical, emotional and social problems.

Conclusion Patients with MUPS have explanations and fears associated with their complaints. The patient comes to the consultation not because of the symptom, but because of what he or she thinks about the symptom. The therapeutic relationship, therapeutic listening, and flexibility should be the basis for approaching patients with MUPS. Patients do not always expect medication, although it is what they most often receive. Diagnostic tests, although used sparingly, can be a way to maintain and build a relationship. Drugs and tests can be a ritual statement of clinical interest in the patient and their symptoms.

Keywords: communication, physician–patient relationship, primary healthcare, qualitative research, somatoform disorders

Introduction

Patients with physical symptoms for which the doctor cannot find an organic explanation are frequent in clinical family medicine.¹⁻⁴ Most of them resolve completely^{5,6} but about 20% are more severe, leading to frequent use of health services, and to physical disability and psychological impairment. Clinicians tend to classify these patients as somatising or 'difficult'.⁷ These symptoms are also known as medically unexplained physical symptoms (MUPS).

The fact that MUPS are not a cause of death may lead to their devaluation. However, they have a major impact on health, disability, discomfort, dissatisfaction, medicalisation, iatrogenesis and economic costs.⁸⁻¹² Somatoform symptoms can be seen as the combination of a patient's subjective complaints and an absence of objective medical findings.¹³ The different explanations (i.e. those of the patient and the doctor) for the symptom may cause frustration in the clinician and dissatisfaction in the patient.¹⁴ If we associate some contextual factors with this disagreement, such as cost limitations, lack of resources, and a relationship of interdependency between the provider and payer,¹⁵ conditions are created for patient mistrust in the care provided.¹⁶ Doctors have a tendency to consider MUPS as minor physical symptoms that cannot be explained, rejecting or belittling the causes presented by the patient¹⁷ and believing that the mere fact that the tests are normal will be enough to reassure them.¹⁸

The family doctor is the specialist of choice when treating such patients, notwithstanding support from other professionals, including psychiatrists.¹⁹ When managing patients with somatoform symptoms, it seems that self-devaluation of the doctor's psychological skills has a more important role in the difficulties experienced when helping these patients than the negative attitudes of the clinicians themselves.^{20,21} For the management of patients with somatoform symptoms, a considerable number of authors have proposed a diverse set of strategies. Of these strategies, we emphasise the validation of the complaints and the patient,²²⁻²⁴ the need to build and maintain an effective therapeutic relationship,²⁵⁻²⁷ and symptomatic medication and treatment.^{8,28,29}

Training gives clinicians greater confidence in the treatment of patients with MUPS and a stronger belief that they can help them. However, doctors tend to decline training in this area,^{20,22} listing a considerable number of obstacles to the proposed approaches. The impact of this training in the control of MUPS¹⁷ has not been confirmed. A significant number of studies recognise the usefulness of cog-

nitive-behavioural therapy,³⁰⁻³⁴ which involves the patient keeping a diary of symptoms and stressful situations, as well as learning relaxation exercises, undergoing therapeutic exposure, setting realistic goals, and learning problem-solving techniques.^{22,35-37} Other studies have not been so clear about the usefulness of cognitive-behavioural therapy.^{38,39}

This study is based on coming to terms with our ignorance about how to help patients to understand and accept their symptoms as not being signs of a physical illness. On the other hand, it assumes that, for this to occur, it is essential to understand the thoughts and fears that determine the patient's behaviour in seeking healthcare with such symptoms. We aimed to determine whether patients with MUPS have explanations for their complaints and associated fears that motivate them to seek healthcare. We also aimed to establish their expectations of the consultation and to ascertain whether these were met. If patients attribute their symptoms to physical causes, to what extent has medical intervention helped to change this idea of causality and how can patients with physical complaints without organic disease be helped?

The authors began this study with the following assumptions.

- 1 When patients with MUPS attend consultations, they have explanatory ideas for their symptoms and fears that prompt them to seek healthcare.
- 2 They bring expectations that are not met, much less evaluated by the doctor.
- 3 They leave the consultation dissatisfied with the doctor's performance.
- 4 They are prescribed large amounts of drugs and tests.
- 5 Diagnostic tests may be more harmful than beneficial, as a result of reinforcing the patient's ideas about an organic cause.
- 6 Patients have opinions about how doctors should treat patients with physical symptoms but no disease.
- 7 At present it is very unclear what patients propose.

The study was designed to assess these beliefs.

Methods

A total of 17 patients with physical complaints with no organic explanation after 6 months were interviewed. Of these, 15 interviews were considered valid for content analysis focused on meaning. Two interviews were discarded because of underlying organic

pathology from which the patients could not or would not accept disassociation of the symptoms.

The interviews

All of the interviews were conducted by the same person in the facilities of the São Julião Family Health Unit at the patients' request. Each patient read or had read to them a leaflet explaining the study, and signed a statement of informed consent before beginning the interview. All of the patients who were contacted agreed to participate in the study. In the pilot interviews, a first version of a script was used with 19 open questions, in accordance with the guidelines suggested by Kvale⁴⁰ and Guerra.⁴¹ With the experience of the pilot interviews, relevant corrections considered were made by the authors and the two validators who read the transcript of these interviews. The validators gave their opinion about the best wording and order of questions. In the interviews, the semi-directive method was used, in which a compromise was sought between the need to provide the interviewee with an opportunity for free expression and the interviewer's compliance with the script, which consisted solely of open questions. The two pilot interviews and 15 research interviews were audio-recorded and transcribed.

Qualitative analysis

After various readings of the pilot interviews, an interview overview grid was prepared. This, together with the transcripts of the pilot interview and the analysis undertaken by the researcher, was presented to three validators, two of whom had experience in qualitative methodology and one of whom had clinical experience in family medicine. Taking into account the experience from the pilot interviews and the contributions from the validators, a definitive interview overview grid was produced, with the following components:

- 1 Three points of analysis, representing the time to which the reported facts relate, taking the consultation as a reference point (i.e. before, during and after the consultation). At each of these points, categories corresponding to the themes expressed were considered.
- 2 Before the consultation:
 - *Explanatory ideas*: statements that reveal the patient's explanatory rationale for their symptoms. They represent the causal hypothesis for the symptoms.
 - *Associated fears*: fears secondary to the symptoms and possible side effects.

- *Impact of the symptoms*: the patient's account of the ways in which the symptoms interfere with their daily working life and relationships.
 - *What they said*: ideas or phrases conveyed to the patient about their symptoms before the consultation.
 - *Expectations of the consultation*: what the patient expected would be done, before the consultation.
- 3 During the consultation:
 - *What was done or proposed in the consultation*.
 - *Degree of satisfaction*: this was expressed either discursively or by scoring on a scale of 0 to 10.
 - 4 After the consultation:
 - *Development*: what happened over time to the symptoms with which the patient presented during the consultation.
 - *Change of ideas*: any change in the ideas that had been offered to explain the cause of the symptoms before the consultation.
 - *Identical situations*: whether the patient identifies with others' situations that are identical to their own.
 - *Proposals*: suggestions made by the patient as to what doctors should take into consideration when a patient shows symptoms with no 'disease.'
 - 5 Discursive units: phrases used by the patient that exemplify the categories.
 - 6 Dimensions: thematic axes of each category.

The analysis of all of the interviews was checked by one of the validators with clinical experience in family medicine who did not work in the practice in which the patients were enrolled. In the transcript that was given to the validator, the names of the patients and doctors involved were encoded by one of the authors (JN) in order to ensure the confidentiality of the information.

The study was approved by the Ethical Committee of the Faculty of Medical Sciences of the New University of Lisbon.

Results

Table 1 shows the characteristics of the 15 patients who were interviewed. Eleven of the patients were female, and most of the patients had completed 4 years of formal education. Their complaints were pain and fatigue. Four of the patients had symptoms that had remained unchanged for 6 months, and the others had experienced an improvement in their symptoms or were asymptomatic.

Table 1 Characteristics of the patients who were interviewed

No.	Gender	Age (years)	Educational level	Symptoms	Development over time
1	M	65	4th grade	Fatigue, palpitations, weakness, and awareness of heartbeats	Unchanged
2	F	52	9th grade	Insomnia, general tension and sore throat	Improved
3	F	48	9th grade	Headaches, sickness, irritability and forgetfulness	Improved
4	F	75	4th grade	Stomach aches, sickness and diarrhoea	Improved
5	M	61	12th grade	Abdominal pain in the bilateral inguinal region	Improved
6	F	66	4th grade	Fatigue, muscle pain and diarrhoea	Improved
7	M	60	4th grade	Headaches, hot flushes and some anxiety	Improved
8	F	56	4th grade	Muscular pains	Maintained
9	F	42	12th grade	Back pain, fatigue and weakness	Improved
10	F	26	12th grade	Headaches, stomach aches and sickness	Maintained
11	F	61	4th grade	Headaches, dizziness and difficulty concentrating	Improved
12	F	49	University degree	Headaches, insomnia, fatigue, dizziness and weakness	Maintained
13	F	58	4th grade	Fatigue and sadness	Improved
14	F	63	4th grade	Headaches, stomach aches, muscle aches and difficulty sleeping	Improved
15	M	46	University degree	Headaches	Improved

We considered three time points, namely before, during and after the consultation. Within these time points we considered the different categories defined earlier. We added another category consisting of proposals made by the patient. The codes represent the location of the discursive units (interview number, page, lines).

Before the consultation

Past experiences contribute to the development of ideas about the causes of the symptoms, especially when they are biophysical in nature:

But as I know I've already had the thing. I don't know. There has to be some kind of surveillance.

(E1, 1, 13–14)

If I had a tendency to cancer-related problems, it could appear anywhere, regardless of the breast ...

(E6, 1, 38–9)

... again related to coronary disease.

(E12, 1, 14–15)

On the other hand, reliance on personal experience or a family history of symptoms associated with psychosocial situations is associated with the attribution of the current symptoms to psychosocial causes:

... with the depression ... with the profession ... it was at a critical time, when I had more work. ... It has always more to do with seasonal phases of my work life ... to do with the depression I suffered for family reasons.

(E9, 1, 14–18)

My mother has had a problem since she was young.

(E10, 1, 8)

In some patients, seeking healthcare is determined less by the anticipated disease itself, and more by fear of the impact that it may have on the patient's

life, and specifically their inability to care for themselves or their dependents:

... a lot of people depend on me.

(E6, 2, 4)

I cannot leave a load of people, mainly elderly, dependent on me and not receive treatment.

(E6, 2, 6–7)

The impact of the symptoms on the patient's life was predominantly emotional or cognitive, with no interference with the activities of daily life being observed. Only one patient was unable to practise their profession, and this was due to anxiety interfering with their work performance.

Six of the 15 interviewees spoke to others about their symptoms, most often to their partner. All of the interviewees were advised to seek medical advice except one, in whom the symptoms had 'normalised':

You aren't like this, this is all nerves.

(E4, 1, 46)

Before the consultation, most of the patients (8 out of 15) had expected to undergo diagnostic tests, three had expected to be given medication, three sought a diagnosis or explanation for their symptoms, four sought 'help' or 'advice', five expected to be 'listened to' and to receive 'attention' and understanding, and one considered the possibility of referral.

During the consultation

Ten of the 15 respondents received new medication or a change to their existing medication, seven were asked to undergo diagnostic tests, two received 'advice' and two were referred to another care provider. Only two respondents understood that listening or the physical examination was a diagnostic procedure or therapy. One said that she did not receive any explanation for her symptoms, but that this would have been unnecessary in any case because she considered that the doctor already knew her well enough to be aware that the patient knew what was happening:

The doctor did not provide an explanation. She saw that I already knew a lot and she didn't provide any explanation.

(E6, 3, 9–10)

This case appears to show the existence of effective normalisation without any explanation if there is a relationship of trust. Normalisation of the symp-

toms was one of the behaviours mentioned by some patients:

They also said it was nerves and that I didn't have anything.

(E4, 2, 31)

Of the symptoms? They attributed the situation a bit to what I went through on an emotional level, as it could have some influence here too on the question of muscle tension, and also due to my profession.

(E9, 2, 14–16)

Normalisation with no explanation was reported by one of the patients, a recent immigrant to Portugal. This brief doctor–patient relationship was associated with the lowest level of satisfaction reported by any of the respondents, and it indicates the consequences of normalisation with no explanation, in a context where no therapeutic relationship has been established:

[The doctor said that] everything was normal. ... For me, there was a question mark, because I think he should have given more. Nobody suffers a headache when there is no problem. There must be something for me to feel pain.

(E10, 2, 32–4)

During the consultation, 10 of the 15 patients were given medication, although medication featured among pre-consultation expectations in only four cases. With regard to the degree of satisfaction with what was done, all of the patients gave a rating of 8 or more on a scale of 0 to 10. However, one patient expressed some dissatisfaction with the doctor's approach:

He should have given more. Shown more skill ...

(E10, 2, 47)

had a deeper understanding ...

(E10, 3, 1)

I'd give an 8.

(E10, 3, 16)

After the consultation

The symptoms persisted for more than 6 months in four of the 15 patients, while the rest had improved or were in complete remission. Patients who had biophysical explanations for their symptoms before the consultation changed their causal explanations

after the consultation, and explicitly described this change.

For example, before the consultation, Patient 2 stated:

I had a mild flu ...

(E2, 1, 24)

I am really scared of having a sore throat.

(E2, 1, 25)

However, after the consultation this patient stated:

I think this is all related to the nervous system.

(E2, 7, 34)

Before the consultation, Patient 6 stated:

Cancer. That was the hypothesis given. I straight away thought of intestinal cancer.

(E6, 1, 45)

After the consultation this patient stated:

I was under a lot of nervous pressure.

(E6, 4, 5)

Proposals for approaching patients with somatoform symptoms

Some patients (5 out of 15 respondents) perceived their doctor's behaviour as a model approach suitable for patients with physical symptoms but no disease. Two different kinds of reasoning appear to underlie this kind of reply. One involves recourse to a model of the doctor's action to illustrate their proposal. It is an easy way to respond that involves minimal effort, and that has function but is devoid of content:

As Dr Y proceeded with me.

(E2, 8, 32)

Another kind of reasoning may represent a complete surrender to medical judgement and decision making, reflecting a belief in the power of medicine or trust in medical knowledge or in 'your doctor.'

There the doctors know. It's them that know.

(E4, 4, 48)

She always resolves the matter for me.

(E11, 5, 33)

In relation to the doctor's behaviour, a high value is placed on availability, and they put medicine and words on an equal footing:

I have also been supported by her. Either through medicine or with a quiet word ...

(E11, 5, 34–5)

However, they also place a high value on the relationship and the transactional processes that the word constructs:

But I think she acted very properly. Without making me panic, she managed to make me feel balanced.

(E6, 4, 47–8)

Four patients placed a high value on diagnostic tests as critical to diagnosis:

It's only through tests that the doctor can find out.

(E5, 4, 42)

They justify the need to resort to diagnostic tests by assuming that pathological changes may be hidden 'inside', and that only through such tests can these be accessed:

Sometimes they are things that are not outside, but inside.

(E5, 4, 41)

For the patient, the request for tests may be perceived as a symbolic expression of interest in the patient:

But there are people who relax if they are asked to do a test. ... There are people who maybe, by doing some tests or an examination ... think that the doctor was taking an interest.

(E2, 8, 44–6)

The pressure to carry out tests may also be a consequence of the difficulty in accepting that there are symptoms with no organic disease:

In principle, if there is a patient with these complaints, I think the doctor has to make them undergo tests or refer them to another specialist.

(E7, 4, 1–2)

The use of medication was proposed by three patients, and is associated with listening or its equivalent:

Maybe knowing what my life was like [interpreted as the desire that the doctor should seek to know the patient in their different dimensions] before and after medicating.

(E14, 3, 35)

Either through medicine or with a quiet word ...

(E11, 5, 34–5)

... with medicines ... doctor's advice as to ... [what] to do in life.

(E8, 3, 26–8)

For some patients, the priority is listening and not medication:

Maybe there is no need to prescribe or they shouldn't prescribe, but maybe they should explain, clarify what it could be. Help them not to suffer a crisis or not to get anxious, to be specific and explain what this, that or the other may be, there really are many ways of doing so.

(E15, 5, 33–6)

The majority (11 out of 15) of the respondents proposed listening that, in a broad sense, involves various nuances such as showing interest, offering reassurance or giving advice. Listening is valued not only in order to know the history of the patient, but also to acknowledge them as a person and validate their complaints:

The doctor can also be there to listen to the person.

(E3, 4, 3)

Doctors ... have to take the patient's complaints seriously; even where they do not have tests at hand that prove the disease they have, they should start from the principle of believing in what the patient is telling them.

(E9, 3, 16–18)

They have to take seriously and believe in the complaints.

(E9, 3, 20–21)

I think they must have the sensitivity to realise that if the patient comes to a consultation, if they take the time to come, if they come to open up, it's because, somehow, that thing is bothering them.

(E9, 3, 22–4)

I think doctors should seek to understand the patient in some way.

(E10, 3, 48)

The doctors have to take psychological aspects into account. They have to take effective action and be aware of the details of the situation. Above all, knowing how to read and listen, i.e. knowing how to read between the lines and knowing that listening is very important in these situations.

(E15, 5, 23–6)

Some patients highlighted the need for the doctor to note the pace of the patient's internalisation pro-

cess, respecting each person's stages of adaptation to illness:

Above all, they must know how to listen and give the right amount of advice, without being aggressive or imposing, because these are aspects of a psychological nature and they need to be dealt with very calmly.

(E13, 3, 29–31)

The doctor must be very careful when diagnosing.

(E15, 5, 11–12)

Discussion

This study confirms the suggestions of other authors^{42–44} that past, personal and family experiences are important for attributing meaning to symptoms and seeking healthcare. These experiences may be associated with fears both of the disease itself and of its consequences. According to Butler and colleagues,⁴⁵ the patient sees the symptom as a reaction to or an interpretation of their situation in the world. What leads the patient to the consultation is not so much the symptom but what the patient thinks about the symptom. The role of the clinician is to help the patient to make sense of their symptoms as a legitimate part of their perception of their world, and even their own body.⁴⁶

The existence of multiple diagnoses in the past, particularly if these are unconfirmed, suggests MUPS.⁴⁷ Many of the patients offered psychosocial causes to explain their symptoms. Those who believed that there was a physical cause before the consultation accepted a psychological cause during the consultation. They behaved as 'facultative somatisers'.¹⁷ A patient may have a number of different explanations for their symptoms, although they may present only one of these to the doctor. Identification of this interpretation is an important step in therapy.²² Many patients with MUPS offer empathic opportunities during the consultation, which suggests that they believe that there may not be any organic disease explaining their symptoms. Often clinicians do not respond to these opportunities.⁴⁸

The impact of symptoms on the patient's life is predominantly emotional, with the patient maintaining their daily routine. The majority of patients reported having spoken to family and friends about the symptoms. Their input also contributed to the construction of the patient's mindset and the decision to consult. The consultation is the result of many hidden inputs that have contributed to the construction of the patient's beliefs.⁴⁹ Clinicians

encourage the patient to talk about the psychological symptoms that are masked by a façade of physical complaints, and at the same time suggest to them the association between emotions and their physical manifestations,^{50–52} without forgetting that the extrapolation of the family context is often the key to understanding the patient with MUPS.⁵³

Most of the patients had expectations about the consultation, including the use of diagnostic tests and, less frequently, being given medication. However, the doctors prescribed more drugs and requested less tests than the patients expected. This difference between the patients' expectations and what they obtained from the consultation may reflect their most deeply felt need. The patients are more concerned about whether the symptoms indicate a serious illness and less concerned about receiving symptomatic treatment. However, the doctor may feel that the patient is seeking medication. Although the patients are seeking a diagnosis or an explanation for their symptoms, it is not uncommon for doctors to tell patients that their symptoms are normal, with either no explanation at all or an ineffective one. The training of clinicians in cognitive restructuring increases their confidence in the management of patients with somatoform symptoms, and their perception that these patients can be helped in this way.^{20,21}

According to Dowrick and colleagues,²¹ normalisation is understood as statements that indicate the likely absence of severe disease, and that the patient's symptoms are within an acceptable range of normality, are most probably benign or self-limiting, and therefore do not require healthcare intervention. Among our interviewees, the behaviour of normalisation without explanation, which is frequently observed among clinicians faced with patients who have MUPS, was also reported as being present in some input from partners and family before the consultation. Although Dowrick and colleagues do not discuss effective normalisation without explanation, on the basis of the present study it seems possible to conclude that it can occur, provided that there is a therapeutic relationship of trust.

Some of the patients (4 out of 15) who were interviewed developed chronicity. Other authors have also reported that 20–30% of patients develop chronicity.^{5,54,55} They propose that the clinician should focus more on recovery of function and less on remission of the symptoms.^{6,56} A strong belief in the presence of physical disease is a significant determinant of chronicity.⁵⁷

One objective of this study was to discover what patients themselves propose for the management of MUPS. Some patients cite the approach adopted by their doctor as a model for dealing with patients with MUPS. They recognise the value of their doctor's

approach and trust them. However, this may also be the path of least resistance. The reference to their doctor as a model of behaviour may also be interpreted as a consequence of the interdependence of behaviours (i.e. the behaviours of both the patient and the health professional are a co-construction).

Patients value doctors' listening behaviour. This puts listening on an equal footing with drugs. Conditions for establishing the 'contested causation' described by Engel and colleagues¹⁶ are created if the patient does not feel that the doctor is listening attentively enough to take them seriously, and if the doctor does not involve the patient in decision making.⁵⁸ Patients with psychological problems place a high value on listening and counselling by the doctor, rather than the prescription of drugs.⁵⁹

The foundation of the plan for managing patients with such symptoms is the therapeutic relationship.^{19,25,60} The therapeutic power of the relationship was demonstrated when one of those interviewed used the doctor's own words to explain the nature of their symptoms. It is as if the knowledge gained has allowed each of them, doctor and patient, to know what the other thinks. An effective therapeutic relationship lies in the context of alliance, characterised by rituals of mutual acceptance. These include the scheduling of periodic consultations, physical examination that is oriented towards the patient's complaints, active listening, diagnostic tests and the prescribing of drugs.^{26,61} In addition, the relationship promotes an understanding of the symptoms, and this contributes to relationship building.⁶²

Regardless of their diagnostic utility, diagnostic tests may be an important way of demonstrating interest in the patient's problems. They function as elements for building the trust that is an important mainstay of the doctor–patient relationship. The need for diagnostic tests may be more pressing in patients with more deep-rooted biophysical beliefs. In such a patient they may be more important for building a therapeutic relationship, according to the principles of the patient-centred approach.⁶³ Clinicians tend to use patient pressure to justify their requests for diagnostic tests. Evidence shows that these requests are a response to the patient's over-dramatised narratives, such as the exuberant descriptions of their symptoms and their impact on their daily life, the use of metaphorical and emotive language, defence of a belief in a biomedical cause, and emotional stress generated by the symptoms. The clinician senses subjective pressure from the patient and responds with emotional stress, which usually triggers automatic behaviours such as a symptomatic intervention response.⁶⁴ This behaviour may reinforce the patient's belief in a purely organic cause of their symptoms.^{65–69} Diagnostic tests should be used sparingly because these patients are more

likely to be subjected to CT scans, stress tests, endoscopy and abdominal ultrasound examinations.⁷⁰ The doctor's behaviour may reinforce the idea of an organic cause in patients, contributing to chronicity, medication use, and medicalisation of benign situations. Shortt has stated that 'It takes two to somatise', to emphasise the responsibility of the doctor's behaviour in constructing the patient's mental schema and behaviours.^{71,72} Studies by Garcia-Campayo and colleagues suggest that the prevention of somatisation does not reduce the frequency of somatoform disorders, but that it does reduce anxiety and depressive disorders.⁷³

The legitimatisation of symptoms is one of the most widely recommended strategies for patients with MUPS.²³ Regardless of the cause of their problem, patients should feel that their symptoms and concerns are being taken seriously.^{74,75} Explanations should be based on a tangible rationale, offering opportunities for self-monitoring and patient empowerment,^{14,76,77} and assessment of the patient's understanding of the explanation that has been given.¹⁸ The patient must feel that the doctor believes in them and that their symptoms are common and reversible.⁷⁸

The clinician should be flexible enough to respect the patient's stages of adaptation to their suffering and acceptance of the explanations for it. This encourages a change in beliefs and inappropriate attitudes and thus the implementation of better adapted behaviours. Because patients with MUPS have a variety of expectations, the professional is required to have a wide range of strategies at their disposal. These include reassurance, verification of the diagnosis, prescribing of medication, diagnostic tests and emotional support. If the doctor reacts in only one way to patients with different needs, the use of services and iatrogenesis may increase.⁷⁹ Patients may leave the surgery apparently convinced, and then relapse into doubt.

At least a proportion of patients⁸⁰ and authors understand that primary healthcare is the setting of choice for effective treatment of patients with somatoform symptoms.^{36,60,81}

This study has practical implications for the daily work of all family doctors. Although patients with MUPS present a special challenge, the principles of care described here are relevant to the care of all patients. Paying attention to the patient's ideas, concerns and expectations, knowledge of the life story of the patient, negotiation to find common ground, and the wise use of limited resources are the fundamentals of patient-centred care. The application of these principles has been demonstrated clearly by Stewart and colleagues.⁸²

Limitations of the study

This study was conducted at a family health unit providing personalised healthcare, with a stable practice population and doctor-patient relationships that had been built up over many years. This may encourage socially desirable responses. However, during the interviews no inconsistency was detected to suggest that this kind of answer was being given. Only one interviewee was unsatisfied with how their health issue had been addressed. There may be ethical concerns raised when the physicians who are providing care ask patients about their satisfaction with that care. However, this study was granted ethical approval, and the patients gave their informed consent to participate. The extent to which these findings can be generalised to patients outside Portugal may be questioned. These patients share clinical characteristics with MUPS patients described in the literature from many other countries, and the conclusions of the authors of those studies with regard to needs and effective interventions are similar to those reported in the present study. More problematic is the fact that these patients have a number of peculiarities resulting from their long-term relationship with their clinicians, such as the contamination of their ideas with those of their doctors, and thus the possibility that the patients' views are more a reflection of those of their clinicians. The doctors from the healthcare unit where the study was conducted are teachers and trainers in family medicine. They place a high value on relationships, regarding them as a therapeutic tool. If the patients who were interviewed had had other doctors, it is possible that their views might have been different.

The interviews focused on events that had occurred more than 6 months earlier, including the patients' ideas before, during and after consultations. This may introduce recall bias. However, the main objective of the study was to discover what the patients proposed for dealing with similar situations. This does not depend on memory. All of the patients expressed their thoughts about this, although a third of them referred to their doctor as a model.

Conclusion

With regard to pre-research assumptions, listed in the Introduction, the following are confirmed:

- 1 When patients with MUPS attend consultations, they have explanatory ideas for their symptoms and fears that prompt them to seek healthcare.
- 2 They bring expectations that are not met, much less evaluated by the doctor.
- 3 Patients have opinions about how doctors should treat patients with physical symptoms but no disease.

Changes occurred in relation to the following beliefs, as described below:

- 1 *They leave the consultation dissatisfied with the doctor's performance.* The interviews revealed that almost all of the patients were satisfied with the doctor's performance. Only one of them reported dissatisfaction, and this was a patient whose relationship with their doctor had begun only shortly before the study.
- 2 *They are prescribed large amounts of drugs and tests.* Among the interviewees, the prescribing of an excessive number of examinations was not detected, at least from the patient's perspective, although more medication seems to have been prescribed than the patients expected.
- 3 *Diagnostic tests may be more harmful than beneficial, as a result of reinforcing the patient's ideas about an organic cause.* Without claiming the truth or falsity of this statement, we identified a role for these tests in maintaining the doctor-patient relationship and providing a way for the patient to perceive greater commitment to their problem and validation of their symptoms and of the patient him- or herself by the doctor.

The following five key points arise from this study.

- 1 Patients with MUPS have explanations for their symptoms and fears that prompt them to seek healthcare.
- 2 They bring expectations to the consultation that are not met and are often not evaluated by the doctor.
- 3 Patients have clear opinions about how doctors should treat patients with physical symptoms but no disease.
- 4 Patients with MUPS are satisfied with the doctor's performance as a result of a positive doctor-patient relationship.
- 5 Patients expect fewer drugs and more tests. These tests may help to build the doctor-patient relationship by showing commitment to their problem and by providing validation of their symptoms and of the patient him- or herself by the doctor.

Proposals for future research

We need to clarify what patients understand by being listened to, and what kind of behaviour they have to see from doctors to make them feel listened to. We hope to study whether patients' ideas vary depending on the ideas, attitudes and behaviours of their doctors, and whether a change of doctor results in changes in the use of health services and in patients' expectations of what these services can offer them. Research is needed to find practical ways to teach the effective communications skills that are necessary to help these patients, for learners at all levels of medical education (basic medical education, vocational training and continuing professional development). Another much wider area of research may involve studying the prognostic value of the different types of mental representation that patients have of their suffering. Does the patient's pessimism or optimism have any impact on the development of their disease? And if so, what is its value?

ACKNOWLEDGEMENTS

The authors are grateful to John Yaphe, MD, for editorial assistance and for helping to respect the language of Shakespeare.

REFERENCES

- 1 Peveler R, Kilkenny L and Kinmonth AL. Medically unexplained physical symptoms in primary care: a comparison self-report screening questionnaires and clinical opinion. *Journal of Psychosomatic Research* 1997;42:245-52.
- 2 Mumford DB, Devereux TA, Maddy PJ *et al*. Factors leading to the reporting of 'functional' somatic symptoms by general practice attenders. *British Journal of General Practice* 1991;41:454-8.
- 3 Burton C. Beyond somatisation: a review of the understanding and treatment of medically unexplained physical symptoms (MUPS). *British Journal of General Practice* 2003;53:233-49.
- 4 Swanson LM, Hamilton JC, Feldman MD. Physician-based estimates of medically unexplained symptoms: a comparison of four case definitions. *Family Practice* 2010; 27:487-93.
- 5 Smith RC and Dwamena FC. Classification and diagnosis of patients with medically unexplained symptoms. *Journal of General Internal Medicine* 2007; 22:685-91.
- 6 Jackson JL and Passamonti M. The outcomes among patients presenting in primary care with a physical symptom at 5 years. *Journal of General Internal Medicine* 2005;20:1032-7.
- 7 Lynch DS, McGray AV, Nagel RW *et al*. The patient-physician relationship and medical utilisation. *Pri-*

- mary Care Companion to the Journal of Clinical Psychiatry 2007;9:266–70.
- 8 Jackson JL and Kroenke K. Managing somatization: medically unexplained should not mean medically ignored. *Journal of General Internal Medicine* 2006; 21:797–9.
 - 9 Hammarström A and Janlert U. Early unemployment can contribute to adult health problems: results from a longitudinal study of school leavers. *Journal of Epidemiology and Community Health* 2002; 56:624–30.
 - 10 Waal MWM, Arnold IA, Eekhof JAH *et al.* Follow-up study on health care use of patients with somatoform, anxiety and depressive disorders in primary care. *BMC Family Practice* 2008;9:5.
 - 11 olde Hartman TC, Lucassen PLBJ, van de Lisdonk EH *et al.* Chronic functional somatic symptoms: a single syndrome? *British Journal of General Practice* 2004;54:922–7.
 - 12 Escobar JE, Golding JM, Hough RL *et al.* Somatization in the community: relationship to disability and use of services. *American Journal of Public Health* 1987;77:837–40.
 - 13 Dimsdale JE and Dantzer R. A biological substrate for somatoform disorders: importance of pathophysiology. *Psychosomatic Medicine* 2007;69:850–54.
 - 14 Salmon P, Peters S and Stanley I. Patients' perceptions of medical explanations for somatisation disorders: qualitative analysis. *British Medical Journal* 1999;318:372–6.
 - 15 Engel CC Jr and Katon WJ. Population and need-based prevention of unexplained physical symptoms in the community. In: LM Joellenbeck, PK Russell and SB Guze (eds) *Strategies to Protect the Health of Deployed U.S. Forces: medical surveillance, record keeping, and risk reduction*. National Academy Press: Washington, DC, 1999. pp. 173–212.
 - 16 Engel CC, Adkins JA and Cowan DN. Caring for medically unexplained physical symptoms after toxic environmental exposures: effects of contested causation. *Environmental Health Perspectives* 2002; 110(Suppl. 4):641–7.
 - 17 Kirmayer L, Robbins J, Dworkind M *et al.* Somatization and the recognition of anxiety and depression in primary care. *American Journal of Psychiatry* 1993;150:734–41.
 - 18 Rief W, Heitmüller AM, Reisberg K *et al.* Why reassurance fails in patients with unexplained symptoms – an experimental investigation of remembered probabilities. *PloS Medicine* 2006;3: e269.
 - 19 Wileman L, May C and Chew-Graham CA. Medically unexplained symptoms and the problem of power in the primary care consultation: a qualitative study. *Family Practice* 2002;19:178–82.
 - 20 Salmon P, Peters S, Clifford R *et al.* Why do general practitioners decline training to improve management of medically unexplained symptoms? *Journal of General Internal Medicine* 2007;22:565–71.
 - 21 Dowrick CF, Ring A, Humphris GM *et al.* Normalisation of unexplained symptoms by general practitioners: a functional typology. *British Journal of General Practice* 2004;54:165–70.
 - 22 Rief W. Analyzing the problems in managing patients with medically unexplained symptoms. *Journal of General Internal Medicine* 2007;22:704–6.
 - 23 Gordon GH. Treating somatizing patients. *Western Journal of Medicine* 1987;147:88–91.
 - 24 Kirmayer LJ, Groleau D, Looper KL *et al.* Explaining medically unexplained symptoms. *Canadian Journal of Psychiatry* 2004;49:663–72.
 - 25 Miller RC. The somatically preoccupied patient in primary care: use of attachment theory to strengthen physician–patient relationships. *Osteopathic Medicine and Primary Care* 2008;2:6.
 - 26 old Hartman TC, Hassink-Franke LJ, Lucassen PL *et al.* Explanation and relations. How do general practitioners deal with patients with persistent medically unexplained symptoms: a focus group study. *BMC Family Practice* 2009;10:68.
 - 27 Fraser FD. Functional somatic symptoms: family practice perspective. *Canadian Family Physician* 1990; 36:1179–84.
 - 28 Fischhoff B and Wessely S. Managing patients with inexplicable health problems. *British Medical Journal* 2003;326:595–7.
 - 29 Yeung AS and Guang HD. Somatoform disorders in primary care. *Western Journal of Medicine* 2002; 176:253–6.
 - 30 Escobar JI, Gara MA, Diaz-Martinez AM *et al.* Effectiveness of a time-limited cognitive behavior therapy-type intervention among primary care patients with medically unexplained symptoms. *Annals of Family Medicine* 2007;5:328–35.
 - 31 Jerjes W, Madland G, Feinmann C *et al.* Psychoeducation programme for temporomandibular disorders: a pilot study. *Journal of Negative Results in BioMedicine* 2007;6:4.
 - 32 Sumathipala A. What is the evidence for the efficacy of treatments for somatoform disorders? A critical review of previous intervention studies. *Psychosomatic Medicine* 2007;69:889–900.
 - 33 Raine R, Haines A, Sensky T *et al.* Systematic review of mental health interventions for patients with common somatic symptoms: can research evidence from secondary care be extrapolated to primary care? *British Medical Journal* 2002;325:2–11.
 - 34 Speckens AEM, Hemert AM, Spinhoven P *et al.* Cognitive behavioural therapy for medically unexplained physical symptoms: a randomised controlled trial. *British Medical Journal* 1995;311:1328–32.
 - 35 Gordon GH, Baker LH and Boverman J. Successful medical and psychological management of recurring chest pain and frequent hospital admissions in a patient with coronary artery disease. *Western Journal of Medicine* 1994;160:371–5.
 - 36 Smith RC, Lyles JS, Gardiner JC *et al.* Primary care clinicians treat patients with medically unexplained symptoms: a randomized controlled trial. *Journal of General Internal Medicine* 2006; 21:671–7.
 - 37 Speckens AEM, Hemert AM, Spinhoven P *et al.* Cognitive behavioural therapy for medically unexplained

- physical symptoms: a randomised controlled trial. *British Medical Journal* 1995;311:1328–32.
- 38 Kolk AMM, Schagen S and Hanewald GJFP. Multiple medically unexplained physical symptoms and health care utilization: outcome of psychological intervention and patient-related predictors of change. *Journal of Psychosomatic Research* 2004;57:379–89.
- 39 Luo Z, Goddeeris J, Gardiner JC *et al*. Costs of an intervention for primary care patients with medically unexplained symptoms: a randomized controlled trial. *Psychiatric Services* 2007;58:1079–86.
- 40 Kvale S. *Doing Interviews*. Sage Publications Ltd: London, 2007.
- 41 Guerra IC. *Pesquisa Qualitativa e Análise de Conteúdo: sentidos e formas de uso*. Principia Editora Lda: Cascais, Portugal, 2008.
- 42 Gregory RJ. Characteristics of patients assigned multiple nonthreatening medical diagnoses. *Primary Care Companion to the Journal of Clinical Psychiatry* 2001;3:164–7.
- 43 Jones E and Wessely S. War syndromes: the impact of culture on medically unexplained symptoms. *Medical History* 2005;49:55–78.
- 44 Helman CG. Disease versus illness in general practice. *Journal of the Royal College of General Practitioners* 1981;31:548–552.
- 45 Butler C, Evans M, Greaves D *et al*. Medically unexplained symptoms: the biopsychosocial model found wanting. *Journal of the Royal Society of Medicine* 2004;97:219–22.
- 46 Alfrell M, Biguet G and Rudebeck CE. Living with a body in pain – between acceptance and denial. *Scandinavian Journal of Caring Sciences* 2007;21:291–6.
- 47 Schrag A, Brown RJ and Trimble MR. Reliability of self-reported diagnoses in patients with neurologically unexplained symptoms. *Journal of Neurology, Neurosurgery and Psychiatry* 2004;75:608–11.
- 48 Salmon P, Dowrick C, Ring A *et al*. Voiced but unheard agendas: qualitative analysis of the psychosocial cues that patients with unexplained symptoms present to general practitioners. *British Journal of General Practice* 2004;54:171–6.
- 49 Hong ZR, Hong SY, Han MJ *et al*. Clinical observation of 12 farmers who believe themselves to have suffered from chronic pesticide intoxication. *Korean Journal of Internal Medicine* 2008;23:1–4.
- 50 Lloyd G. Medicine without signs. *British Medical Journal* 1983;287:539–42.
- 51 Lloyd G. Hysteria: a case for conservation? *British Medical Journal* 1986;293:1255–6.
- 52 Lempp HK, Hatch SL, Carville SF *et al*. Patients' experiences of living with and receiving treatment for fibromyalgia syndrome: a qualitative study. *BMC Musculoskeletal Disorders* 2009;10:124.
- 53 Weiss R, Fogelman Y and Yaphe J. Somatization in response to undiagnosed obsessive compulsive disorder in a family. *BMC Family Practice* 2003;4:1.
- 54 Kooiman CG, Bolk JH, Rooijmans HGM *et al*. Alexithymia does not predict the persistence of medically unexplained physical symptoms. *Psychosomatic Medicine* 2004;66:224–32.
- 55 Khan AA, Khan A, Harezlak J *et al*. Somatic symptoms in primary care: etiology and outcome. *Psychosomatics* 2003;44:171–8.
- 56 Main CJ and Williams AC. Musculoskeletal pain (ABC of psychological medicine). *British Medical Journal* 2002;325:534–7.
- 57 Wilson A, Hickie I, Lloyd A *et al*. Longitudinal study of outcome of chronic fatigue syndrome. *British Medical Journal* 1994;308:756–9.
- 58 Dirkwager AJE and Verhaak PFM. Patients with persistent medically unexplained symptoms in general practice: characteristics and quality of care. *BMC Family Practice* 2007;8:33.
- 59 Cape J. How general practice patients with emotional problems presenting with somatic or psychological symptoms explain their improvement. *British Journal of General Practice* 2001;51:724–9.
- 60 Smith RC, Lein C, Collins C *et al*. Treating patients with medically unexplained symptoms in primary care. *Journal of General Internal Medicine* 2003;18:478–89.
- 61 Chambers TL. Semeiology – a well established and challenging paediatric speciality. *Archives of Disease in Childhood* 2003;88:281–2.
- 62 Reid S. Multiple chemical sensitivity – is the environment really to blame? *Journal of the Royal Society of Medicine* 1999;92:616–19.
- 63 Dwamena FC, Lyles JS, Frankel RM *et al*. In their own words: qualitative study of high-utilising primary care patients with medically unexplained symptoms. *BMC Family Practice* 2009;10:67.
- 64 Ring A, Dowrick C, Humphris G *et al*. Do patients with unexplained physical symptoms pressurise general practitioners for somatic treatment? A qualitative study. *British Medical Journal* 2004;328:1057.
- 65 Creed F. Should general psychiatry ignore somatization and hypochondriasis? *World Psychiatry* 2006;5:146–50.
- 66 Escobar JI. Does simple “reassurance” work in patients with medically unexplained physical symptoms? *PLoS Medicine* 2006;3:e313.
- 67 Greenberg DB. Clinical dimensions of fatigue. *Primary Care Companion to the Journal of Clinical Psychiatry* 2002;4:90–93.
- 68 O'Brien MC. Medically unexplained neurological symptoms. *British Medical Journal* 1998;316:564–5.
- 69 Page LA and Wessely S. Medically unexplained symptoms: exacerbating factors in the doctor-patient encounter. *Journal of the Royal Society of Medicine* 2003;96:223–7.
- 70 Reid S, Wessely S, Crayford *et al*. Frequent attenders with medically unexplained symptoms: service use and costs in secondary care. *British Journal of Psychiatry* 2002;180:248–53.
- 71 Shortt SED. An approach to somatization in family medicine. *Canadian Family Physician* 1986;32:2521–4.
- 72 Staneley I, Salmon P and Peters S. Doctors and social epidemics: the problem of persistent unexplained physical symptoms, including chronic fatigue. *British Journal of General Practice* 2002;52:355–6.

- 73 García-Campayo J, Arevalo E, Caroco LM *et al.* A prevention programme for somatoform disorders is effective for affective disorders. *Journal of Affective Disorders* 2010;122:124–32.
- 74 Mayou R. Medically unexplained physical symptoms. *British Medical Journal* 1991;303:534–5.
- 75 Stone J, Carson A and Sharpe M. Functional symptoms in neurology: management. *Journal of Neurology, Neurosurgery and Psychiatry* 2005;76(Suppl. I):i13–21.
- 76 Butchart J. Empowerment for patients with medically unexplained symptoms. *Journal of the Royal Society of Medicine* 2005;98:187.
- 77 Salmon P and Hall GM. Patient empowerment or the emperor's new clothes. *Journal of the Royal Society of Medicine* 2004;97:53–6.
- 78 Stone J, Carson A and Sharpe M. Functional symptoms in neurology: management. *Journal of Neurology, Neurosurgery and Psychiatry* 2005;76(Suppl. I):i13–21.
- 79 Rief W and Broadbent E. Explaining medically unexplained symptoms: models and mechanisms. *Clinical Psychology Review* 2007;27:821–41.
- 80 Fritzsche K, Armbruster U, Hartmann A *et al.* Psychosocial primary care – what patients expect from their general practitioners: a cross-sectional trial. *BMC Psychiatry* 2002;2:5.
- 81 Horder J. The role of the general practitioner in psychological medicine. *Proceedings of the Royal Society of Medicine* 1967;60:261–70.
- 82 Stewart M, Brown JB, Weston WW *et al* (eds). *Patient-Centered Medicine: transforming the clinical method*. Sage Publications: Thousand Oaks, CA, 1995.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

José Mendes Nunes, Department of General and Family Medicine, Faculty of Medical Sciences, New University of Lisbon, Campo dos Mártires da Pátria, 130, 1169–066 Lisbon, Portugal. Tel: +351 99 08 929; email: josemendesnunes@gmail.com

Submitted 25 April 2013

Accepted 1 June 2013

