

Medically Unexplained Symptoms (MUS) in Family Medicine: Patients' Perspectives on Treatment

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Abstract

Aim: This research examined the experiences of patients with Medically Unexplained Symptoms (MUS) treated with Intensive Short-Term Dynamic Psychotherapy (ISTDP) within a family practice setting.

Methods: Patients who had attended the MUS service were sent a semi-structured qualitative questionnaire about their symptoms, and their relationship with their physicians before and after their participation in the service. The surveys also included two validated scales: the Illness Attitudes Scale (IAS) and the Patient-Health Care Provider Communication Scale (PHCPCS). The IAS provides insight into patients' symptom severity and frequency of treatment while the PHCPCS provided an indication of the degree and quality of communication between patient and family physician. In addition to the scaled instruments, thematic analysis was used to elicit themes from the semi-structured questions.

Results: This study found that family physicians utilize high-quality, non-negative communication skills with MUS patients. It also confirmed earlier findings showing that ISTDP is effective in treating MUS [1].

Conclusion: It concludes that having a MUS service embedded within an existing family practice office builds on the existing relationships family physicians have with their patients through accessible, non-judgmental contact with the service.

Keywords: Medically unexplained symptoms; Functional; Intensive Short-Term Dynamic Psychotherapy

Introduction

It is estimated that between 16 and 32% of primary care visits are for symptoms that remain unexplained despite numerous investigations [2,3]. These are termed Medically Unexplained Symptoms (MUS) and could include chest pain, fatigue, dizziness, headache, back pain, dyspnea, insomnia, abdominal pain and numbness [4]. MUS lays at the intersection "between physiology, bodily sensations, and symptom experience [that] reflect the complexity of the central nervous system (CNS) processes that translate physiological perturbations into experience" [4]. MUS patients report more functional impairment, social isolation and psychological distress than patients without MUS with similar

healthcare utilization rates [4,5]. The distress and disability of MUS is heightened by social factors, co-morbid depression and anxiety and because some MUS patients struggle to differentiate between feelings, thoughts and bodily sensations [5,6]. Therefore, when patients with MUS describe being physically ill, a plausible physiological explanation is possible [4]. Unfortunately, without an explanation for their symptoms they live with uncertainty which can result in ambivalence towards medicine and physicians [7].

Conversely, physicians believe MUS is the product of social and psychological distress, intolerance of benign somatic symptoms, limited medical knowledge, and unrealistic expectations [8,9]. Doctors can feel resentful because they believe MUS patients control the clinical encounters [4]. Part of this agenda-setting struggle could be the complexity of discussing MUS in short primary care visits [4]. While patients ultimately want to

alleviate their symptoms, patients require time to explain how their symptoms developed and what treatments and investigations have been tried thus far. Therefore, MUS patients utilize their primary care physicians in their search to bring explanation and meaning to their symptoms [10]. In short, there are divergent agendas: patients seek support while doctors seek to alleviate symptoms. It is often assumed by physicians that MUS patients want a physical explanation of their symptoms, but patients actually have insight that social and psychological factors contribute to their physical complaints [11].

However, patients struggle to reveal these insights because they believe physicians make distinctions between body and mind, they fear stigmatization if labelled psychologically, and perceive doctors as unwilling to discuss emotions [12]. Therefore, physicians often respond to repeated visits with further investigations rather than exploring the root psychosocial stressors [11]. Constraints on time and physicians' inability to recognize patient cues signaling a likely MUS presentation lead to more visits, decreased patient satisfaction, and a troublesome doctor-patient relationship. Healthcare costs also increase through sick leave, unemployment, multiple tests, and frequent physician visits. A systematic review [3] found that MUS causes excess costs per patient between \$432 and \$5,353 (2006 US\$ values). It also found indirect costs through lost productivity and absenteeism amounting to \$18,000 per year per patient (2006 US\$ values).

In summary, MUS patients respond best when physicians are aware of emotional and psychological cues being provided and when their concerns and symptoms are validated [5]. Symptom distress can be reduced if patients can create an illness narrative to "create meaning for symptoms by exploring their characteristics, context, and antecedents" [4]. These narratives can be created through cognitive behavioural therapy (CBT) as a primary treatment for MUS. It can help patients "come round to viewing their symptoms in more psychological and less catastrophic ways" [5]. However, CBT does not always address the social, emotional

and cultural components which are important contributing factors to MUS [2,4,6,11].

Another approach is Intensive Short-term Dynamic Psychotherapy (ISTDP). In summary, [13] ISTDP case based research has determined there are unconscious feelings past attachment wounds that establish the pre-conditions for somatic symptoms [14]. If a stressful incident in the present activates these feelings then defense mechanisms and unconscious anxiety pathways are activated. If the feelings are not consciously recognized, then the defense mechanisms used may not be consciously recognized either. Unconscious defense mechanisms are common in those with a past history of trauma at the hands of someone close to them as "feelings of rage toward a loved one are unacceptable, frightening, and avoided through somatization and other defenses" [15]. ISTDP focuses on the "unconscious process by which emotions translate into somatic symptoms... making unconscious phenomena conscious and working through underlying conflicts" [1].

These phenomena are made conscious by observing characteristic bodily patterns in patients undergoing ISTDP. These patterns (see Table 1) include striated muscle tension, smooth muscle tension, cognitive perceptual disruption and conversion [16]. ISTDP uses observations of patient behaviour during interviewing to uncover corresponding emotions. The initial interviews allow the therapist and patient to directly see the somatic effects when unconscious anxiety is activated: this allows a collaborative diagnostic and treatment process [15]. Contrasted with traditional psychoanalytic psychotherapy, ISTDP allows treatment of greater numbers of patients because it takes less therapeutic time. The process builds anxiety tolerance as needed then helps patients observe and experience their underlying feelings. By feeling these feelings, the need to block and avoid the feelings somatically is reduced or removed [13].

Indeed various research findings show that emotional processing is a critical component of treatment effectiveness seen in ISTDP for MUS patients [17].

Anxiety Format	Observations During Emotion Focused Assessment	Examples of Clinical Presentation
Striated muscle	hand clenching, arm tension, sighing, body tension	Headache, globus, chest pain, hyperventilation, shortness of breath, panic, backache, abdominal pain, tremor
Smooth muscle	Spasm of smooth muscle	Irritable bowel, abdominal pain, reflux, nausea, bladder spasm, bronchospasm, coronary artery spasm, hypertension, migraine
Cognitive and/or perceptual disruption	Anxiety affecting cognition or perceptual	Blurred vision, blindness, confusion, dizziness, pseudo-seizures, paresthesias, fainting
Conversion	Loss of voluntary muscle tone	Weakness, unilateral or bilateral paralysis, aphonia

Table 1: Somatization patterns and examples of clinical presentations and observations during ISTDP [16].

There is an association between MUS and childhood trauma, but there is little understanding of “the diagnostic and therapeutic value of uncovering this history” in the treatment of MUS [5]. Furthermore, patient-centred primary care treatment for MUS is important, but there is little patient-centred, primary care research on MUS [5,10] that examines “the actual encounters between patients with [MUS], of all levels of severity, and their doctors, to identify and promote the best methods for dealing with these challenging problems” [17]. This paper is a qualitative, descriptive study addressing these gaps by examining the effectiveness of ISTDP in treating MUS patients from a patient-centred perspective. It reports on the patient perspectives of a novel family medicine based ISTDP MUS service [18], the effect of treatment on symptoms, and communication with their physicians' experiences pre- and post-treatment. In a separate but related study, the staff and resident physician views on the newly implemented ISTDP MUS service was evaluated [19].

The MUS service itself is a partnership between the Nova Scotia Department of Health, Dalhousie Family Medicine (DFM) and the Centre of Emotions and Health. A psychologist was embedded within the existing DFM team structures to provide services for patients of the DFM academic practices along with Staff and Resident education to enhance the primary care management of these patients [18].

Materials and Methods

Approval was obtained from the Research Ethics Board at the Nova Scotia Health Authority for this qualitative, descriptive research. A combination of either an online or paper survey was sent to patients who had attended at least one MUS service session. Demographics on symptom duration, treatments received, age, sex and occupation were collected. The survey had two validated scales and semi-structured qualitative questions about patients' attitudes towards their physicians, and their experience with the MUS service. The illness attitudes scale (IAS) [20] provided insight into patients' burden of disease. Communication between the family physician and patient figures large in MUS treatment: the Patient-Health Care Provider Communication Scale (PHCPCS) [21] measured the degree and quality of this communication. The semi-structured qualitative questions were evaluated using thematic analysis [22] to uncover themes.

Results

This section will describe patients' views of the MUS service, the effect of treatment on their symptoms, and any changes in communication with their physicians' pre- and post-treatment with the MUS service. It will describe the themes encountered in the patients' responses to the survey and will provide representative examples from patient statements.

Response Rate

Thirty-nine patients who met the inclusion criteria of two or more visits to the MUS service within the last year were sent invitations to participate in this study by email or by post. A total of eight responses were received giving a response rate of 8/39= 20.5%. All respondents were female, and the average age was 45.8 years.

Pre-Consultation Experience with MUS Service

Patients were asked about the mind-body explanations their doctors offered for their symptoms. Example responses included “*it could potentially offer me non-pharmaceutical treatment for my emotional issues*” (Patient ID #42), “*generally just that there may be a connection*” (Patient ID #73), and “*it may help with my pain*” (Patient ID #23). When asked “How did you feel about your doctor's mind-body explanation for your symptoms before you were referred?” respondents answered “*Hopeful*” (Patient ID #42), “*Curious*” (Patient ID #73) and “*we had tried everything else so I was willing to try anything*” (Patient ID #23).

View of the MUS Service

Patients were asked “How did you feel about your doctor referring you to the specialist mind/body service?” Themes were hopeful/grateful or fearful/negative. For example: “*I have been desperate to get well. I was willing to try anything. I was fearful, but willing*” (Patient ID #56).

Post-Consultation Experience with MUS Service

Symptoms

When asked “Has your participation in the specialist mind/body service changed how you view the cause of your symptoms?” the emergent theme was recognition of a mind-body link between symptoms. One participant said: “*I knew I had bad bowel days during times of stress but I did not realize how much my feelings really affected my physical ailments.*” (Patient ID #32) while another said “*Yes, I can see more clearly how emotional tension affects my body.*” (Patient ID #42).

Treatment

When asked “[have you noticed any differences in how your doctor manages your symptoms since you were referred?” the theme of less medication emerged. One respondent said “*Let's see where this takes us, instead of treating me with anti-depressants, [my doctor] seems to feel this will help much more with life*” (Patient ID #60). Another said “*My family doctor has always been supportive... [in] trying to have me use other methods and not medications. I just feel she was limited in Psychology training (normal) and that's what I needed the most help with.*” (Patient ID #45)

Doctor-Patient Relationship

When asked “Has your participation in the specialist mind/body service had an impact on your relationship with your doctor?” the emergent theme was that of better communication. One participant commented they were “*more comfortable talking to my doctor about my mental health. Despite my doctor’s open and empathetic manner, I had previously felt uncomfortable opening up to anyone, even my trusted family doctor*” (Patient ID #42).

View of the MUS Service

Patients were asked “Do you think it is a good idea to have a specialist mind/body service based at the family medicine practice?” Themes that emerged included easy accessibility to the service, comfort in being with familiar, non-judgmental healthcare providers, and the effectiveness of the service in reducing symptoms. In contrast, one respondent did reply that they were “*Not aware if there is a need or not, so cannot answer with any degree of certainty*” (Patient ID #23). Table 2 lists examples of respondent answers and the associated themes.

Theme	Example
accessibility	“the referral time was much better” (Patient ID # 32) “Need access nearby – this service is incredibly helpful and it needs to be accessible, without the expense of travel, extended periods of wait...” (Patient ID # 56)
comfort and lack of judgement	“I know I was much more willing to try as I was already comfortable in this clinic” (Patient ID # 56) “its very important convenient and comforting. They go hand in hand” (Patient ID # 93) “I feel I am being followed more closely than seeing someone at Mental Health” (Patient ID # 32) “the specialist did not make me feel like there was something wrong with me” (Patient ID # 45) “I would say most people have a story to tell that is causing them a lot of suffering with mind/body” (Patient ID # 45)
expertise and effectiveness in symptoms reduction	“It has given me a new perspective on how to deal with life, gave me some self-esteem back, as well as significantly decreased my physical symptoms that I continuously sought medical attention for” (Patient ID # 45) “Having someone trained to help explore the emotional turmoil I have been dealing with inside felt exhilarating” (Patient ID # 45) “the pain may also be brought on by sources of emotional stress” (Patient ID # 73)

Table 2: Themes emerging from patient views on having the mind-body service present in a family practice office.

Responses to Scaled Instruments

Illness Attitudes Scale

Table 3 summarizes responses for the IAS. The maximum possible score for the IAS is 108, with 9 sub-scales each scored out of 10. The average score was 45.5 (SD of 16.8). Higher sub-scale scores reflect increased or worsening quality of the corresponding property [23]. For example, high scores on the worry or treatment experience scales indicate increased worry about illness and frequent use of different medical practitioners respectively. When symptoms interfere with normal daily activities, patients score high on the effect of symptoms scale. IAS data demonstrated that over the past year most patients saw a doctor either monthly or quarterly, used between 2 to 5 different practitioners, and were treated between 1 to 5 times.

Scale Item	Average	SD
Worry about illness	6.5	1.77
Concerns about pain	4.25	2.82
Health habits	5.625	1.77
Hypochondriacal beliefs	3	3.16
Thanatophobia	4.625	3.20
Disease Phobia	3.125	3.09
Bodily Preoccupations	3.875	3.44
Treatment Experience	7.5	1.69
Effect of Symptoms	7	1.93
Average Total Score	45.5	16.76

Table 3: Scale response summary for the IAS (N=8).

Patient-Health Care Provider Communication Scale (PHCPCS)

Table 4 summarizes the results from the PHCPCS. Responses in the “very much like” range indicate a positive quality of communication, while responses in the “not at all like” range for the negative communication subscale were indicative of good communication between provider and patient [21].

	Very Much Like	Much Like	Somewhat Like	Not at all Like
Quality Communication Subscale core	80	44	12	0
Negative Patient-Healthcare Provider Communication Subscale Score	0	0	5	27

Table 4: PHCPCS subscale scores.

Discussion

The goal of this research was to understand the overall patient experience of care by their physicians pre- and post-involvement, with an embedded MUS service. It addressed some gaps in the literature calling for more patient-centred, primary care research on MUS. It found that MUS patients see their physicians frequently, and make frequent use of treatments and other healthcare providers. Consistent with findings in the literature, patients in this study had a high burden of disease. Before treatment, patients had neutral views about their doctors' suggestion that a mind-body link might be responsible for their symptoms, but following treatment, patients reported a better understanding of this link. This implies that patients had limited insight into possible psychosocial explanations for their somatic symptoms but treatment can unlock this insight. However, patients reported that their physicians did not always offer this mind-body explanation and relied upon numerous tests and treatments prior to MUS consultation. This is consistent with the literature that found despite knowing that MUS is the product of psychosocial distress, primary care physicians continue to offer medical treatments and investigations. All this suggests that further work could be done on educating primary care physicians about the pathophysiology of MUS.

Patients were apprehensive about treatment with ISTDP, which is not surprising given the numbers of previous interventions. However, following treatment, respondent patients reported that their symptoms were eased. This is consistent with the literature on ISTDP and its effective use for MUS in other settings [24]. Patients saw the benefit of having a MUS service in the family practice sites. They appreciated the accessibility, felt comfort in being with existing, non-judgmental healthcare providers, and were re-

assured with the effectiveness of the service in reducing symptoms, and the literature supports these findings. Thus, the findings of this paper re-confirm the importance of family medicine in managing and treating MUS. It suggests that the MUS service should focus on remaining accessible and continue to encourage referring physicians to be non-judgmental in their interactions with MUS patients. One patient stated that “*most people have a story to tell that is causing them a lot of suffering with mind/body*” (Patient ID # 45). The importance of story-telling was noted in the literature as being beneficial in the reduction of symptom distress. This idea could be utilized by the MUS service in the future, through the development of a group that provides an outlet for these narratives through a “Stress Medicine Group” appointment: a type of support group where the link between bodily symptoms and the mind can be made in a non-threatening group environment.⁵

Family physicians in this study engaged in quality communication with their MUS patients. Some patients thought their participation in the MUS service had changed their relationship with their doctor. The literature does note that despite trusting their family doctors, patients were hesitant to talk to them about their symptoms, and this is supported by a comment from one of the patients who said “[*d*]espite my doctor’s open and empathetic manner, I had previously felt uncomfortable opening up to anyone, even my trusted family doctor” (Patient ID # 42). It may be the case that the MUS service has addressed these concerns by providing longer appointments to explore mind-body symptoms, or by providing physicians with the tools to think beyond medical investigations and treatment. This would be an interesting area for further research.

This paper had a relatively low survey response rate. However, its purpose was not to seek generalizability, but to explore in rich detail the experiences of patients referred to the MUS service. This approach is supported by qualitative research methodology in general [25], and the so-called “n of 1” studies in the health sciences that “starts out small and focused, and then works its way towards insights that would immediately benefit a much larger group of patients by combining n-of-1 trial outcomes” [26]. A strength of this study is the mixed-methods approach. Combining the use of validated scales with open-ended qualitative survey questions allows for a triangulation of the data to arrive at a fuller and richer explanation of the research questions. This seems to be supported by the results of this study, in that the IAS and PHCPCS scales could quantitatively support the qualitative statements of participants.

This paper has re-emphasized the central role of the primary care physician in the care of the MUS patient. It has found that family physicians utilize high-quality, non-negative communication skills with MUS patients. Having the MUS service embedded within an existing family practice office builds on the

existing relationships family physicians have with their patients through accessible, non-judgmental access to the service [18]. It has confirmed earlier findings [1] that the use of ISTDP is effective in treating MUS. One benefit of the project and the service is that it helps increase hope and reduce patients from thinking that MUS is “just something you’re going to have to deal with” [27].

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