CHAPTER 2
Integration of Biomedical and Psychosocial Management
DAVID R. FLEISHER

Two concepts helped and hindered clinicians throughout the 20th Century: 1) the most important and legitimate use of physicians’ time is in the diagnosis and cure of disease; and 2) patients are cured of illness through cognitive learning and compliance with rational prescriptions based on biomedical science. What has made these concepts a hindrance is that they exclude most of what doctors and patients do together.

The majority of patients referred to pediatric gastroenterologists have functional disorders, including toddler’s diarrhea, gastroesophageal reflux, functional fecal retention, and recurrent abdominal pain (RAP). Toddler’s diarrhea is incurable, but is self-limited. Functional fecal retention can be cured by the child, with the aid of physicians and parents. Recurrent abdominal pain and gastroesophageal reflux have no cure and may not be self-limited. Other disorders, such as inflammatory bowel disease, cystic fibrosis, and chronic liver disease, are managed with drugs and surgery, none of which completely restores the child’s health.

Every clinician encounters patients who want to get well but are unable to recognize or change behaviors that limit the success of optimal medical treatment. Helping patients who feel troubled by illnesses that may not be amenable to diagnosis or cure, and helping them overcome self-inflicted impediments to recovery will remain the clinician’s greatest challenge and, perhaps, most noble achievement.

The doctor-patient relationship is where clinical care and research begins and—ultimately—succeeds or fails. What follows is an attempt to review the nature and dynamics of that relationship and the clinical process that begins the moment a patient and physician engage in it. Recurrent abdominal pain, perhaps the most common condition encountered in pediatric gastroenterology, is used in the following discussion. However, the validity of the concepts put forth rests on their applicability to almost any disorder encountered in clinical practice.

DISEASE, ILLNESS, AND THE ROLE OF THE PHYSICIAN

Criteria for successful management for RAP have yet to be clarified or tested. If therapeutic goals extend beyond rigorous diagnostic elimination of organic disease and success is viewed as keeping the symptom from impairing the ability of the child to function normally, then sophistication in the use of the doctor-patient relationship becomes necessary. If the physician’s role is limited to the diagnosis and treatment of disease, how does a clinician help someone troubled by symptoms that cannot be reduced to physicochemical terms or “cured” by technologic means?

An alternative role for the clinician is based on the distinction between “disease” and “illness.” Disease is objectively demonstrable tissue damage and organ malfunction. Illness is the subjective sense of feeling unwell, suffering, or being disabled. An alternative role, then, defines the clinician as one who views the diagnosis and treatment of disease as important, but only part of what is needed to overcome illness.
Basic Values of Clinical Practice

Patient-oriented practice requires conceptual tools that aid the doctor-patient relationship, as well as communication skills.\textsuperscript{13,16-18} The clinical process is predicated on three values: the intrinsic worth of the individual, acceptance, and the patient’s right to self-determination.\textsuperscript{19}

A belief in the intrinsic worth of the individual allows the doctor to care about the individual who needs help. It leads to a more conservative approach to health care and allows the patient to trust the physician.

The value of acceptance implies that the doctor is committed to try to help the patient regardless of whether the patient is attractive or unpleasant, or the disease is interesting or mundane.\textsuperscript{20} Acceptance is the basis of professionalism—the value that helps the clinician be nonjudgmental.

The patient’s right to self-determination implies that physicians do not own patients. We are hired by patients to engage in a collaborative effort aimed at overcoming their illness. If we want patients to follow our recommendations, we must use language the patient understands and explain the reasons for recommendations so that the patient can make a rational choice.

The Doctor-patient Relationship

Three models of the doctor-patient relationship have been proposed.\textsuperscript{16} The activity-passivity model is one in which the physician ministers to the patient, who passively receives these actions and whose participation is not required. This model is appropriate for patients in coma or who are otherwise unable to respond. Responsibility for outcome rests solely with the physician. In the guidance-cooperation model, the physician tells the patient what to do. It is the patient’s responsibility to answer the doctor’s questions and comply with the doctor’s orders. The mutual participation model, however, is based on a partnership of experts: the physician, whose expertise is in the knowledge of illness and disease, and the patient, whose expertise is in his or her unique personal experience with illness and disease. The importance of their respective roles is equal.

In collaborating, the physician helps the patient overcome illness and, in return, receives compensation.\textsuperscript{21}

The doctor-patient relationship malfunctions when inappropriate models are utilized. For example, a child with RAP is brought to a physician who only allots a few minutes of time to each patient. The history is taken by the nurse. It is read by the doctor, who enters the examining room, asks few questions, palpates the child’s abdomen, prescribes an antispasmodic, then leaves. The activity-passivity model thus applied is not likely to ease the child’s pain or satisfy the parents.

Another example of malfunction can be seen when parents bring their child with RAP to a pediatric gastroenterologist. The consultant spends 30 minutes obtaining a history. The chronology of the child’s pain is obtained, and questions searching for causes of abdominal pain are asked from a differential diagnostic list. There are no open-ended questions, questions about what the parents have been told previously, or description of parental fears or concerns regarding the child’s symptoms. This illustrates the use of the paternalistic guidance-cooperation model of doctor-patient relationships. The physician determines “what’s wrong,” but he misses the opportunity to discover “what’s going on.” What are the present concerns? What may have caused the child’s pains to have become problematic at this time? What feelings and attitudes may either impede or facilitate reassurance and compliance with treatment?

Dane Prugh stated that any of these three models can be appropriate, depending on the individual situation:

Sometimes the doctor-patient relationship passes through all three phases. For example, if the physician is called upon to treat a late adolescent in a diabetic coma, an active and authoritative approach to immediate diagnosis and treatment is vital, and can be most assuring to the parents and the patient. Later, as the patient learns to control his diabetes, the guidance of the physician becomes paramount, and the mutual participation phase gradually evolves.\textsuperscript{22}

Some patients are only comfortable with
the activity-passivity or guidance-cooperation models for personal or cultural reasons. Although these models place less responsibility on parents and child, the mutual participation model is more realistic when coping with clinical problems that elude total understanding and control, requiring mature participation by all members of the doctor-patient relationship for optimal results.\(^{23}\)

**Rapport.** Good rapport promotes disclosure. Rapport is built when the physician is perceived as professionally competent, conveying an attitude of concern, respect, and trustworthiness. Rapport is not bedside manner—a bag of conversational or behavioral tricks by which patients can be charmed and manipulated. It is the conduit through which the patient reveals illness and enables treatment to be maximally effective.\(^{23}\)

**Assessing pain and pain behavior.** A child’s complaint of pain is determined by many factors: the intensity of sensory input, pain threshold, level of development, capacity to filter the environment, the child’s emotional state and its influence on pain tolerance, cultural context, the expectation of response (or lack of response) from others, models of pain behavior in the environment, and the degree to which pain is used for somatizing (see page 17).\(^{10,24,25}\)

Children’s ability to differentiate between emotional distress and bodily pain is limited.\(^{26}\) They may complain of a “tummy ache” when most or all of the distress is fear or anxiety.\(^{24}\) Children may use “tummy ache” to mean hunger, the urge to stool, or nausea. Children cannot accurately describe subjective phenomena. Their statements require objective corroboration.

**Effects of a child’s illness on parenting.** The parent-child relationship normally requires parents to set limits and place expectations on the child that foster development and protect from harm.\(^{22-30}\) When the child becomes ill, obligations of school and chores are put aside. Parents become more attentive and compliant with the child’s wishes. If the illness is prolonged or perceived as potentially tragic, the parent-child relationship tends to change. The child begins to ask for—and often receives—what he would never have asked for or gotten when well. The parents find themselves accepting limits, eg, cancelling vacations, taking time off from work, or tolerating behavior they would not have put up with previously. These changes are driven by parents’ realistic or unrealist, fears and guilt that they have failed to preserve their child’s well-being, notwithstanding that there may have been nothing they could have done to prevent the illness. When the diagnosis and cure are not forthcoming, parents go to increasing lengths to find a cure. The child’s anxiety may increase as parents’ control over attitudes and behavior weakens, and he may be exposed to increasingly stressful diagnostic procedures by a succession of physicians. In the process, the child’s suffering intensifies. When a clinical presentation is dramatic and alarming, clinicians may jump to procedures that are unwarranted or even harmful. Children with RAP may develop incapacity and invalidism out of proportion to objective evidence of pain. To help the child and family, the clinician must address the child’s exaggerated incapacity as a related but separate issue, with respect to abdominal symptoms.

**The form and content of consultations.** It is important to elicit the history from the parents in the absence of the child to allow them to speak freely and not expose the child to adult-level concerns.\(^{31-33}\) At the end of history taking, the parent is asked: 1) “What have you been told by other physicians regarding your child’s abdominal pain?” 2) “What are your concerns, your worst fears?” 3) “What are your spouse’s concerns?” In answering these questions, the parent may reveal misconceptions derived from statements by other physicians as well as realistic or irrational fears derived from their own experiences and thoughts. The answer may provide clues about one parent’s view of the other’s concerns, parenting abilities, and the quality of their relationship.

A private chat with the child provides the opportunity to elicit the child’s description of symptoms. It demonstrates the physician’s respect for the child, respect that per-
mits the physician to require the child’s participation in understanding and coping with pain. Sometimes, the child discloses information that neither the physician nor the parents knew. This chat might be the only opportunity the physician will have to discreetly question the child about possible abuse.

After the examination, the doctor and parents confer. What transpires during this conference largely determines whether management succeeds or fails. Success depends on three essential communications: 1) an understanding of the child’s symptoms; 2) effective reassurance; and 3) an offer of continuity and accessibility by the physician until the child’s problem resolves.

**Understanding the Symptom**

Parents want to know: 1) What is the diagnosis, and what creates pain? 2) Is the condition safe or dangerous? 3) What can be done to relieve the pain? 4) Can the condition be cured? Will it resolve quickly or will recovery take time?

They can be told that the pains result from the most common cause of pain in healthy school-aged children, namely, the recurrent abdominal pain syndrome. Apley’s prevalence data are used to convince the parents that the condition is recognizable, occurs in other children, and is therefore not unique, puzzling, or ominous. The relationship of gut motility to pain can be explained in nontechnical terms. An analogy between gut spasm and leg cramps lessens the mystery surrounding the abdominal cramp. Although both may be painful, neither is caused by disease and both are self-limited. This speaks to the safety of the symptom.

Parents want to know what can be done to alleviate the abdominal pain when it occurs. If gut pain is likened to skeletal muscle spasm, it follows that the first remedy to relieve pain is for the child to lie or sit in a peaceful, quiet place, perhaps apply a heating pad, and expect the brunt of the pain to pass within 30 minutes. If the pain does not subside within that time, an antispasmodic, (eg, propantheline or hyoscyamine) may be taken. Parents are told that medication may help a great deal, only a little, or not at all.

They should not expect the medicine to immediately eliminate the pain. They should not administer the medicine for mild abdominal discomfort.

If an hour has passed and, despite these measures, the pain is the same or worse, the doctor should be called. Parents worry that a serious cause of pain may have supervened, (eg, appendicitis), or that a serious disease may have been missed and is now declaring itself. It would be ill-advised for the physician not to share these concerns about an unusually severe or prolonged episode of pain. The appropriate response is to reassess the child by phone, by examination in the office or emergency room, or by hospitalization, depending on the presentation.

The parents and child should understand that although RAP neither results from nor causes disease and tends to diminish with time, there is no cure. Any disappointment caused by this statement is, with few exceptions, outweighed by the clarity gained during the consultation and the partnership established between the child, parents, and physician.

**Effective Reassurance**

Explanations transmit information on a cognitive level, but information alone may not enable parents to change their focus from the illness to the need for the child to proceed with development. To change their behavior, parents must shift emotionally, from being worried to feeling safe. The medical data are different from the parents’ subjective reality, which may hold unrecognized, irrational, or displaced fears. Such unspoken fears may cause them to seek yet another “second opinion” and more diagnostic intervention. It is when we speak to their feelings that reassurance becomes effective. How can the clinician discover the patient’s unstated fears? An open ear can discern clues during the history taking. These clues are often seemingly unimportant statements about events and experiences that were deeply painful, eg, a parent who had surgery as a young child, or lost a sibling or parent during childhood or more recently, or whose favorite aunt developed abdominal pain, was told.
by her doctor that it was nothing to worry about, and then turned out to have colon cancer. When parents are asked what their worst fear is regarding their child’s pain, they often mention cancer or the loss of their child. Once this emotional burden is uncovered, it may be easily relieved by, in this case, telling them that cancer of the colon is extremely rare in children.

The moment reassurance becomes effective is signaled by a change in the parents’ mood, from frustration and worry to perceptible relief. The value of effective reassurance is that it enables the parent to once again expect their child to cope with symptoms and the tasks of growing up.

**Continuity and Accessibility**

“If Jenny is still having pain a month from now, bring her back for a follow-up visit. Let me see her again to determine if something has been missed or if we are still on the right track. In the meantime, should her symptoms become worrisome, call me anytime, day or night.”

Individuals cope more confidently and independently when they know that support is available. The offer of continuity does not oblige the family to return for unnecessary visits. The need for follow-up visits varies widely. The physician’s offer of ongoing availability is a warranty for the diagnosis, plan of management, and open-mindedness. The offer allows the use of time as a diagnostic and therapeutic tool and may substitute for stressful, costly diagnostic procedures.

**THE ETIOLOGY OF RAP: SEMANTIC CONSIDERATIONS**

Is RAP organic, functional, psychosomatic, or psychogenic? There is a great deal of semantic confusion regarding RAP and other disorders in which patients’ emotions influence symptoms. The terms we use may aid or impede our understanding and enhance or destroy the therapeutic effects of what we say to patients.

Zighelboim and Talley contend:

Because of the overwhelming evidence that pathophysiologic and psychophysiological disturbances exist in patients with irritable bowel syndrome who present for medical care, and because of the real distress that patients with IBS endure, we conclude that this condition must be considered a disease.37

The reasons given by these authors for calling IBS a disease are sound, but the usefulness of classifying as “diseased” 10% of otherwise healthy schoolchildren (28% of fourth-grade girls)4 is dubious. A diseased child is handicapped, vulnerable, and less capable of tolerating the stresses and enjoying the fun inherent in normal development.29 Parents have a need to view their child as sound, and symptoms as discomfort, rather than disease.27,28 Although identifying IBS as a disease may make physicians take it more seriously, the suffering and monetary costs of RAP in children are more than enough to justify its seriousness.38

Conditions in which organ malfunction is secondary to tissue damage are appropriately called disease. In contrast, symptoms caused by events that are in the repertoire of responses inherent in healthy organs are called “functional.” The term is useful when explaining the mechanism of gut pain and its relationship to physical and emotional phenomena if the presumption of psychopathology is explicitly avoided in discussion with parents.1

The term “psychosomatic” has been applied to children with nonorganic recurrent abdominal pain.39,40 Psychosomatic symptoms are the demonstrable and measurable physical accompaniments of primary neurotic illness.41,42 Again, the presumption of psychopathology inherent in this term is unwarranted in the absence of neurosis.

The term “psychogenic” has similar implications and creates the same obstacles.53,44 Psychogenic symptoms are those that the patient feels are located in the body, but are actually the result of disordered perception such as that which occurs in conversion disorder or somatoform pain disorder.45

**SOMATIZING**

Somatizing is defined as the conscious or unconscious use of physical symptoms for
psychologic purposes or personal advantage. Attention is shifted away from distressing thoughts or emotions towards bodily symptoms and concerns about disease for the purpose of keeping anxious feelings out of awareness. The following vignette illustrates somatization.

Case 1. A 19-year-old man with Crohn’s disease returned for an unscheduled visit. He was distressed by increased abdominal pain and diarrhea, which he identified as an exacerbation of his inflammatory bowel disease (IBD). His agitation seemed out of proportion to his symptoms. He was afebrile, had gained a pound since the previous visit, and had no new abdominal findings. Although he seemed more anxious than usual, a 35-minute discussion failed to reveal any external cause of anxiety. “Honest, Doc, nothing’s bothering me. It’s just my stomach!” he insisted. The physician was ready to accept that the new complaints were caused by increased Crohn’s disease activity, attribute the anxiety to it, and raise the dose of prednisone. As the patient was going out the door, he mentioned that he had been speeding the day before and was stopped by a policeman. On further questioning, the patient said that he had been surly with the officer, who responded by forcing him to undergo a humiliating search of his car and his person.

Comment: This patient’s distress was not caused by a flair of Crohn’s disease, but by the upsetting experience of the day before. He had a characteristic common to individuals who somatize: he was not aware of his emotions. In somatizing, he unwittingly used his Crohn’s disease and his transient increase in stoolsing to deny the existence of his emotional distress. As soon as the physician recognized the somatization, he was able to help the patient discover the emotional distress, validate it by reflecting on how upsetting such an experience would be for anyone, provide an alternative explanation for the increased symptoms, allow the patient to stop worrying about an exacerbation of Crohn’s disease, enable the patient to ameliorate his anxiety by resolving not to repeat the behavior that caused the trouble, and avoid an unnecessary increase in prednisone.

Another use of physical symptoms is to manipulate an interpersonal relationship or communicate a need that would be unacceptable if asked for directly.

Case 2. A 10-year-old girl with sickle cell disease was experiencing frequent abdominal pain crises and spending more time in hospital than at home. Diagnostic interviews with each parent revealed that their marriage, the mother’s third, had become stormy and that the “sickle crises” had increased in frequency at about the time the parents’ arguments had become violent. No matter how intensely the parents fought, the fracas stopped the moment the patient pitched over in pain and they rushed her to the hospital.

Because somatizing usually occurs without patient awareness, the physician needs to recognize its presence. Confronting parents with the observation that their child is somatizing will cause them to feel that the doctor does not understand. It is usually necessary to start from the parents’ view and not insist on our view of the problem before they are ready to hear it.

Somatoform Disorders

It is necessary to clarify the distinction between ordinary somatizing and somatoform disorders. Ordinary somatizing is encountered in everyday practice as part of the larger clinical picture of illness in many patients. The somatoform disorders are a group of five psychiatric syndromes, each consisting entirely of somatization. Four of these sometimes present to pediatric gastroenterologists. Conversion disorder (300.11DSM-III-R) is marked by “an alteration or loss of physical function that suggests physical disorder, but that instead is apparently an expression of psychological conflict or need.” Hypochondriasis (300.70, DSM-III-R) is a morbid “preoccupation with the fear of having, or the belief that one has a serious disease based on the person’s interpretation of physical signs or sensations as evidence of physical illness.” Somatization disorder (300.81, DSM-III-R) is often en-
countered in adolescent girls who present with "recurrent and multiple somatic complaints of several years duration, for which medical attention has been sought...from a number of physicians, sometimes simultaneously...but apparently are not due to any physical disorder...Complaints are often presented in a dramatic, vague, or exaggerated way, or as part of a complicated medical history in which many physical diagnoses have been considered." Somatoform pain disorder (307.80, DSM-III-R) is defined as a "preoccupation with pain in the absence of adequate physical findings that would account for the pain or its intensity."

Patients with somatoform disorders believe that their symptoms result from organic disease. They pressure physicians to pursue extensive diagnostic studies and therapeutic adventures. In some instances, the patient's relentless pursuit of medical procedures prompts suspicion of factitious disorders such as Munchausen's syndrome or Munchausen's syndrome-by-proxy.

Three categories of psychiatric illness in addition to the somatoform disorders are important in pediatric gastroenterology. In the section of DSM-III-R entitled, "Disorders Usually First Evident in Infancy, Childhood, or Adolescence,"42 two disorders are mentioned that frequently present with abdominal pain: separation anxiety disorder (309.21, DSM-III-R), and over-anxious disorder (313.00, DSM-III-R). The section entitled "Factitious Disorders"43 contains Munchausen's syndrome and Munchausen's syndrome-by-proxy. The section entitled "Codes for Conditions Not Attributable to Mental Disorders That Are a Focus of Attention or Treatment" contains malingering—the intentional production of false symptoms for the purpose of personal gain or advantage.45

Three somatizing disorders are frequently confused with each other: conversion disorder, factitious disorder, and malingering.15 In conversion disorder, physical symptoms are not intentionally produced but are motivated by unconscious conflicts, which are "converted" to physical symptoms. In factitious disorder, the symptoms are intentionally produced, but are driven by psychologic forces that the patient does not understand and cannot control. When the factitious nature of the symptoms is disclosed, the patient cannot stop producing them, moves to another medical facility, and repeats the behavior. In malingering, symptoms are premeditated and intentionally produced for consciously manipulative purposes. The malingerer can discontinue symptoms as soon as they lose their desired effect.

By gaining familiarity with psychiatric disorders that entail somatizing, the physician's recognition of somatization is enhanced and inappropriate procedures are avoided. Such knowledge should not devalue the importance of a thorough database regarding the somatic health of somatizing patients, but will assist the physician in avoiding endless quests for the diagnosis and cure of nonexistent organic disease.47

REFRACTORY RAP

Management succeeds when parents feel reassured of their child's health, let go of the responsibility for "taking away" all pain from their child, and then place a clear expectation on the child to cope with the pain and not allow it to interfere with accomplishing important tasks. The child responds by rising to the parents' expectations, functioning better, and complaining less or not at all.1,13,48,49 In some cases, however, the patient continues to complain of symptoms and the parents remain focused on the pain, their fears regarding its origin, and their helplessness in not being able to relieve their child's suffering. In most cases, treatment failure in children with incapacitating RAP is due to failure to recognize or effectively manage the accompanying somatizing.

The following vignette illustrates the use of the doctor-patient relationship, communication skills, and a hospital experience to understand a child's RAP and the family crisis that accompanied it. The parents rejected suggestions that their child be evaluated by a psychiatrist. They were willing, however, to work with the pediatric gastroenterologist, whose efforts included individual diagnostic interviews of each parent.50
Case 3. Donald, 12 years old, presented with incapacitating RAP in October. The previous summer he was sent home early from music camp because of "the worst case of home sickness they had ever seen," according to his parents. On a Monday morning 10 days prior to the consultation, he had one of many recurrences of sore throat. That was also the day his mother was to have begun working—her first job outside the home. Instead of going to work, she took Donald to his allergist, who prescribed amoxicillin. On the way home, the patient ate a hamburger that "tasted funny" and began complaining of abdominal pain. Two days later, still in pain, he was examined by his pediatrician, who diagnosed a viral illness, discontinued amoxicillin, and prescribed an antispasmodic, an antacid, and a bland diet. Donald's pains worsened, although there were no new physical findings. First, acetaminophen, then oxycodone were prescribed. The oxycodone caused Donald to nap for 45 minutes, after which he resumed his complaints of abdominal pain. Continued use of oxycodone seemed to make him more talkative and have nightmares; he began waking up during the night with "pains." His temperature rose to 99.8°. He was given milk of magnesia for constipation.

At the time of the gastroenterology consultation, he had spent the previous 8 days at home, moaning, holding his abdomen, but able to watch TV and eat normally. It became obvious that the parents' concerns were focused on their son's abdominal pain. They showed no recognition of his anxiety and therefore had no motivation to pursue psychologic issues. The consultant, therefore, did not insist on a psychiatric evaluation, but addressed the parents' concerns about their son's abdominal pain. After discussing the diagnosis of RAP, attempting to effectively reassure them, and committing himself to their service until the illness resolved, the physician stated that the greatest danger to Donald's well-being was not whatever was causing his abdominal pain, but continued school absence. The parents were urged to get their boy into school even if he were in pain. A liaison was established with the school nurse to keep Donald in school even when he might be too uncomfortable to sit in class some of the time.

Donald was in too much pain to go to school the next day and his mother was desperately worried. No alternative was apparent, so the patient was hospitalized for 5 days. His complaints subsided within 24 hours of admission. He assured the doctor that he was well, that he saw no purpose in continuing the in-patient assessment, and stated that he wanted to go home to prepare for Halloween. Interviews with each parent revealed stress within the family. The patient's 22-year-old half brother, the mother's child by a previous marriage, still lived at home, showed no desire for gainful employment or independence, and was causing increasing marital discord. In her interview, the mother described herself as someone who worried too much. "I'm very conscientious, maybe too much so. I want everybody to be happy. I hate arguments. I can't stand to have people mad at me." In his interview, the father said, "Ninety percent of our arguments are about Steve (the older boy). When Steve gets mad, she feels bad, unsure of herself."

Donald had been surprisingly symptom-free for 4 days and diagnostic studies had confirmed the absence of organic disease, supporting the diagnosis of RAP. The physician suggested that Donald be discharged that evening and that the family return to the office the next afternoon. "He'll be ecstatic when he hears that he can go home tonight instead of tomorrow," the father said. The physician went to the patient's room and told him, in the presence of his mother, that he could go home so as not to miss another day of school or the opportunity to carve his pumpkin. Surprisingly, Donald suddenly became agitated, saying that he preferred to stay in the hospital and not have to make the trip back to the doctor's office the next day. The physician and the mother had to insist that he go home.

The patient and his parents returned as planned the next afternoon. Donald had been unable to go to school that morning. He entered the office holding his head and moaning in much the same way he had moaned
While holding his abdomen the week before, he assured the doctor that he no longer had abdominal pain, only a terrible headache. Donald and his parents were separated for consultation. His parents had become skeptical of his complaints and were now ready to insist that he return to school, even though he might be uncomfortable. Donald had no more absences from school and became free of complaints within 2 or 3 days.

Comment: Separation anxiety disorder most commonly occurs in school-age children; onset during adolescence is rare. The families are close-knit and caring. This kind of "school phobia" is unlikely in neglected children. Diagnosing this disorder requires that the clinician search for the elements of the diagnosis: 1) symptoms of anxiety in the child, eg, the history of extraordinary home sickness; 2) recent stress, in this case the parents' heightened marital discord; 3) a triggering event, eg, the mother's new job outside of the home; 4) "receptor sites" in the parents that could foster the child's use of physical symptoms, such as the mother's guilt-prone, indulgent attitude towards her sons.

The success in managing Donald's case was limited. The parents did not acknowledge their son's psychiatric disorder or seek psychologic help; they did not use family therapy to help resolve their marital and family problems. It could not be said that Donald would avoid somatizing when confronted with future circumstances that exacerbate his anxiety. Nevertheless, the present episode resolved, inappropriate utilization of medical resources ended, and the child returned to school. Perhaps the family learned from the experience and might thereby better cope with future difficulties.

**Why Somatizing Patients Are Difficult to Manage**

Society assigns three rights and three obligations to anyone deemed sick. The rights are: 1) to be held blameless for the affliction; 2) to receive help and care from others; and 3) to be released from normal responsibilities. The obligations include: 1) a desire to get well; 2) a search for competent care; and 3) cooperation with care givers. A patient who discharges these obligations has normal illness behavior, which physicians assume all patients should have. Although somatizing patients feel entitled to the rights accorded the sick, they are unable to live up to their obligations. They may seek competent care, but prevent its benefits by going to too many doctors for any of them to be effective. They are often noncompliant and engage in abnormal illness behavior.

Donald's case was challenging because his complaints seemed false from the start. This created a pitfall that could have been catastrophic to successful management. Implying or frankly stating that Donald was malingering would have destroyed the clinical effort in two ways: First, it would have been judgmental and caused his parents to defend their suffering child from insult. Second—and perhaps more important—a diagnosis of malingering would have precluded any opportunity to discover what was really troubling this boy. He would not be complaining, thereby bringing on himself so many distressful experiences, if there were not some hidden source of emotional pain. It is the clinician's task to suspect and discover this "pain underneath the pain," even if the patient cannot acknowledge it. This can be achieved by recognizing the anger that may be triggered in us by the patient who distorts symptoms, by avoiding judgmental pronouncements, and by searching for the unrecognized suffering that is at the heart of the clinical problem. Discovering and coping with it, even if this means little more than not compounding it, is a test of clinical skill. Abnormal illness behavior is a legitimate clinical problem that provides opportunities for learning and therapeutic success.

**THE GAP BETWEEN PEDIATRICS AND CHILD PSYCHIATRY**

To care for a patient, a clinician must care about the patient, and be honest and empathic. Arguably, these characteristics require no special training or theory.
ever, they may not be sufficient to deal with many somatizing patients, whose attitudes and behaviors may be frustrating to physicians and mental health professionals. In discussing how to convince the doubting parent of the need for psychologic treatment, Lask & Fosson designate those families who ultimately reject all psychologic treatment as choosing the “chronic illness option.” Although their “choice” creates an impasse to clinical progress, such families nevertheless do seek further care for their physical complaints.

There are several role options available to the pediatric gastroenterologist when encountering such patients. The physician can avoid the mental health issue by opting to define his or her responsibility as the diagnosis and treatment of disease, not psychologic issues. The physician could recognize the presence of a psychologic component to the patient’s illness, feel inadequately trained to deal with it, and refer the family to a mental health professional. However, the referral would then be based on the physician’s need to procure expert care, not the family’s readiness for such a referral. The physician might attempt to compel reluctant parents toward a mental health referral by warning them that not doing so would prevent their child from “getting the treatment she needs,” or by threatening to withdraw medical care if they do not comply. Parents who feel judged or coerced might counter by blaming the physician for not being able to find the organic disease that caused their child’s symptoms. In an attempt to prove the absence of disease, the physician might subject the child to more invasive tests. It is impossible, however, to prove the absence of all disease, especially in families who “need” one.

Another option is for the patient to be cared for by an interdisciplinary team, as exemplified by the Philadelphia Child Guidance Clinic/Pediatric Liaison model. The team includes a pediatric gastroenterologist, nutritionist, nurse clinician, psychologist, and psychiatrist. The advantages of such team care are 1) the range and depth of expertise offered are more comprehensive than any individual clinician is capable of providing; and 2) mental health consultation is obligatory; those families who might have been disinclined towards psychosocial assessment may be less reluctant when it is presented as a requirement for receiving medical care. The possible disadvantages of team care are: 1) it is more cumbersome, requiring coordination of several busy clinicians; 2) the patient’s motivation for forming a strong doctor-patient relationship may be weakened by the necessity for relating to several individuals instead of one principal physician; and 3) patients who are unwilling to accept assessment by mental health team members may reject the entire team and proceed with further doctor-shopping.

Another option is care by a psychologically trained pediatric gastroenterologist who is familiar with the psychotherapeutic aspects of clinical management and able to recognize the myriad ways somatizing may contribute to a patient’s illness. Rather than permit the patient’s refusal of a mental health referral to be a roadblock, the physician uses the rapport developed during management of physical disorders to concurrently assess and manage psychosocial components of illness. He or she is enabled to do this by avoiding the dichotomy of physical versus mental disorders and instead takes a personal interest in the child and family as human beings. By avoiding psychologic jargon and other connotations of the mental health professional, the physician is able to approach mental health issues in patients who would have rejected such attention were it offered by a psychiatrist. Such a physician is capable of providing supportive psychologic care, while remaining alert to opportunities for lessening patients’ resistance to formal mental health referral when needed. At the same time, the physician continues being responsible for protecting the patient’s health from chronic and/or intercurrent disease and ill-advised procedures, and is capable of providing unfragmented care to somatizing patients.

MODELS OF ILLNESS

One model of illness casts the patient as “a vessel of disease” and dichotomizes dis-
ease as either in the mind or the body. Lask and Fosson address the defects in the dichotomized model of illness by proposing that virtually all illnesses fall on a scale, one end of which represents illnesses that are psychosocial, the other end of which represents illnesses that are organic. The rest of the scale represents illnesses which are mixtures of psychosocial and organic components. Instead of these two aspects of illnesses being dichotomized, they are blended.

Where does the emotionally healthy child with RAP and no organic disease lie on this scale? The scale implies that both a pediatrician and a child psychiatrist might be required to treat patients whose illnesses are represented by intermediate points on the scale, but how does one serve the child and parents who may be unwilling to utilize psychiatric treatment? If the "organic" doctor has insufficient psychosocial skills, the child will fall into a gap created by the limitations of each kind of doctor.

Barr offered a tripartite model for classifying recurrent abdominal pain that takes into account the child with RAP who has no organic or psychiatric disease. He classified abdominal pain as organic, dysfunctional, or psychogenic. Levine criticized this as being an "either-or" classification which obscures the fact that any patient has the potential for having all three categories of pain simultaneously or at different times during his course.

**Sorting Out Components of Illness**

The following is offered as a tool for analyzing the components of the patient's illness and developing a plan of management.

Most factors contributing to illness fall into six categories: 1) organic disease, 2) mental disorders, 3) functional symptoms, 4) somatizing, 5) symptoms that accompany normal development processes, and 6) problems caused by a malfunctioning relationship between the individual and society. "Organic disease" requires no further definition. A "mental disorder" has been defined as a clinically significant behavioral or psychologic syndrome or pattern that is associated with distress or disability and does not result from a normal response to a particular event, such as the death of a loved one, but rather from dysfunction. "Functional symptoms" are produced by organs free of organic disease. Somatizing is the use of bodily symptoms for psychologic purposes or personal advantage. This term is not related to bodily symptoms caused by emotional stress, eg, diarrhea before a final examination or tension headache associated with nerve-wracking work. Only if such symptoms are used to avoid obligations or the recognition of emotional distress can somatizing be applied to them. If they are not so used, such symptoms are functional.

Symptoms that accompany normal physical or psychologic development are sometimes mistaken for pathology, eg, premenarchal vaginal discharge mistaken for a yeast infection, adolescent gynecomastia mistaken for a breast tumor, or crying at night in a 20-month-old with developmentally appropriate separation anxiety being mistaken for abdominal pain. Illness may be more severe and difficult to treat when the normally supportive relationship between the individual and society malfunctions. For example, patients who lack health insurance or are homeless have a component of illness that may override all other aspects of clinical importance.

Analyzing an illness enables the clinician to apply management strategies appropriate to each part. The young man with Crohn's disease in Case 1 had an organic disease (IBD), an emotional disturbance (acute anxiety), functional symptoms (acute diarrhea), and somatization (the unconscious use of his organic disease and functional symptoms to prevent awareness of his anxiety and its cause). The girl with more frequent sickle cell crises in Case 2 had an organic disease (sickle cell anemia), psychosocial problems (family dysfunction and resultant emotional distress), and somatizing (the largely unconscious use of her disease to bring comfort during stress). In Case 3, Donald had no organic disease, a psychiatric disorder (separation anxiety associated
with family dysfunction), functional symptoms (RAP), and somatization (his use of RAP and other physical complaints to gain the comfort of his mother’s presence and avoid recognition of his emotional pain).

Any patient can suffer any or all of the six possible components of illness at any time. Common diagnostic and management errors result when, for example, an emotionally disturbed child develops symptoms of organic disease that are mistakenly attributed to his psychiatric disorder. Or, a patient with a chronic organic disease may somatize and distort symptoms, misleading the physician into performing procedures that may be inappropriate. Some of the most intractable somatizers also have some of the most severe organic diseases.

**Therapeutic Approaches to Each Component of Illness**

Many clinicians doubt their competence in managing the psychiatric components of illness. When they recognize emotional illness or family dysfunction in their patients, they feel they have no option but to refer the patient to a mental health professional, regardless of whether the patient will accept such a referral. Pediatricians and mental health professionals alike often seem unaware that overcoming a patient’s resistance to a mental health referral is a procedure that requires the utmost sensitivity and patience during a collaborative doctor-patient relationship. In evaluating a family’s readiness for a mental health referral, consider the following:

1. Are the parents able to recognize psychologic (rather than exclusively physical) distress in their child?
2. Does the child’s psychologic distress cause enough concern in the parents for them to seek help for it? Some parents recognize their child’s distress, but are able to dismiss their worry about it.
3. Do the parents view a mental health referral as potentially useful? Many, especially families prone to somatizing, do not.
4. Is a mental health referral feasible in terms of cost and distance?

5. A successful referral for psychologic treatment should be viewed as the recruitment of an added care modality rather than the transfer of the patient to another caregiver. The referring physician should remain involved in the management of the child’s abdominal pain and responsible for assessment of new symptoms of any etiology.

These conditions are not met by many patients who need psychiatric care. The question remains: What is a nonpsychiatrist physician’s competence with respect to psychiatric aspects of management? Hollis’s hierarchic classification of psychotherapeutic procedures serves as a guide to physicians whose patients are reluctant to receive psychiatric treatment. Its six levels, from elementary to complex, are: 1) sustaining procedures, ie, demonstrating an interest, a desire to help, understanding, and expressions of confidence or helpful reassurance; 2) procedures of direct influence, eg, suggestions and advice; 3) catharsis or ventilation, eg, encouraging the patient to pour out pent-up feelings to relieve tension; 4) reflective discussions about the patient’s current situation, eg, helping the patient to consider the effects of his actions on others and himself or to look at relevant but withheld feelings, attitudes, and beliefs; 5) encouraging the patient to think about the emotional forces that cause response patterns, eg, thinking about feelings that cause unwanted behavior; and 6) reflective discussions on the origins of response patterns and tendencies.

Sustaining procedures and those of direct influence occur during most visits to a doctor. Catharsis or ventilation takes place whenever a physician gives a patient a sympathetic ear. Reflective discussion of a patient’s predicament is a procedure that physicians perform if they take the time and avoid viewing it as “not really practicing medicine” or as a lapse in the efficient use of time. The following vignette illustrates the procedure of encouraging the patient to think about emotional forces that cause response patterns.

**Case 4.** An 11-year-old girl was brought by her mother for evaluation of recurrent abdominal pain and excessive school absence.
It was obvious to the observer that the girl’s incapacity was out of proportion to the severity of symptoms. The patient had a dour demeanor. Her mother was intensely concerned. When they went into the examining room, the patient was asked to undress except for her underwear, put on a gown, and sit up on the examining table. When the doctor returned a few minutes later, the patient had done most of what had been requested. Her mother was sitting in a chair facing her child. Noticing that the patient had not removed her shoes and socks, the physician asked her to take them off, too. The girl, without saying a word or changing her facial expression, extended one foot. Her mother leapt from her chair and began untying her daughter’s shoe. The doctor intervened and said that he’d prefer the girl to take off her own shoes and socks. The girl shot her mother a look of annoyance. The mother then appeared embarrassed and flustered.

After the physical examination, the girl returned to the waiting room and the mother and doctor retired to the consultation room. The physician told the mother that her child’s pains were due to RAP and explained the mechanism and safety of this common symptom. He then voiced his concern about how much invalidism and distress her daughter’s mild, nondangerous symptoms had caused. He recalled her mentioning that her two older sons seldom missed an opportunity to berate their sister. The physician remembered that, in eliciting the history of the mother’s childhood, she too had grown up as the only girl with older brothers. He asked her what it was like during her own childhood. She said her brothers had made her life miserable with taunting and denigration. The physician then mentioned that he had noticed how uncomfortable she seemed when he stopped her from taking off her daughter’s shoe. “What were your thoughts at that moment?” he asked. “I felt as though I had to help her!” she said. She acknowledged feeling this need to provide assistance whenever her daughter appeared distressed or complained of abdominal pain. The physician then reflected on how hard her sons were on their sister and how good it must make her daughter feel each time her mother responded to the girl’s expression of pain or need. Perhaps the girl needed her pain complaints to get this special feeling. The physician wondered out loud about the effect the mother’s devotion had on her daughter’s ability to master adversity, compete successfully, and, in the process, develop self-esteem. The mother immediately recognized that she viewed her daughter as a child who suffered the same emotional abuse she had sustained during her own childhood. Her facial expression changed from sorrow to mild annoyance and her tone of voice in speaking to her daughter became more matter-of-fact. Stomachaches became less of a problem and the child’s school attendance normalized.

Hollis’ sixth and most complex category of psychotherapeutic procedures is elucidation of the origins of psychopathologic response patterns. This is the goal of analytic psychotherapy, in which the patient is helped to understand pathologic emotional forces as well as the defense mechanisms that obscure their recognition and prevent change. This level of intervention requires psychologic training and is generally beyond the scope of medical practitioners. Nevertheless, medical practitioners can and do incorporate a great deal of psychotherapy in their daily practice.

Hollis made an observation beneficial not only to her social work students, but to all clinicians:

There is a tendency to think that there is something mysterious about the case work relationship, something that makes it fragile and untouchable except by the very expert. In fact, it is no more complicated than—but just as complicated as—any other relationship.¹⁹

The functional component of illness is treated with education, effective reassurance, and the offer of continuity and accessibility by the physician. Any symptomatic treatment that is effective and safe should be employed. However, when the physician and parents focus mainly on the pain and its
treatment, as though it resulted from organic disease rather than a harmless event causing discomfort, the child is likely to move into the sick role, with all of its entitlements.

The child's complaints may become more intense as dependency needs are indulged. As soon as the functional nature of pain is established, the goal of management should dramatically shift to preventing the symptom from interfering with school attendance and other developmental pursuits. Everyone goes to school or work on days when he or she does not feel entirely well. Missing school only adds to the child's problems; the longer the absenteeism, the further behind the child becomes both academically and socially.

Efforts by the parents, physician, teacher, and school nurse must be coordinated, and all inappropriate "gains" eliminated. 48,62 If a child cannot go to school, the physician must be notified immediately. Such calls should be responded to as an emergency because the event acutely endangers successful management. When the physician senses that the parent (especially the single parent) may not have sufficient strength to effect the immediate return of the child to school, the physician may go with them. As Nader stated, a school visit can be exceedingly productive and is worth the physician's time. 49 It almost always convinces the child of his parents' and doctor's resolve. The physician speaks with the school nurse and/or principal with the child present, explaining the importance of not missing another day of school. Communication is established between the school nurse, parent, and physician so that the physician immediately participates in any decision about what should be done if and when the child becomes ill at school.

The management goals of the somatizing component of illness depend on its pervasiveness within the family. Families prone to somatizing are less able to recognize and stop somatizing in their child than families in which abnormal illness behavior is viewed as aberrant. 15,52,58,63 When the parents' preoccupation with their child's abdominal pain is so tenacious that all explanations, attempts at reassurance, and appeals to reason fail to change parental attitudes and behavior, the management goal must shift towards ongoing supportive care and the relinquishment of a cure as the index of success. Successful management keeps the persistently somatizing patient from switching doctors and possibly encountering iatrogenic harm, while at the same time recognizing and treating intercurrent disease appropriately. 52

It is a mistake to prejudge the complaints of patients who somatize. The more it appears that the patient is somatizing, the more important it is to be open-minded, take a careful history, and do a thorough physical examination. Invasive procedures should not be based on subjective complaints alone; objective findings must suggest organic disease. Avoid using psychiatric terms; eg, "stress" may be a more acceptable term than "anxiety." 15 The functional symptoms they experience are best explained in terms of the mechanical events occurring in the organ from which symptoms originate. Allow patients to develop ideas about the meaning of their symptoms. Prescribe medications in small amounts with limited or no refills. Avoid, as much as possible, potentially addictive psychotropic drugs. Avoid the paternalistic role that patients often want the physician to assume. The more a patient views the doctor as omnipotent, the more he views his own role as passive and dependent on the physician, to whom he assigns responsibility for making him well.

Charles Ford, a liaison psychiatrist, wrote: Referral to a psychiatrist is frequently not well accepted and not necessarily of benefit...Despite the severity of the underlying psychopathology, these patients may do better with a primary care physician, with whom they can have a long-term relationship, than with a psychiatrist. 15

He then summarized how the doctor-patient relationship can be used to treat somatization:

As the doctor becomes better acquainted with the patient, there can be increased recognition of the patient's use of physical symptoms as a metaphor. Symptoms are often attempts to convey feelings of hurt, needs for affection, anger, and a wish for help in an
ongoing psychosocial crisis. The physician’s ability to communicate that these feelings have been recognized, without ever directly confronting the patient concerning the symptom, may alleviate the need for the symptom. With receptive encouragement extending over time, the patient may gradually learn to express emotions and needs more directly, thereby making somatization unnecessary.15

Management of symptoms that accompany normal developmental processes requires little more than clarity, effective reassurance, and the offer of continuity and accessibility. Management of problems caused by malfunction in the relationship between the individual and society requires the doctor to be the patient’s advocate. The assistance of colleagues in clinical social work is helpful, if not indispensable.

HOSPITALIZATION FOR INTRACTABLE RAP

Hospitalization on the pediatric ward is a valuable option in the management of children whose symptoms have created a crisis refractory to outpatient management.40,64,65 Outpatient studies often fail to identify an organic cause of the child’s symptoms and accumulate in number and cost.38 Outpatient management may fail because the responsibility for gauging and interpreting the child’s symptoms and administering remedies rests entirely on the parents. They may be stressed, prone to irrational guilt, inclined towards somatizing, and so enmeshed in their child’s illness that objectivity is impossible. Health insurers may try to disallow hospitalization because they equate illness only with organic disease.

A 5- to 7-day hospitalization for RAP is different from hospitalization for acute pediatric illnesses. It has four purposes: 1) testing the premise that the child is in pain by observation and documentation of symptoms; 2) developing a data base regarding the child’s somatic well-being; 3) exploring family life and the parents’ life experiences to elucidate sources of distress that trouble the child and family; and 4) conducting pre-discharge conferences with the parents and child to review what has been learned and plan future management.52

Two caveats are needed before describing how these four purposes are accomplished:

1. There must be no prejudices of the causes of the child’s illness. If the parents feel that the physician and other hospital personnel are biased and view their child’s symptoms as nonorganic, they may not collaborate. Remain open-minded and avoid an adversarial tone with the parents regarding who is “right” and what is best for the child.

2. Although individuals from several disciplines participate in assessment and management (nurses, house officers, social worker, play therapist, psychologist, and medical, surgical, or psychiatric consultants), there must be a principal physician who leads the effort, keeps all the participating colleagues accountable, and who in turn remains accountable and freely accessible to the child and parents during and following the hospital stay. A team effort without this kind of leadership is counterproductive.

Observation is at least as important as any diagnostic test. Parent-physician collaboration is strengthened by acknowledging that two kinds of expertise are necessary to arrive at a true picture of the child’s symptoms: the parents, who know the child more intimately than any doctor or nurse can ever know him, but who, by virtue of their parental feelings, lack objectivity; and the principal physician, who knows a great deal about abdominal pain in children and can be objective.

Diagnostic tests scheduled over several days allow time for observation. The child’s symptoms may change in surprising ways. Distortions and inconsistencies which become apparent allow parents and physicians to question their erroneous but firmly held preconceptions. The parent and physician speak to each other about their observations and thoughts during hospital visits, out of the child’s presence.

Asking the child or parents for a subjective account of pain, however, does not provide an accurate estimate of its severity. Teaching them to report pain intensity on a
scale of one to ten substitutes a numerical expression for a qualitative description, but adds nothing to the objectivity of their description. Second-hand descriptions of pain should not be used for assessment. Personal observations yield more useful, less distorted information.

Subjective feelings of extreme bodily distress may accompany anxiety attacks. Prompt administration of an anxiolytic agent with little or no analgesic properties, followed by close observation of its effect, may reveal that the cause of distress was acute anxiety.

Rarely, exacerbations may become so intense that analgesia is required. If analgesics are given for RAP, they should be ordered as a single dose and given only after a prompt clinical assessment. It is helpful to assess the hospitalized child in apparent acute distress by walking with him to the examining room, where a thorough physical examination can be performed. If his complaints are heavily influenced by anxiety, or if he is somatizing, the way he walks, gets on and off the examining table, and responds to a request to jump in place ten times may reveal more to the physician and observing parent than any blood test or x-ray. Should the child’s performance during this out-of-bed procedure show surprisingly little impairment, in contrast to his pain behavior while in bed with parents and visitors present, it is imperative that the clinician not express satisfaction in proving that the child’s pains were exaggerated. The parents may feel accused of misjudging their child and react by being less open-minded and more intent on proving the doctor wrong. A more useful response by the clinician is to reflect on how well the child performed and wonder out loud about what the discrepancy between his description of pain and his behavior could mean. This avoids damaging the collaborative relationship that will be needed in discussions concerning the nature of the real distress—the pain underneath the pain.

A database of diagnostic studies should be developed for organic disease. A prudent but thorough series of tests should be based on the differential diagnoses of organic causes of the presenting symptoms and any other bodily symptoms that may appear during hospitalization. Physicians are often tempted to omit large portions of the work-up because the nonorganic nature of the patient’s symptoms seems so apparent. These omissions become important deficiencies when the patient develops symptoms after discharge and the parents experience renewed doubts about their child’s health and the integrity of the physician.49 The diagnostic process succeeds if it identifies not only what is wrong with the child, but also affirms the extent of his health. In this regard, every test result that is negative for disease has therapeutic value.

The feelings and attitudes of the child can be explored through skillful interviews34 and during therapeutic play in a child activity program. The parents’ feelings and attitudes that enhance somatization in their child can be investigated during individual diagnostic interviews. If parents are willing to speak with a social worker, psychologist, or psychiatrist, arrange for them to do so. Forcing unwilling parents to talk with mental health colleagues, however, is likely to damage rapport and subsequent management.

The diagnostic interview supplements and deepens the clinician’s knowledge of the parents’ feelings and attitudes during their child’s evaluation and treatment.26,50 It is typically an hour-long, relatively unstructured discussion with an individual parent during which information is elicited concerning their values, the parenting they received during childhood, the stresses experienced during personal illnesses or those of significant figures, their marriage, and any other area that might be relevant to helping their child towards well-being.33,66,72

If hospitalization succeeds in helping the parents understand the sources of their child’s distress and recognize somatizing, they are then ready to implement management strategies to prevent the child from staying out of school or using the illness to solve problems. Both parents need to collaborate.49 The pre-discharge conference is the physician’s opportunity to organize this effort. Issues regarding family dysfunction can be addressed
and the options available for overcoming it discussed. A follow-up appointment is made. The physician calls the school principal so that the school is prepared for the patient's return. The parents may transport the child directly from the hospital to school.

CONCLUSION

The clinical process raises questions regarding the dynamics of the doctor-patient relationship, its diagnostic and therapeutic use, the nature of illness and disease, and the often difficult distinctions between what is therapeutic, nontherapeutic, and counter-therapeutic. Nontechnologic, interpersonal procedures are just as worthy of study and support as pharmacologic, surgical, or physiologic procedures. Clinical process theory, communication skills, and relevant psychiatric concepts add a powerful dimension to our capacity for solving clinical problems.

The author thanks Paul E. Hyman, MD, whose encouragement and editorial assistance made this work possible; Giulio J. Barbero, MD, Edward J. Feldman, MD, Jane Fleisher, RN, Johnna Russell, MD, Dale Fitch, LCSW, Deb Gayer, RN, and Soraya Kashani, MD, for helpful discussion and criticism of the manuscript, and Shirley Haden for her unstinting efforts in its preparation.

REFERENCES


18. Lipkin M, Quill, TE, Hapodano RJ. The medi-


46. Rickles WH. Personality characteristics of psychosomatic patients. In: Rickles, Sandweiss, Jacobs, Grove, Criswell, eds. Biofeedback and Fam-


