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Explaining the unexplainable

Crafting explanatory frameworks for medically unexplained symptoms

Background

Patients with multiple medically unexplained symptoms are common in general practice. Comorbid depression, anxiety, substance abuse and significant psychosocial stressors are common. It can be challenging to find a balance between excluding and treating organic causes and overinvestigating and overtreating.

Objective

This article provides the general practitioner with a suggested framework for explaining multiple medically unexplained symptoms to patients.

Discussion

An adequate explanation of the problem is important. General practitioners can use a number of explanatory models, including reassurance, somatisation and narrative techniques. Sometimes a solution to a specific problem is available and may involve referral to other health professionals. In many cases the more important management strategy may be to provide supportive care by being with the sufferer and acknowledging the suffering, without succumbing to the urge to fix the problem. General practitioners have a unique role in supporting patients who cope with symptoms, but without a clear medical diagnosis.

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agreement around the best diagnostic framework for this group of patients.⁴⁻¹⁰ In addition, existing diagnostic categories for medically unexplained symptoms tend to overlap, and comorbidity with other physical and psychiatric disorders is also common.

Diagnostic frameworks

Diagnostic frameworks that have been used in patients with MMUS are outlined in *Table 1*. They include diagnoses that are focused on symptom count (the 'somatoform' disorders) or particular bodily systems (the 'functional' disorders) as well as diagnoses that incorporate affective, cognitive and behavioural elements. The symptom count approach has been criticised for encouraging dualistic thinking. Symptoms in this framework can be seen as either organic (and therefore 'medically explained') or psychological (and therefore 'medically unexplained').¹¹ This dualism does not do justice to the complex interplay of psychological, social, genetic, cognitive and biological factors that characterise symptoms.¹² It is also helpful to see MMUS within a cultural context. For instance, 'somatisation' behaviour, or 'the tendency to experience and communicate somatic distress in response to psychosocial stress'¹³ is seen as 'disordered' in Western psychiatry but is a culturally expected and sanctioned response to stress in some communities.^{14,15}

Epidemiology

It is difficult to estimate prevalence without consistent diagnostic frameworks, however overseas data suggests somatisation is present in 20% of general practice attendees.^{16,17} A recent study by Clarke et al¹⁸ collected self reported

● 'Nobody wants an anonymous illness'¹

Medically unexplained symptoms are defined as 'those symptoms having little or no basis in underlying organic disease (or) when organic disease exists, the symptoms are inconsistent with it or out of proportion to it'.²

Patients with multiple medically unexplained symptoms (MMUS) are common in general practice and can be difficult to manage.³ Part of this difficulty lies in the lack of understanding or

Table 1. Some current and proposed diagnoses for medically unexplained symptoms**Diagnoses based on symptom count****Somatisation disorder (DSM-IV Axis 1)**

A chronic and severe form of somatoform disorder where the patient seeks medical attention for many physical symptoms with no evidence of organic pathology. DSM-IV requires a minimum of eight symptoms (pain in four sites: two gastrointestinal symptoms, one sexual or reproductive symptom and one neurological symptom) and the pattern beginning before the age of 30 years. Less severe forms are also described (eg. multisomatoform disorder requires three or more symptoms for more than 2 years)

Functional disorders**Functional somatic disorders (DSM-IV Axis III)**

These disorders are a heterogeneous group of syndromes that do not have a known cause. They include irritable bowel syndrome, fibromyalgia and multiple chemical hypersensitivity. These syndromes often overlap with each other, and with the somatoform disorders in Axis I. They share similar diagnostic criteria, aetiology, neurobiology, psychological mechanisms, patient characteristics and treatment response. This has led researchers to conclude that they share a common core with different subtypes. They also overlap with the somatoform disorders in Axis I. In DSM IV, they are coded under Axis III as general medical conditions^{67,68}

Diagnoses incorporating cognitive, behavioural and affective elements**Hypochondriasis (DSM-IV Axis I)**

A preoccupation with fear of having a serious disease. The preoccupation must last at least 6 months, persisting despite appropriate medical evaluation and reassurance. Some authors have proposed that hypochondriasis be reclassified as 'health anxiety disorder' in DSM-V⁶⁷

Complex somatic symptom disorder (proposed for DSM-V Axis I)⁶⁹

One or more somatic symptoms that are distressing and/or result in significant disruption in daily life. The patient must be symptomatic for at least 6 months, and have 'excessive thoughts, feelings and behaviours related to these symptoms'. These symptoms must include two of the following:

- a high level of health related anxiety
- disproportionate and persistent concerns about the seriousness of the symptoms
- excessive time and energy devoted to these symptoms or concerns.

DSM-V proposes three subtypes, for patients with predominant somatic complaints, predominant anxiety and predominant pain

questionnaires from 10 507 patients attending 340 Australian general practitioners to determine the prevalence of somatisation. For the purposes of the study, somatisation was defined by the presence of multiple physical symptoms and hypochondriasis, and the prevalence in this context was 18.5%.

Impact and associations

Many patients with MMUS are significantly unwell, and require complex chronic care. Many have high morbidity,^{19–21} make frequent use of health services²² and suffer from functional limitations, including unemployment.^{23–24} There is high comorbidity both with medical and psychiatric disorders, particularly anxiety and depression,^{16,25–27} personality disorders²⁸ and

substance misuse.²⁹ Most are women³⁰ and many are victims of childhood trauma.³¹ The relationships between these patients and their doctors tend to be fraught with difficulties.^{25,32–34} Doctors may use pejorative terms to describe these patients, and some of these terms are incorporated within the Diagnostic and Statistical Manual of Mental Disorders (DSM), eg. 'doctor shopping', 'inconsistent historians' and patients who use 'colourful exaggerated terms'.³⁵ In general practice, these patients may be described as 'heartsink',^{36,37} 'difficult' or 'hateful'.³⁸

The diagnostic phase

The process of diagnosis for patients with MMUS can be slow and frustrating for both patient and doctor. Symptoms are often presented individually,

so it takes several consultations before the GP can identify that the patient is a 'frequent attender' with symptoms out of proportion to any organic pathology. Patients may be on a quest to find a biomedical cause for their symptoms and doctors can become anxious about missing a medical diagnosis. It can therefore be challenging to find an appropriate balance between excluding and treating organic causes and causing iatrogenic harm through overinvestigation and overtreatment.^{39–42}

One strategy for managing the diagnostic phase in these patients is to set aside time for a longer consultation to complete a full health assessment. This can help avoid getting caught up managing each symptom individually and allows the GP to look at the patient more holistically. During this assessment, take the opportunity to establish an empathetic alliance with the patient that broadens the clinical agenda beyond the biomedical. It is important to validate the patient's suffering and not simply reject it because we are unable to provide a biomedical explanation. Areas to cover in a full health assessment of these patients include:

- excluding rare biomedical syndromes, especially Murtagh's 'serious disorders not to be missed'⁴³
- assessing for psychiatric disorders such as anxiety or depression and psychosocial stressors such as occupational issues, caring responsibilities, interpersonal trauma, financial concerns and grief
- detecting substance abuse and other damaging behaviours
- addressing developmental concerns, such as childhood trauma
- completing a family history, including psychiatric and medical illnesses
- looking at belief systems and illness behaviours, including fears and past experiences.

The management phase

An important aspect of management involves explaining the problem. But how can you craft a 'good' explanation without a diagnosis? Patients often seek legitimacy for their problems through an appropriate diagnosis.^{44–47} However, perceived blame and stigma can exacerbate somatisation behavior,¹⁴ leading some writers to talk about the

iatrogenic potential of the consultation itself.^{32,48–50} Use of explanations that create common ground can help patients to achieve better outcomes.^{51–55}

Finding common ground avoids allowing consultations to become a contest of power^{56–58} with doctors trying to normalise symptoms and patients trying to legitimise them.^{32,59,60} Salmon describes this process using the colourful metaphor of a medieval siege: ‘each party seeks to pull the consultation into the territory in which they can get a firm foothold in their own area of authority – their own suffering for the patient and their privileged view inside the patient’s body for the (doctor)’.³²

There are several alternatives for explaining MMUS to patients.

Reassurance: ‘I have looked carefully, and there seems to be nothing of concern’

For mild and transient symptoms, reassurance that there is nothing seriously wrong may be all that is needed. However, patients know their own experience and in some cases telling them there is ‘nothing wrong’ can create cognitive dissonance. They may remain concerned that the doctor has not looked hard enough or does not know where to look.⁵⁵ For reassurance to be effective, the doctor has to clearly demonstrate that they have listened carefully and carried out an appropriate examination and/or investigations.

To craft a useful explanation using reassurance, it is helpful to start by first presenting information to indicate that you have appropriately examined the patient (‘I have listened to your heart’), and appropriately examined the symptom (‘and done an ECG’). Then express an understanding of the symptom (‘and while I cannot give you a definite reason for your chest pain’) before reassuring (‘there does not seem to be a serious problem with your heart’). The symptom can then be managed with ‘watchful waiting’ and appropriate safety netting if new symptoms arise.

Somatisation: ‘perhaps your body’s trying to tell you something’

The idea that psychological distress can cause symptoms is classically described in the context of conversion disorder.⁶¹ More broadly, somatisation is ‘the tendency to experience, conceptualise

and communicate mental states and distress as physical symptoms and altered body states’.⁶² In this way, somatisation emphasises the idea of mind body dualism: the mind ‘does things’ to the body. Using this splitting of psychological issues from bodily complaints to explain MMUS may actually exacerbate tensions around diagnosis: it is easy to get into a debate as to whether this is ‘all in the body’ or ‘all in the mind’. In Western cultures, things that are ‘in the mind’ are seen as less legitimate than ‘real’ diseases. Patients fear that a psychological diagnosis will mean the doctor will not take them seriously.^{57,58,64} Symptoms and causes that are ‘in the mind’ can be interpreted as imagined or reflecting a lack of ‘willpower’; patients can be seen to be responsible for their own suffering.⁵⁵

One way of approaching the problem is to discuss the role of ‘stress’, which can be psychological, social, environmental, existential and physical. In Western cultures, ‘stress’ is often accepted as a cause for illness, or at least of illness exacerbation. Discussing the role of ‘stress’ allows doctors and patients to construct an alliance against a number of external precipitants, avoiding perceived blame and shame and a dualistic view of human suffering.⁵⁵

The ‘functional’ approach: ‘your body is not working as well as it should’

The idea of functional disorders is that the body may appear normal, with no obvious disease, but may not function well. The advantage of this explanation is that techniques such as mindfulness, stress management and lifestyle interventions fit with this idea. It is possible to talk about ‘optimising function’ rather than investigating and treating disease.

Narrative and coping: ‘just one damned thing after another’

When people are sick, they interpret their symptoms according to available meanings (‘I’m just run-down’, ‘I have depression’). These meanings are usually culturally grounded, shaping diffuse symptoms into structured entities that have meaning in the patient’s sociocultural context. When illness interrupts a patient’s expected life story, there are cultural expectations around what should happen next. In Western

cultures, we have a preference for the ‘restitution narrative’ which fits with the biomedical model: ‘yesterday I was well, today I am sick and tomorrow I will be better again’.⁶⁵ Sickness is seen a temporary interruption to one’s life story, and we expect it to resolve with the remedies available to us. However, for the patient who is overwhelmed by psychological, social and physical trauma and suffering, this narrative may be unhelpful.

For some patients with MMUS, there may never be a simple remedy that restores wellness and symptoms and suffering will remain overwhelming and insoluble. For every problem solved, there is another, deeper problem to be addressed. These problems can range from childhood abuse and neglect, to social disadvantage, to the suffering associated with chronic illness and often they are a combination of all of these factors. It can be hard to listen to a story of insoluble suffering and to know how to respond. In this case, offering a restitution narrative is generally not helpful as it is not faithful to the patient’s experience.⁶⁶ One way of recrafting the story is to diagnose such patients with depression. Depression may, of course, be part of the story, but for these patients, it does not begin to describe their experience.

Sometimes a solution to a specific problem in these patients may be appropriate and it may be helpful to enlist the expertise and support of other health professionals. However, it is likely that the doctor and patient will experience the ‘perpetual interruption’ of chronic illness. The challenge for the GP is to respect the story: to be with the sufferer and acknowledge the suffering, without succumbing to the urge to fix the problem. This means providing supportive care, even when the problems are diffuse, ill defined and chronic. As GPs, we are uniquely placed to provide this care when cure and restitution is not possible.

Key points

- Patients with multiple medically unexplained symptoms are common in general practice.
- Many of these patients have comorbid depression, anxiety, substance abuse and significant psychosocial stressors, including a history of childhood trauma.
- It is important to find a balance between excluding and treating organic causes and

overinvestigating and overtreating.

- Explaining the problem is important and GPs can use a number of explanatory models, including reassurance, somatisation and narrative techniques.
- Sometimes a specific treatment may be appropriate but often the more important management strategy is to provide supportive care by being with the sufferer and acknowledging the suffering, without succumbing to the urge to fix the problem.

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