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PATIENT CENTERED APPROACH IN THE MANAGEMENT OF MEDICALLY UNEXPLAINED SYMPTOMS IN PRIMARY CARE SETTING

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ABSTRACT

The management of medically unexplained symptoms (MUS) can be very daunting and frustrating in a primary care setting. The purpose of our writing is to review and come up with up to date published evidence that will guide family physicians and other primary care physicians working in a culturally diverse and challenging environment, in the care and treatment of MUS.

We therefore searched for literatures on the care and treatment of MUS as it relates to primary care. We have organised this paper in a manner that the primary care physician can understand based on the relevance to primary care.

We have also written a description of the existing gaps based on the literatures reviewed and the clinical experience of the authors.

We concluded the review by summarizing what needs to be done by the primary care physician in order to develop a personalized approach to the management of MUS in the primary care setting.

INTRODUCTION

Authors have tried to describe the economic impact, classification and quantification of patients with MUS and even the role of the primary care physician in the management of MUS.^{1,2} The syndrome which commonly present to clinicians without discernable and or measurable concrete symptoms include Chronic back ache, irritable bowel syndrome, whiplash syndrome, chronic fatigue syndrome, post viral syndrome, chronic stress headache, chronic muscle pain e.t.c.^{1,2,3,4}

Medically unexplained symptoms or syndromes can be described as the physical symptoms which cannot be explained by any specific disease entity or biomedical pathology. The symptoms can be persisting leading to significant distress and impaired functioning.^{2,5,6,7}

Other descriptions of MUS include:

1. Persons presenting with persistent bodily complaints in which adequate examinations have failed to reveal sufficient explanatory structural or other pathological problem.
2. Persons having physical symptoms which cannot be explained by any organic pathology but yet having distress or impaired functioning of the patient.
3. Person or persons who have had adequate and appropriate assessment and testing without any finding to explain the unexplained symptoms being manifested.

Family Physicians and other primary care physicians are quite familiar with the clinically puzzling nature of MUS. Ten of the most common

problems which often present in primary care clinic consultation (abdominal pain, back pain, chest pain, dizziness, fatigue, headache, insomnia, numbness, swelling and shortness of breath) are responsible for about 40 per cent of all visits in such setting.⁴ However only about 26 per cent of these problems have identifiable biological cause.⁴

Other studies found worldwide, showed that between 25 per cent and 50 per cent of primary care patients have MUS. This makes MUS the most common category of complaints in primary care setting.³

Majority of the patients with MUS do not complete the process of referral to the mental health physician, hence the burden of caring for them usually fall on the family physicians and other primary care physicians who are often overwhelmed with the challenging nature of the care.⁴ The patients of such physicians are equally frustrated, concerned, disappointed and often not satisfied with the care and treatment provided by the physician.

There has been much debate as to what clinicians should call this complex syndrome of medical anomymities in the last decade. The reason for this much debate is the evidence suggesting that MUS exists on a continuum of increasing severity.⁴

Another description of MUS severity is the DSM – IV- TR that includes categories like somatisation disorder, conversion disorder and pain disorder.⁴ This classification lacks clarity, cumbersome, difficult to use and restrictive in its usefulness amongst primary care clinicians.^{4,7,8,9}

However a study amongst secondary care attenders

revealed that physicians were in agreement on the recognition of MUS as a medical syndrome entity.^{4,10} In another study family physicians demonstrated high level of accuracy in intuitive recognition of MUS without the aid of standardized assessment tool.^{4,10} Though the definition of MUS that satisfies every clinician remains obscure, doctors seem to recognise MUS when patients with MUS present to them.^{4,9,10}

Despite the identification of MUS on presentation some clinicians still advocate for a more precise way of identifying MUS.^{4,8,9,11} Others believe that specific classification of MUS may not solve the precision problem considering the ill – defined physical and psychological complaints presented by the affected clients in primary care.^{4,11,12}

We therefore discuss MUS as a social and clinical entity that includes a broad spectrum of manifestations leading to difficulty in accounting for symptoms based on pathology. This approach allows the primary care clinician avoid the challenging decision of choosing, either a psychological or pathological explanation for MUS; thus allowing a comprehensive, bio-psychosocial treatment which addresses both hypothesis concurrently.

Having an inclusive definition of MUS informed our literature search in order to recognise studies that relate to the care and treatment of MUS particularly in primary care setting. We therefore carried out literature search on the internet using the key words: medically unexplained symptoms, together with primary care or secondary care. We also identified possible studies from bibliographies.

FEATURES OF PATIENTS WITH MUS

Even though MUS present variously, they have certain features in common. In comparison with other chronic illnesses MUS clients have less quality of life, poorer perception of general health and mental health.^{4,12,13}

Conditions regulating affect like alexithymia have been connected to MUS. Alexithymia is a personality concept recognised by difficulties in identification of feelings and distinguishing between feelings and body sensations, having trouble describing emotional state and an externally focused cognitive style.⁴ This relationship however have not been well elucidated, since similar studies from different regions report variously on this relationship. Some reported strong association between MUS and alexithymia while others vary from weak association to no relationship at all.⁴

Disabilities associated with MUS include economic cost like taking more sick leaves, more unemployment rate and generation of higher healthcare cost due to increased laboratory costs and longer visits to clinicians in comparison to patients without MUS.^{4, 13-15} A study in England showed that entire summative cost of somatisation amongst working class adults together with health care use and disability was approximately 18 billion pounds per annum.⁴ Another qualitative study on high consuming primary care clients with MUS discovered three features and behaviours:^{4,15}

- a. The coping high utilizers achieve success in their life and have some degree of psychological insight. They neither focus on their symptoms nor manifest noticeable health anxiety and are not scared of being labelled with undiagnosed terminal illness; but want explanation for their illness experiences.
- b. The classic high utilizers persevere over their vague symptoms, show little psychological insight and or express strong prerogative to be excused from their social obligations.
- c. Worried high utilizers show high health anxiety and become angry, complaining about their health when they observe opposition to their expectations and demands.

Common with the three was the existence of current or past family dysfunction which was consistent with other studies that found a history of trauma and abuse in association with MUS.^{4,15,16}

RELATIONSHIP BETWEEN THE DOCTOR AND THE PATIENT IN THE TREATMENT OF MUS

The patient's physiognomies referred to previously will certainly impact on the clinician patient relationship. If clinicians are not able to provide a clear diagnosis for their patient's illness experiences, the patients feel discounted, misunderstood and even deceived.^{4,17,18}

A search through cultures globally revealed that patients receive utmost satisfaction when primary care clinicians are able to share their own understanding of patient's illness experiences and the treatment modalities available. Doctors like patients do also experience MUS as a very difficult and exasperating entity.^{4,17-19} The general practitioners exasperation is tied to certain negative emotions such as feelings of inadequacy, anger and dread of patients who are likely to manipulate the course of treatment.^{4,20} Although family physicians appreciate the importance of sufficiently explaining MUS to their clients but frequently feel inadequate to clearly do so or simply think that they have little power to

influence their clients' understanding of their illness experience.^{4,20-22}

Family Physicians in a study reassure patients, that there is no disease using metaphors in an attempt to make the symptoms normal life experience.⁴ Another study of MUS clients revealed that reassurance and normalization like suggesting that negative test results means nothing was wrong and this was the most given explanation for MUS and MUS clients view this as rejection of their symptoms.⁴ Physicians and patients have frustrations due to misapprehension and poor communication.²¹⁻²⁵ The MUS clients requires more passionate support from their primary care physicians when compared with other patients and as a matter of fact do willingly discuss their psychosomatic or spiritual symptoms with their primary care family physician when asked to do so.^{4,26-27} One study on patients consulting general practitioners, discovered that patients clearly stated their need for emotional support, but were less direct about their need for explanation and were protective on their need for physical intervention.²⁶⁻²⁸ Some clinicians that concentrate mainly on physical symptoms relief do not recognise the need for emotional support.^{4,24,28} Another study showed that doctors that encounter clients with MUS do demonstrate less patient centred – communication behaviours. This was reflected in their response to their client's expressed concerns when compared with clients who had straight forward symptoms, though the MUS visits were longer.^{4,29-30} It has also been noted that physicians do not explore or validate the psychosocial concerns when compared with patients who has straightforward symptoms.³⁰ Show of sympathy and validation by primary care physicians to the patients was associated with higher patient ratings of interpersonal care, when there is ambiguity in the way the patient presented.^{4,29-30} The implication of the above findings from various studies clearly demonstrate the need for primary care physicians to acquaint themselves with these findings in order to provide optimum care for their clients with MUS.

TREATMENT OF MUS IN PRIMARY CARE SETTING

General practitioners want MUS clients managed in primary care setting but remarked that there were inadequate and effective strategies within this setting to manage such complex ill-defined clients' condition.⁴ Their concerns stems from the fact that treatment guidelines for MUS are few and not readily available at primary care centres. There are also very few studies on MUS care in primary care settings, since practically all the studies carried out

on MUS were conducted in secondary care settings. Instead of overlooking the secondary care writings, the full collection of MUS treatment publications in the medical literature was reviewed trying to answer the following questions in the process:

A. What information in the primary, secondary and tertiary care MUS medical publications will be useful for the primary care physicians? Literatures from primary, secondary and tertiary care studies showed repeatedly that antidepressant medicine, cognitive behavioural therapy, hypnotherapy (CBT) and other non-specific interventions like reattribution were effective in the treatment of clients with MUS.^{4,31-32} Other findings included the fact that most patients studied had accepted referral for mental health treatment whereas the number that did not accept referral were not reported in the various publications reviewed. The criteria for somatoform disorders formerly hypochondriasis, were not in all cases distinguished from others classified as MUS.

The few randomised controlled trials, based in primary care setting showed that multidimensional treatment modalities that included CBT, use of pharmacological agents and client centred management improves depression, leads to higher satisfaction, an increased antidepressant use but decreased use of addictive substances.^{18,33} One follow up study showed that the multidimensional treatment modality could also be cost effective.³⁴ The interventions which shall be described below include different evidence based designs which can be integrated into a treatment package for clients with MUS.

DEPLOYING PATIENT CENTRED CARE INTO THE TREATMENT

From the above literature reviews it is obvious that physicians will benefit more by strengthening physician – client relationship through careful listening to the patient's complaints, authenticating the various concerns of the client by direct affirmation that the symptoms presented were real, discovering signals about emotional concerns and responding appropriately to the emotions. Thus when a client gives an emotional or psychosomatic cue/directly articulates an emotion, the physician then treats the emotion by mentioning it, appreciating it, respecting it and being supportive.³⁵ Clinicians should also provide flawless explanations tying emotional and physical processes. It is more beneficial to view symptoms as both somatic and emotional and not as separate entity.⁴ Physicians commonly explain MUS by reassurance and normalisation for example saying to the client "There is nothing wrong with you, all the tests are normal"

Thus psychological factor becomes the last diagnosis considered.^{36,37} Though well intended, reassurance and normalisation with unclear explanation has been shown to be ineffective and may actually exacerbate the symptoms.

INTERVENTION IN THE FORM OF ASSESSMENT

Some client's clinical evaluation can in itself have therapeutic outcome and thus lead to modification of the patient's illness experience and their conviction about the illness which is consistent with patient care.³ Reassuring listening alone have been shown to help the client feel understood and play an important role in patient care. Putting it together, a good initial assessment can help the client create clearer description and gain broader understanding of their pain and fear.^{38,39}

To sum it up, a comprehensive client interview and brief emotional tests like (PRIME MD – comprehensive patient depression check questionnaire) help form a good valuation. The PPP (predisposing, precipitating and perpetuating factors) model is a good example of an intervention in the form of assessment.^{40,41} This model considers three factors that could start or sustain the process of MUS -

- i. Predisposing factors that include chronic childhood illnesses, childhood maltreatment, chronic social stress and low social support.
- ii. Precipitating factors that include psychiatric disorder, social, fiscal, or occupational stress, changes in social support and change in routine.
- iii. Perpetuating factors that include decreased activity and weight gain, social isolation and decreased self-confidence.

One good approach to using the PPP model is to aim at limiting the damage of perpetuating factors, avoiding new precipitating factors and decreasing the power of predisposing factors.

Reattribution:

This is a client – centred, yet structured approach designed to provide clients with explanation thus linking their physical symptoms to psychosocial issues. The primary goal of this approach is to alter unhelpful client attributions for symptoms so as to broaden client attributions.⁴² There are four stages of reattribution that exists:

1. Stage of empowering the patient to feel understood
2. The stage of broadening the agenda beyond physical symptoms
3. The stage of making the link with psychosocial issues and
4. The stage of negotiating further treatment.

One study on the experiences of clients with reattribution showed that it was important that the patient felt understood and also wanted to be assured of continuity of care. The desire for continuity of care gives the general practitioner and the client with MUS time to understand the complexity of the problem over successive consultations.⁴² The study also revealed that talking to clients plainly, paying attention to psychosocial issues does not negate the need to also recognise the presence of physical disease. Family Physicians trained on reattribution have demonstrated that reattribution helps to positively change their views about clients with MUS.⁴³ Despite the above findings some family physicians trained in reattribution still find clients with MUS complex and difficult to treat.^{44,45} Clients with MUS favourably view reattribution, though this treatment modality was not more effective than other usual treatment.⁴⁵

USE OF DRUGS IN THE TREATMENT OF MUS

Antidepressants have proved beneficial for the following cases of MUS – clients with dysthymia, major depression and mood symptoms yet to reach the threshold for co-morbid mood disorder. Antidepressants also benefit MUS clients with major depression.⁴⁶⁻⁵¹ Antidepressant effect in the last case is basically two – independent improvement in the related anxiety symptoms and improvement in the severity of pain; however the effect on other somatic symptoms are usually less. This stresses the importance of using screening tools and completing mental state examination (MSE) in all cases of MUS and helps to identify underlying depression and anxiety.⁵ The quick and easy approach to MSE is the look, listen and test (LLT) chart.⁵² This applies observation and communication skills which family physicians already have thus enabling them to develop a formulation through observation of the client's behaviour and activities. The moment the client enters the consultation room, by listening to and assessing the content of the speech, recognition of fundamental themes of despair, disquiet or paranoia are made. Such recognition also occurs when testing for severity through questionnaires for assessment of mood and anxiety disorders. As soon as depression is diagnosed the family physician will then prescribe the normal dose of selective serotonin reuptake inhibitors (SSRIs) or Tricyclic antidepressants (TCAs) accessible within their practice area. Clients with MUS and mood disorder symptoms yet to reach threshold for formal depressive disorder also benefit from lower doses of SSRIs or other anti-depressants. When low dose antidepressants are used, symptoms of insomnia and pain are the target.⁵⁵ Primary care physicians should

mental health related care.³⁵ Similarly clients with MUS are frequently well suited to such collaborative care arrangement due to the high occurrence of depression, anxiety and psychosocial problems amongst them.^{26,35} Studies carried out on collaborative health care with respect to MUS have been very favourable. A simple do and don't psychiatrists' lists when used showed improved client's physical functioning and decreased medical costs for the following year.^{4,75} Such lists helps family physician's understanding of somatisation disorder and the chronic relapsing nature. It also encouraged them to avoid telling the client with MUS that it was all in your head. Planned regular visits of 4 to 6 weeks and to focused physical examination at each of the visits was also useful.

Collaborative care for high – utilising clients with MUS by specially trained nurses led to improvement when the nurse practitioners (NP) used the stepped care method that included 12, twenty – minutes appointments within one year (inclusive of phone contacts) and provided anti-depressants, reduction/elimination of substance abuse and ineffective narcotics, exercise, relaxation training, physical therapy and management of organic disease.

Another research showed that, a onetime, one – hour reflecting interview conducted by a mental health physician, a primary care physician and the patient led to reduction in health care costs. Contents of the reflecting interview included – curiosity about symptoms and emphatic listening; opportunities to reinterpret the symptoms and decision – making process; and the construction of a family genogram to identify maladaptive relationship patterns.

THINKING ABOUT THE FAMILY IN THE TREATMENT OF MUS

Just like majority of health problems, family members are not only involved, but are affected when member has MUS. The family members also in turn exert their own effect on their member who has MUS. Though there is paucity of data on MUS effect on family relationships as well as family relationship effect on health of the family. The available data shows that adult clients with somatisation complaint reported significantly greater numbers of family conflict and significant lower levels of family cohesion, characterised by recurrent quarrels, emotional detachment and reduced support.^{4,72-75} Conflict and detachment perhaps are in a demand – withdraw interactional configuration; thus client's attention – seeking behaviour is associated with partner withdrawal.²¹

Often the family blame their ill member for faking symptoms, suggesting that the person is weak resulting in disaffection and tension within the family. Education on the link between psychological and physical processes helps family members to better understand MUS client MUS, thus reducing misunderstanding and conflicts in the family.²¹ A good interaction between the clinician and the family members lead to patient satisfaction and improvement in symptoms and is therefore mutually beneficial.²³

Even when family involvement is practically ruled out, enquiring about the family in the course of treating the client is still beneficial especially in non-western countries where more value is placed on the family of the client.

WHAT ABOUT THE CULTURE OF THE CLIENTS WITH MUS

To manage MUS comprehensively the physician must consider the cultural background of the client being treated. Though this document does not have full discussion on culture as part of its scope of work; it has to be acknowledged that the particular culture that the client and family members come from does link social conditions like social conflict with physical symptoms.^{4,7}

To understand cultural context of MUS one has to use illness narratives. Illness narrative can be referred to as a form of storytelling that links physical symptoms with the psychosomatic, societal or cultural background of the patient.⁴ The narratives vary with different cultures.⁴ An example is the West Indians where the Caribbean immigrants attribute their illness experience of MUS to chronic work overload and irregularity of their daily living wage. They cite symptoms like gas, dizziness, fatigue, joint pain and muscle tension as the manifestations of such illness experience,⁴ while those from Korea explain illness experience of MUS as hwa-byung (a syndrome of somatic and depressive symptoms in the Korean language) resulting from repressed wrath or temper.⁴ The clarity of clients illness narrative goes to an extent to tell whether or not the client will develop MUS after trauma experience.⁴ When one finds him/herself in a culturally diverse society eliciting the illness narratives will help the clinician to understand why different clients presenting with different group of symptoms.

The rule is to be open minded and keep eliciting new illness narratives; since conventional western societies that are culturally diverse have not given sufficient understanding of anxiety and mood disorders emanating from such diversity to help the

clinician communicate effectively with the families and clients who present to us with MUS.

WHAT ABOUT THE GAPS FOUND IN THE LITERATURE

Several physicians struggle with application of lessons from empirical literature to their individual clients. Detailed interpersonal care for MUS may challenge one's documentation capacity. Reattribution is promising, however sustained interest and a knowledgeable mentor is required to develop skills linking psychosocial issues with symptoms in an individual.

Furthermore there is paucity of data to address common clinical dilemma with MUS and multiple vegetative symptoms of depression. Again it is difficult to apply findings in the literature to the full range of clients with MUS, since most of the studies compare usual care with treatment provided for clients who accepted referral to the mental health service centres. This set of clients is a small subset of the entire MUS population; hence cannot be representative of the entire MUS community.³¹ In addition, the study that compared CBT with structured care showed no difference in outcomes.³¹ Complexities resulting from variation in definition of CBT as practiced in different centres have increased.⁴

Several key aspects of MUS have not been properly represented in the literature; for example features of MUS clients who will likely respond to CBT, other treatments and those who will not respond have not been well-defined. Also information about long term outcomes are lacking in most of the literatures reviewed. While the relationship between MUS and adverse childhood experience is usually highlighted and published, the diagnostic and therapeutic value of disclosing the history in individuals are not published.

Another case is that of post-traumatic stress disorder, a common condition with lifetime prevalence of 5 – 10%, however its presentation with somatic principal complaint is frequently not stated in published research work about MUS.^{4,73-75} Though our expectation is that the bio-psychosocial model will remain the fundamental approach to the management of MUS, however further studies are needed to expand our understanding of how biological and behavioural factors interact and the outcome of such interaction.

CONCLUSION

To conclude on this paper it is clear that there is no single approach that can effectively treat all clients

with MUS in the primary care setting. The MUS clients described as chronic high-utilising clients need the type of care that is both client – centred and will pay attention to their bio-psychosocial needs as well.

In order to lay a good foundation for treatment of MUS clients, careful evaluation of the family and cultural issues, psychological concerns, presence or absence of dysfunctional childhood, symptoms of depression and anxiety; and the possibility of a post-traumatic stress disorder should be carried out and the most appropriate treatment made clear.

Antidepressants have been shown to be beneficial in the primary care setting for those MUS clients who manifest with MUS alongside depression. In such clients a full dose of antidepressants should be prescribed whereas those who do not meet the criteria for depression but complain of sleeplessness and ache could respond to treatment with low dose antidepressant treatment. Benzodiazepines are rarely beneficial to MUS.

Compared with organic medical conditions, it becomes a herculean task for the primary care physicians to help clients with MUS considering the fact that a lot of patience and empathic communication is needed to carry the clients along and proffer possible solution for their illness experience.

There are manifold approaches and fundamentals within these approaches available for use, the terrain however is unfamiliar and less explored when compared with organic medical conditions. It is therefore critical that each physician should take the necessary time to develop one's own clinical approach from among the various approaches available.

This way one can contribute to the welfare of the clients suffering from MUS, their family and contribute also to the primary care physicians own personal and professional growth.

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