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Research Article

Exploring the Impact of a Brief Psychotherapy Service on Physician's and Resident's Attitudes towards Medically Unexplained Symptoms

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Abstract

Background: Medically unexplained symptoms (MUS) are associated with frequent visits to health care providers, high costs, and frustration for patients and providers.

Objective: To assess the impact of an Intensive Short-Term Dynamic Psychotherapy (ISTDP) service on physician attitudes and perspectives in two family practices.

Design: Descriptive; online questionnaire and semi-structured interview.

Setting: Two family medicine clinics in Nova Scotia, Canada.

Subjects: Staff physicians and second-year family medicine residents.

Main Outcome Measures: 1) staff physicians' and residents' attitudes and perceptions regarding MUS, before and after the service was introduced, 2) if and how the service is valued, 3) recommendations for improvement and barriers to learning about MUS.

Results: 15 questionnaires were completed (41.7%). Patients with MUS were encountered weekly by 60%, and 87% did not feel prepared to manage these patients before the service was introduced. Primary barriers to learning about MUS were the lack of familiarity with MUS (40%), limited continuing medical education (40%) and limited time to put towards education (67%). Attitudes initially evoked when discussing patients with MUS were frequently frustration and exhaustion. The ISTDP service improved physicians' attitudes and feelings about MUS; they enjoyed their encounters more, felt less anxious about seeing MUS, and worried less about missing underlying disease. Participants appreciated the teaching sessions and developed a better approach to the MUS population.

Conclusion: The collaborative ISTDP service is highly valued by physicians and residents. Future directions include earlier and increased teaching about MUS and continued collaborative approaches to managing MUS along with educational support of physicians.

Keywords: Medically unexplained symptoms; Primary care; Psychosomatic medicine; Psychotherapy; Qualitative research; Surveys

Introduction

Medically Unexplained Symptoms (MUS) are associated with frequent visits to health care providers, high costs, and frustration for both patients and providers [1]. In primary care, frequent attenders account for over one-third of all encounters. These patients are more likely to have health anxiety and ill-defined physical conditions compared to age- and gender-matched normal attenders [2]. Avoidance of strong emotions leads to unconscious anxiety, which can be experienced in the form of physical symptoms [3]. Unconscious anxiety can present in four main patterns: striated muscle tension (e.g., headache), smooth muscle tension (e.g., bladder spasm), cognitive perceptual disruption (e.g., dizziness), and conversion (e.g., paralysis) [4]. Addressing emotional factors in frequent attenders with MUS has been shown to reduce healthcare costs, workload, unnecessary investigations, unnecessary prescriptions, and specialist referrals.

Intensive Short-Term Dynamic Psychotherapy (ISTDP) is a form of therapy that is designed to help patients learn to tolerate strong emotions, which can reduce the physiological manifestations of anxiety [3]. It begins with an evaluation to see if there is a connection between a patient's emotions and symptoms. The initial interview focuses on a patient's experiences that caused strong emotional reactions. The patient and the interviewer can observe the way that the patient identifies and experiences these emotions, including any physical effects [4]. ISTDP was developed in Montreal in the 1970s, to mitigate long waitlists and the financial burden of publicly funded therapy [5]. It has been repeatedly shown to be cost effective through reductions in health service use, medications and disability in samples including somatic symptoms disordered patients [5,6]. Given the constant financial strains within the publicly funded healthcare system, and general lack of publicly funded mental health support, ISTDP could offer a more accessible treatment for patients with MUS.

Research on ISTDP has shown promise in treating a number of somatic conditions, including psychogenic nonepileptic seizures, medically unexplained pain, headaches, back pain, movement disorders and pelvic pain along with depression and anxiety [3,7-11]. In a pilot study at a Nova Scotian emergency department, ISTDP led to a 70% decrease in repeat visits in patients with MUS, and a decrease in overall symptoms [4]. That study included patients who were given a provisional diagnosis of anxiety, or somatic symptoms such as chest pain not yet diagnosed (NYD) or abdominal pain NYD. Following that study, a long-term MUS service was implemented in that emergency department [4] and it has become an Accreditation Canada Leading Practice [12].

In the setting of medically unexplained symptoms, patients and physicians may hesitate to consider emotional factors as a cause for symptoms. Patients may feel that their symptoms are not being taken seriously. Physicians may feel uncomfortable making a diagnosis of a somatic symptom disorder because of a lack of training in that area [1]. Such a diagnosis is often thought of as a diagnosis of exclusion, but it does not have to be [13].

In April 2015, a pilot project operated by a Clinical Psychologist specialized in ISTDP was initiated at two Family Medicine clinics in Halifax, Nova Scotia. Patients referred to the ISTDP service undergo an emotion-focused diagnostic assessment, then are invited to continue with regular ISTDP treatments or sent back to the referring physician for follow-up, which could include a request for further medical investigations. This program has been described and its initial outcomes have been promising [14].

The purpose of this study was to explore staff and resident physician views on the newly implemented ISTDP service in two primary care clinics in Halifax. The cost-effectiveness and patient perspectives of this project are being separately evaluated [15].

Our research questions included:

1. What are staff physicians' and residents' attitudes and perceptions regarding MUS and its management, both before and after the service was introduced?
2. Is this service valued and how so?
3. What are recommendations for improvement and barriers to learning about MUS?

Materials and Methods

A mixed methods approach was used, loosely following that used by Howman et al. [16], a study in the UK exploring similar physician attitudes and experiences regarding MUS. The authors adhered to the consolidated criteria for reporting qualitative research (COREQ) as best as possible.

Twenty-two staff physicians and 14 second-year family medicine residents from two family medicine clinics in Halifax were eligible to participate. First-year residents were excluded, as they had not yet been exposed to the ISTDP service. Participants were not compensated for their time.

Phase 1: Questionnaire

In July 2016, an e-mail invitation for an on-line questionnaire was sent to all participants. The survey (Supplement 1) was disseminated three times over two months. The last question of the questionnaire invited participants to a semi-structured interview (Supplement 2) to further explore their views on MUS and the ISTDP service (Phase 2). The questionnaire examined perceptions and attitudes of MUS before and 12 months after the implementation of the ISTDP service. Because the questionnaires were completed after the MUS service was implemented, the pre-service data are retrospective. The perceptions and attitudes scale was

based on one used by Howman et al. [16] and Rosendal et al. [17], modified to suit our study goals, and to have a survey length of 20 questions. The survey also examined perceptions of the service and barriers to learning about MUS. Survey results were collected and anonymized through FluidSurveys™. Data were analyzed into percentages.

Phase 2: Interview

Semi-structured interviews were conducted by two of the authors, PL and AS, second-year family medicine residents working at the Spryfield and Mumford clinics in Halifax, Canada, respectively. PL interviewed participants from Mumford and AS interviewed those from Spryfield. Interviews were conducted at the participants' workplace or by telephone and were audio-recorded. PL and AS transcribed each other's interviews verbatim. Data were extracted and coded using an inductive approach by PL and then reviewed by AS [18]. This approach was selected to extract the most meaningful summary of results from the interviews.

Results

Phase 1: Participant Characteristics

We received 15 completed surveys (41.7%); 47% of participants were from one clinic and 80% were female (Table 1). Work experience varied from residents to having over 20 years of practice. Only one participant had previous training in Psychology. Most respondents first encountered a patient with MUS in medical school (53%). Official training related to MUS, however, only started in post-graduate education for 20% of participants, and even later for 60% (Table 2)

Characteristic	Number (%)
Gender	
Male	3 (20)
Female	12 (80)
Clinic	
Mumford	7 (47)
Spryfield	8 (53)
Current level of training or employment	
Post-graduate year 2	3 (20)
Post-graduate year 3	0
Staff ≤5 years	2 (13)
Staff 6-10 years	2 (13)
Staff 11-15 years	3 (20)
Staff 16-20 years	2 (13)
Staff 21-25 years	1 (7)
Staff ≥26 years	2 (13)

Table 1: Participant characteristics.

Characteristic	Number (%)
Other related training in:	
Psychiatry, Neuroscience	0
CBT	1 (7)
Psychology	1 (7)
Teaching obtained about MUS	
Didactic lecture/session in medical school	0
Didactic lecture/session in post-graduate training	3 (20)
Didactic lecture/session as a staff physician	9 (60)
Conference	0
Self-learning module	1 (7)
Read literature	4 (27)
First exposure to management of patients with MUS	
In medical school	8 (53)
In residency/internship	3 (20)
In practice	3 (20)
Previous career	0
None	1 (7)

Table 2: Participant experiences with MUS.

Responses

Before the implementation of the MUS service, the majority of participants did not "feel prepared to manage patients with MUS" (87%) (Figure 1). After the service was introduced, 60% agreed that they felt more prepared. Most participants reported seeing a patient with MUS at least one to two times monthly (Figure 2).

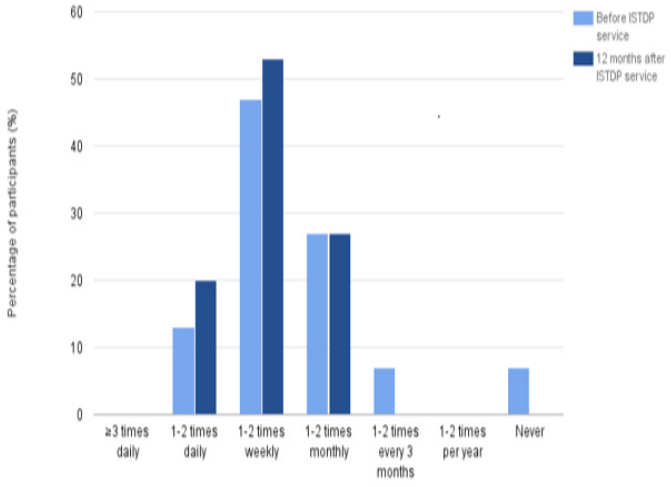

Figure 1: "I feel prepared to manage patients with medically unexplained symptoms".

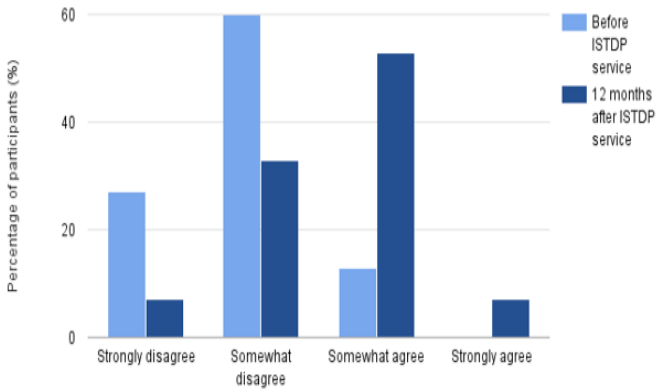

Figure 2: Frequency of encounters with patients with medically unexplained symptoms.

Attitudes and perceptions regarding MUS before and 12 months after the implementation of the MUS service are highlighted in Figures 3 and 4. When asked how participants felt when seeing a patient with MUS prior to the institution of the MUS service, 47% reported "not at all" enjoying working with them, 67% often felt unsure of what to do, 53% worried about missing illness, and 47% felt a little angry. After the service was introduced, 33% reported feeling more comfortable, 47% felt more confidence in knowing what to do, and 40% reported feeling less worried about missing illness. Before the MUS service, one participant felt confident in their approach to patients with MUS, and 47% reported feeling "a little" anxious; after the service was implemented, 27% reported feeling more confident in their approach, and 27% felt less anxious when encountering a patient with MUS.

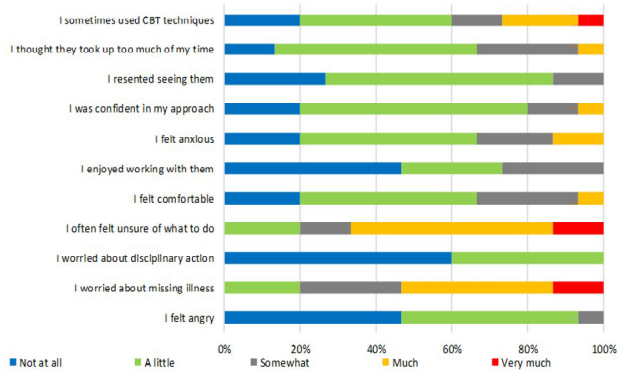

Figure 3: Before the Intensive Short-Term Dynamic Psychotherapy service, "How did you typically feel when you saw a patient with medically unexplained symptoms?".

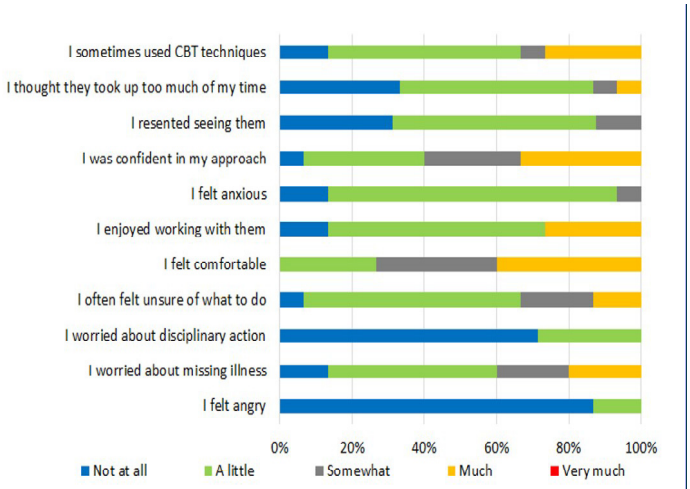

Figure 4: Twelve months after the Intensive Short-Term Dynamic Psychotherapy service was introduced, "How did you typically feel when you saw a patient with medically unexplained symptoms?".

The primary barriers to learning about MUS were "MUS not being a widely known term or concept" (40%), "limited Continuing Medical Education on MUS" (40%) and "limited time to put towards learning about MUS" (67%). Some respondents felt it was challenging to bring up MUS to patients, or that patients did not seem to buy into the concept (Figure 5).

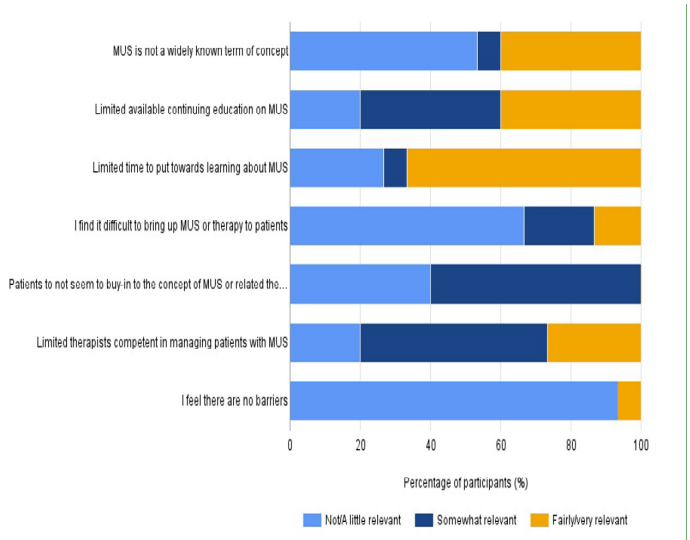

Figure 5: Barriers to learning about medically unexplained symptoms.

Some comments about the MUS service obtained in the open text question:

"Excellent collaborative service that is teaching me new ideas and approaches and massively helping my patients."

"I feel that I can broach the concept with the patient, but still feel like I would like more specific teaching and tools to help facilitate the appointments between seeing a psychologist/other therapist."

"Excellent program. This is a vital primary care service that should be more widespread and accessible. It would likely be cheaper and better medicine."

Phase 2

Five participants consented to participate in follow-up semi-structured interviews; four staff physicians and one resident. Interviews ranged from seven to 22 minutes in length. The main themes from the interviews are reported in four categories.

Perceptions of current environment and approach to patients with MUS:

Frequency of encounters with patients with MUS: Participants agreed that patients with MUS are regularly seen in practice.

"I have a number (of patients) who have significant distress from it (MUS), who are losing time away from work and so forth, so it's a significant problem in my practice for sure." (ID1)

Lack of defined approach to managing MUS: The ambiguity and lack of a framework for managing patients with MUS was voiced by all interviewees.

"It's (MUS) very much been a marginalized, underserviced, part of our population. We all have patients like that but we haven't really had a good approach with adequate resources to deal with them as a group, like we do with diabetics." (ID1)

Concept of "it's all in your head': The comparison of MUS with the "it's all in your head" idea, was brought up by most interviewees, often as a barrier to therapy being accepted.

"To really look at a particular symptom, like belly pain, and make that leap into maybe this is a very emotionally-based, is difficult for some people, and they very much can easily think you are telling them "it's all in their head" or that they're a little bit crazy." (ID2)

"I think that "you think this is something in my head" is a barrier...and sort of how it might change the dynamics of the relationship (between patient and physician)." (ID4)

Attitudes and perceptions engendered by patients with MUS:

Sense of futility and frustration: The attitudes evoked when discussing patients with MUS were those of frustration, exhaustion, and a sense of futility and hopelessness when trying to help.

"It's very frustrating because as a physician, you want to be able to help people out in some way. And it's very difficult when you feel that there's nothing you can do, or nothing you can do to make them feel better." (ID2)

"They take a lot of time. They take a lot of energy. They take up a lot of appointments. They take up a lot of money from the health-care system for investigating…" (ID4)

"He's had a million investigations and specialist consultations... it's difficult...for some reason the things that you're trying to do or suggest that might be helpful are not helpful." (ID3)

Perception of missing an illness: Interviewees all reported feeling worried about missing an illness in their patients, and a sense of anxiety.

"I think initially when I see patients like this I'm very cautious and careful...just because they have a known somatization or medically unexplained symptom it doesn't mean they still couldn't get something that I could help with in the traditional way." (ID4)

Importance of self-awareness: The recognition of one's own emotions and reflections in response to patients with MUS was also noted by participants.

"I don't want to give the impression that I find these patients frustrating; I have to accept them the way they come...very careful to make sure there is no transference of emotions." (ID1)

"I think it's also made me personally reflect on my practice in terms of moving away from trying to solve problems to trying to help people solve their own problems. That's been something that's been an insight for me." (ID3)

Sense of satisfaction: Some interviewees reported a feeling of satisfaction when patients with MUS were able to recognize their mind-body symptomatology and "get better"

"I was pleased that that (broaching the concept of mind-body symptoms to a patient) actually helped her somewhat to recognize the cause and it may have helped her move towards getting better." (ID3)

Opinions on and attitudes towards the MUS service:

Benefits of the MUS service: All participants positively endorsed the MUS service, related specifically to the availability, expertise, and increase in communication with the psychologist.

"I think Dr. Cooper's presence has been fundamental to the success of the clinic (service)." (ID1)

"It's (MUS service) allowed me to have something that I can actually suggest to these people as an option...to start talking about how their brains and bodies might be working...to be causing and/or aggravating the symptoms they have early on." (ID2)

Increase in comfort level when managing patients with MUS: Some interviewees reported changes in their approaches to patients with MUS, attributed to the implementation of the MUS service.

"I'm getting better at picking out who...I think I would almost ignore it because I thought there was nothing you could do...so I would start investigating because what else do you do to give people reassurance?" (ID2)

"You have to get a sense of whether they're ready to be asked those questions….She's (Dr. Cooper) given us some ways to approach the conversation and normalize it." (ID3)

Barriers and future steps for the management of MUS:

Major barriers: The lack of information, training, and resources were often mentioned as barriers to the management of MUS.

"If the service was more readily available, it could have stopped a few emergency department visits and also an admission to the hospital...When we don't have the training, we don't have the confidence to stop looking for other causes." (ID5)

"I think the lack of information...physicians simply to be aware that there is a structured approach to this that has been validated and is well recognized by psychiatry." (ID1)

"I didn't feel like I was adequately prepared for this patient population (patients with MUS) in medical school or residency. I think the curriculum could be improved in both places." (ID4)

Future steps: Earlier and more training throughout all specialties, the availability of an expert in a collaborative approach, were recommended as future steps to improve the management of MUS.

"For me, that (Continuing Medical Education sessions) is a very effective means of disseminating new methods of treatment and new approaches." (ID1)

"Certainly increasing the competence and learning of people before they go out into practice so they are entertaining MUS as a possibility on their differential diagnosis." (ID2)

"I think it's good to have a session in the curriculum, but also to be able to work in that collaborative care model with a psychologist is invaluable for learners." (ID3)

Discussion

Medically unexplained symptoms can be challenging to diagnose and treat, often leading to extensive investigations, medication trials, and specialist referrals. This study explores physicians' attitudes towards and perceptions of MUS, before and after the implementation of an ISTDP service embedded within family practice clinics. The value of the service was assessed, in addition to barriers to the management of MUS.

Our study shows that patients with MUS are seen frequently in primary care, as documented by others [1,10]. Almost 75% of survey respondents reported weekly encounters with patients with MUS. Several participants felt that they were able to recognize MUS prior to the implementation of the service, but they did not feel prepared to help these patients. A study of 80 trainees in the UK reported similar perceptions, with a mean score of 4.3 out of 7 when asked how prepared they felt to manage patients with MUS [16].

Most interviewees felt that encounters with patients with MUS could be frustrating and exhausting. This finding is consistent with other studies [19-22]. Rosendal et al. [17] explored attitudes of general practitioners towards somatization in Denmark, with 90% (n=43) reporting a score >5 (0 = "strongly disagree", 10 = "strongly agree") for "working with somatising patients is heavy going." The introduction of the ISTDP service helped our participants feel more comfortable managing patients with MUS. It also improved their attitudes and feelings about seeing patients with MUS.

Feedback on the ISTDP service was overwhelmingly positive. When asked about suggestions for improvement, the most common recommendations were to make the service more widely available and to have more teaching sessions on MUS. Despite the majority of participants (73%) first encountering patients with MUS in medical school or residency, none of the participants received formal teaching in medical school, and only 20% in postgraduate training. Yon et al. [22] studied 22 junior doctors in the UK and also found that very few had received formal education on MUS. Residents and physicians felt that increased training in undergraduate and postgraduate studies, as well as continuing medical education would help physicians recognize and discuss MUS with patients. It has been shown that even brief, multifaceted training can positively affect attitudes of GPs towards medically unexplained symptoms [17]. However, increased education alone was not felt to be sufficient to improve management of this problem. The availability of a psychologist trained in ISTDP was seen as essential. Respondents felt that working in a collaborative care environment with a psychologist was more beneficial than just having sessions on MUS in the medical curriculum. Stone et al. [20] suggests that supervisors can also play an important role for learners, by sharing their own strategies and management methods.

One limitation of our study, due to the snapshot approach to the questionnaire, is the potential of recall bias. Voluntary participation in the semi-structured interviews may have introduced an element of selection bias, in that interviewees could have had more passionate opinions about the topic. However, the qualitative data correlated well with the questionnaire responses. Finally, the response rate for the questionnaire (42%) is below that recommended in medical research of 60% [23], possibly incurring non-response bias.

Conclusions

The ISTDP service at two family medicine clinics is highly valued by residents and physicians. Our study demonstrates the positive impacts of the service on attitudes towards MUS. Participants report feeling more confident and having a better approach to the management of patients with MUS due to the collaborative approach of the service. Ultimately, identifying and treating MUS may have the potential to reduce healthcare costs and reduce frustration for patients and physicians. Next steps should focus on earlier and increased teaching about MUS, continued collaborative approaches to managing MUS, and ready availability of an expert collaborator.

Acknowledgements

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