Diagnosing and Treating Patients with Medically Unexplained Symptoms

A Training Program for Primary Care Clinicians in Integrated Care

Presenters

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- Holly Cleney, MD, Managing Physician, Latham Medical Group

Disclosures

- Clarke – Book royalty for *They Can't Find Anything Wrong!* is donated to the Psychophysiologic Disorders Association

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Learning Objectives

- Identify the importance of diagnosis and treatment in primary care of MUS patient
- Understand how diagnosis and treatment of MUS patient in primary care supports the quadruple aim leading to improved physician-patient care, reduced physician stress, enhanced patient satisfaction, lower cost of care and improved outcomes.
- Describe key components of the diagnosis and treatment of MUS patients in primary care.

Bibliography / Reference

Barsky, A. J., Orav, E. J., & Bates, D. W. (2005). Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. Archives of General Psychiatry, 62, 903–910. http://dx.doi.org/10.1001/archpsyc.62.8 .903

Clarke, D. D. (2007). They can't find anything wrong! 7 keys to understanding, treating, and healing stress illness. Boulder, CO: Sentient Publications.

Clarke, D. D. (2016). Diagnosis and treatment of medically unexplained symptoms and chronic functional syndromes. Families, Systems, & Health, 34(4), 309.

Escobar, J. I., Gara, M. A., Diaz-Martinez, A. M., Interian, A., Warman, M., Allen, L. A., . . . Rodgers, D. (2007). Effectiveness of a time-limited cognitive behavior therapy type intervention among primary care patients with medically unexplained symptoms. Annals of Family Medicine, 5, 328–335. http://dx.doi.org/10.1370/afm.702

Weiland, A., Blankenstein, A. H., Van Saase, J. L., Van der Molen, H. T., Kosak, D., Vernhout, R. M., & Arends, L. R. (2016). Training Medical Specialists in Communication about Medically Unexplained Physical Symptoms: Patient Outcomes from a Randomized Controlled Trial. International Journal of Person Centered Medicine, 6(1), 50-60.

Agenda

- Medically Unexplained Symptoms: Overview
- Research Study Overview
- Methods: Patient Protocol
  - Discussion
  - Stress Evaluation
  - Treatment
- Take Homes

Medically Unexplained Symptoms Explained

Stress-Related Illness or Psychophysiologic Disorder (PPD)

- Illness caused by past or present psychosocial stress.
  - (Associated with altered neuroanatomy.)

Neuroanatomic Changes

- In Fibromyalgia
  - links from the Somatosensory Cortex to the Anterior Insula are increased and correlate with pain severity and degree of catastrophizing.

Kim J et al. The Somatosensory Link... in Fibromyalgia.
Arthr & Rheum, Jan 2015.

Francis Peabody, MD

(1881-1927)

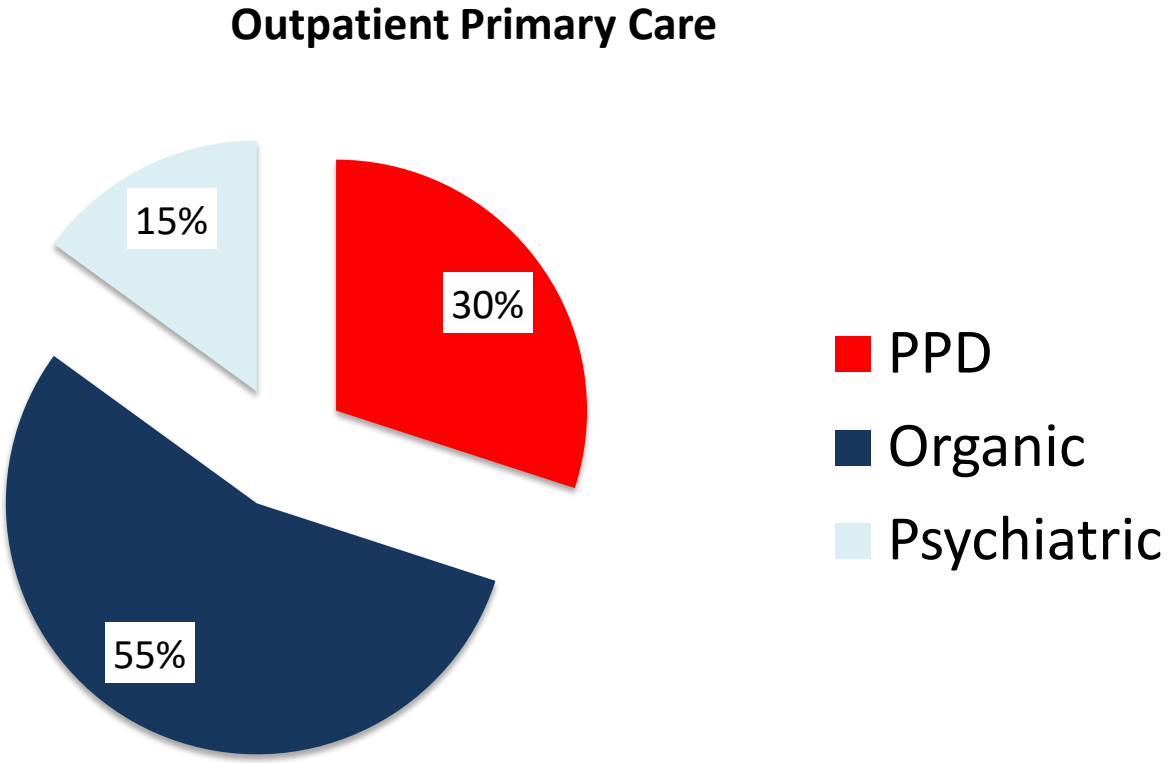
Harvard Medical School

"In all your patients whose symptoms are of functional origin, the whole problem of diagnosis and treatment depends on your insight into the patient's character and personal life."

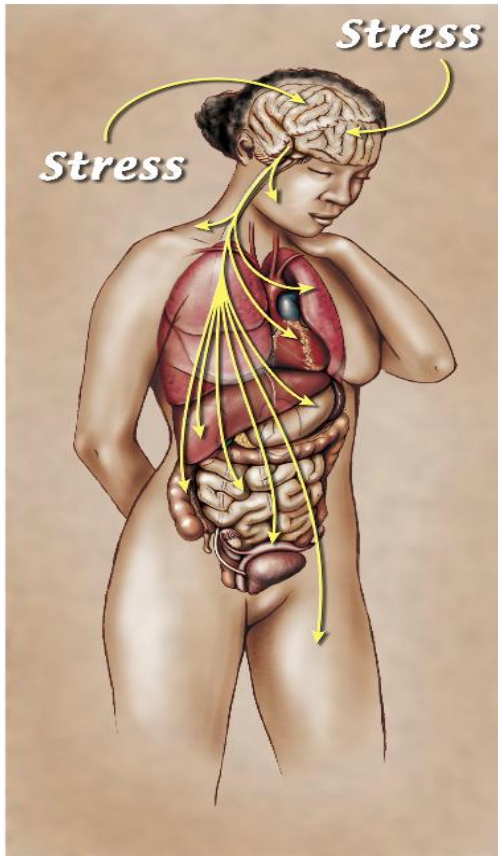
•*JAMA. (1927). Care of the Patient. 88: 877-882.*

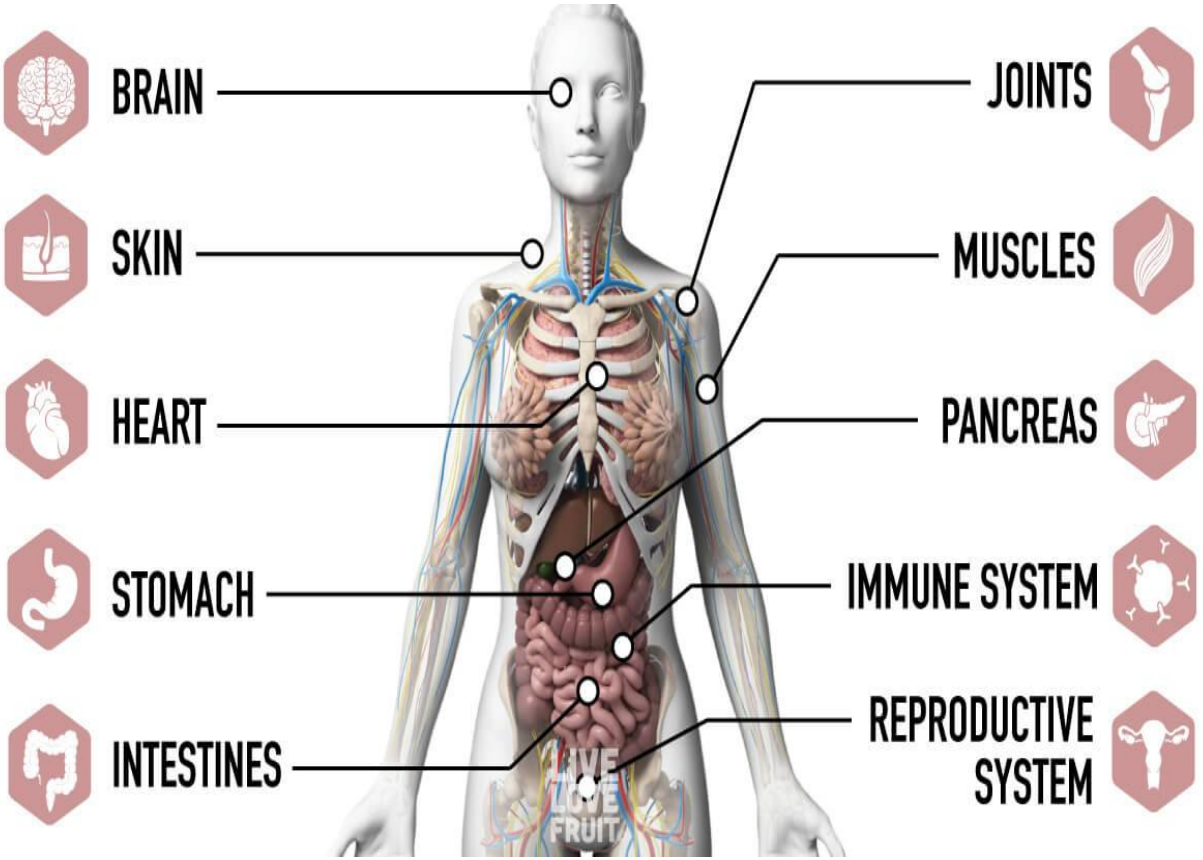
Cause of Presenting Symptoms

Landa, Psychosomatic Medicine, 2012.



A Wide Range of Presentations





PCP Stress: Treating MUS Patients

- Dread over seeing certain patients in one's schedule
- Unproductive visits
- Long visits with multiple physical complaints
- Frustrated and exhausted after these visits
  - not getting to the root of the problem
  - minimal improvement
- Unnecessary testing by specialists with negative findings

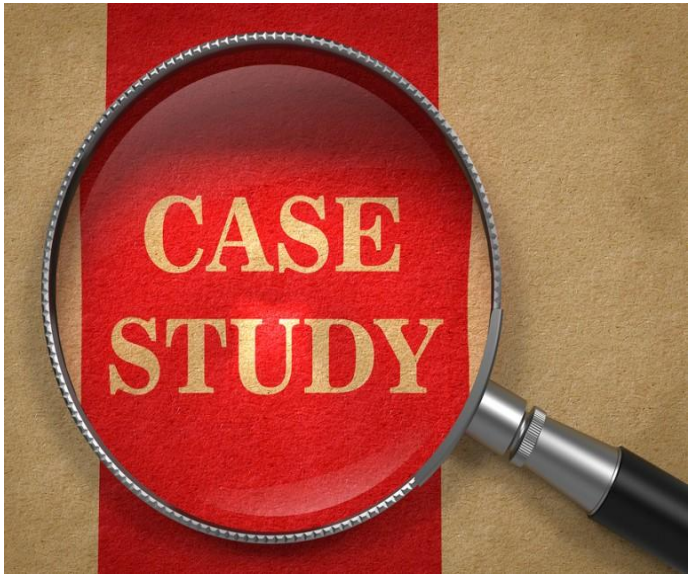
Problem: MUS and Primary Care

- MUS patients prevalent >30%
  - Hard to treat
  - “heartsink” patients
- Creates stress for PCPs

  - How do we treat these patient more effectively?
  - What can we do in primary care to better discuss stress illness, diagnose and treat patients with stress illness?

Case Study: Study Origin

- Dannie
  - Diagnosis's, presenting problems
  - Referral to BH
  - Treatment
  - Results
    - Beginning of MUS Study



Solution: What? Pilot Research Study

PHYSICIANS IN PRIMARY CARE AND THEIR PATIENTS

Study Overview: Training for PCPs

- Developed and led by BHC
  - Material developed primarily from Dr. Clarkes work
  - Leveraging teams in new ways

- Format:
  - Six 30 minute experiential, interactive face-to-face group trainings
  - 6 online training modules
    - Delivered via Coursesite (BB site)
  - Hallway conversations
  - BHC/ PCP co-visits

Research Question #1

Will a 3-hour training enhanced by 6 online didactic and interactive modules on the diagnosis and treatment of patients with medically unexplained symptoms for primary care providers (PCPs) decrease PCP stressors in treating MUS patients?

Measured Pre-Post: PCP Stress

Evidence-based measure: Primary Care Provider-Stress Checklist Adapted (PCP-SC Adapted)

- **Domains**
  - **Interactions with patients- 8 items**
  - **Practice management- 2 items**
    - Time in schedule
  - **Education/Learning- 1 item**
    - Learning new procedures of treatment modalities

**added items -Robinson, P.J., Gould, D. A., & Strosahl, K.D. (2011)

Conferen
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Primary Care Provider Stress Checklist- Adapted (PCP-SC- Adapted)

NAME:_____Date: _____Years in practice: _____

Below you will find a list of specific situations that may cause stress for people who work in medical settings. Please rate the extent to which each of the situations is stressful for you *at this moment in time*. Use the scale below to choose your response. For example, if you believe a situation is highly stressful for you "Highly Stressful," you would record a 5 in the Response column and if it is "Not Stressful" for you, you would record a 0.

Specifically in referring to "stressful" consider "why" to be filed in at the end of the items.

0	1	2	3	4	5	6
Not Stressful	Very Mild Stress	Mild Stress	Moderate Stress	Greater than Moderate	Highly Stressful	Extremely Stressful

I. INTERACTIONS WITH PATIENTS	
Response	Stressful Situation
	1. Patients who don't manage their chronic diseases
	3. Patients who complain of chronic pain
	4. Patients who are angry and demanding.
	5. Patients complaining of depression, anxiety and other common psychological problems.
	6. Patients with physical, behavioral, or emotional problems stemming from PTSD
	7.Patients who have unhealthy lifestyles (overeat, under-exercise, over-work)
	8. Patients who are non-adherent to medical advice
	9. Patients with medically unexplained symptoms
	Total (Sum of 1-7)
II. PRACTICE MANAGEMENT	
Response	Stressful Situation
	10. My schedule is too tight to address more than one or two problems
	12. Not enough time to address multiple medical and mental health problems in complex patients
	Total (Sum of 8-13)
IV. EDUCATION / LEARNING	
Response	Stressful Situation
	13. Learning new procedures or treatment modalities

Self-Reflection: **Why** are these situations stressful?

Results
Training Impact on PCP Stress

- **Research Question:**
  - Will a 3-hour training enhanced by 6 online didactic and interactive modules on the diagnosis and treatment of patients with medically unexplained symptoms for primary care providers (PCPs) decrease PCP stressors in treating MUS patients?

- **Results:**
  - Paired Sample T-Test results were significant $t(7) = 4.58$, $p = .004$.

- **Results indicate:**
  - PCPs stress in treating patients with MUS (PCP-SC Adapted), significantly decreased by an average of 1.0 point as a result of training.

Table 1: Descriptive Statistics of Study Outcome Variables

	Pretest		Posttest	
Variable	M	SD	M	SD
PCP-SC-Adapted MUS	3.29	0.755	2.29	0.359

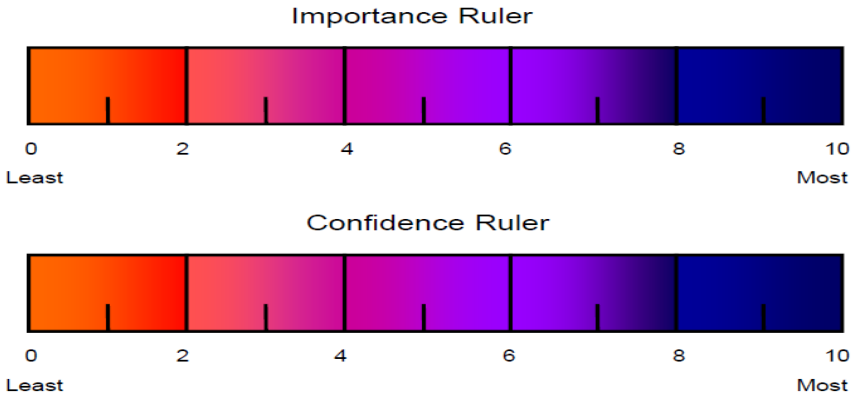
*Note: PCP-SC-Adapted *n* =10

Research Question #2

Will a 3-hour training enhanced by 6 online didactic and interactive modules on the diagnosis and treatment of medically unexplained symptoms for primary care providers (PCPs) increase the importance of and confidence in diagnosing and treating MUS patients in primary care?

MUS Primary Care Provider Importance and Confidence Scale (MUS-PCPICS)

- How important is it for you to:
  - Discuss Stress Illness with your patients
  - Diagnose Stress Illness in your patients
  - Treat the Stress Illness of your patients



Results: Increase Importance and Confidence

- **Research question:**
  - Will a 3-hour training enhanced by 6 online didactic and interactive modules on the diagnosis and treatment of medically unexplained symptoms for primary care providers (PCPs) increase the importance of and confidence in diagnosing and treating MUS patients in primary care?

- **Results:**
  - Paired sample T-Test results were statistically significant in all 6 domains (statistics available upon request).

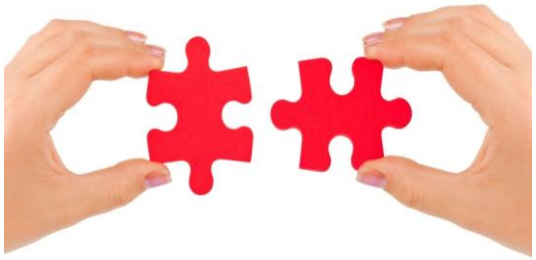
- **Results indicate:**
  - PCPs perception of the importance of and their confidence in diagnosing and treating patients with medically unexplained symptoms (MUS-PCP-ICS)*, significantly increased by an average of 4.25 points.

*instrument not validated

Results

Importance of discussing MUS	Statistically significant results
Importance of diagnosing MUS	Statistically significant results
Importance of Treating MUS	Statistically significant results
Confidence in discussing MUS	Statistically significant results
Confidence in diagnosing MUS	Statistically significant results
Confidence in treating MUS	Statistically significant results

Discussion



- Training achievable in PC
  - PCPs can learn how to do this in limited time frames
  - Treatment in steps-don't have to do everything in 1 visit
- Paves way for further study
- Heightens value for integrated care and model
- Illustrates recognizing Stress Illness is important and more prevalent than anticipated
- Conceptualizes the marriage of medical/ psychosocial treatment modalities which are the foundation of integrated care.

How? Study Training Program

WHAT WE DID, LEARNED, AND HOW WE CONTINUE TO IMPROVE

Identify Patients

Physician Identification of MUS

- Create how to systematic way to identify
  - Most get a sense of patient with MUS
    - List of complaints
    - Frequent flyers
    - Multiple specialists
    - Additional testing
    - Non responders
    - SE
    - Years and years of counseling with no visible results
    - No change in condition year after year
- Sometimes it takes time to identify/ manifest

Now What?

- Before
  - I can identify these patients but…
  - I didn't go there with them because I was not sure what I could actually do for them other than refer…
    - "What I could do??"

Discussion

Discussion: Dr. Clarke

- Explain Stress Illness to patient
  - As early as possible discuss the effect of Stress on the brain as a possible cause of symptoms.
    - Stress alters CNS pain-processing circuits
  - Use analogies
    - “knot” in the abdomen when tense
  - Stress-related pain is real & not self-inflicted
  - Effective treatment is available.

PCP Discussion with Patients

INPUT FROM STUDY

Discuss with Patient

- Physician concern
  - "What's the plan for follow up?"
- NO Treatment plan: Follow patient
  - No plan needed
    - Plan will come in collaboration with patient as a result of education and conversation
  - One of the hardest parts of study moving from directing to eliciting

Follow Up

- Ref to BH… NO!
  - Requirements of study did not allow
- Co-visits with BHC or
- Follow up with physician
  - Ask patient to read Dr. Clarke's book or Chapter 3 at follow up (or during initial conversation

Five Types of Stress: Often Interrelated

The Stress Evaluation
Dr. Clarke

- Begin with the “Illness Chronology”
- Five Types of Stress
  - Current Stress
    - lack of self-care skills)
  - Childhood Stress
    - ACEs
  - Depression
  - PTSD
  - Anxiety Disorder

Illness Chronology

- When symptoms began
- Symptoms over time
- Patterns

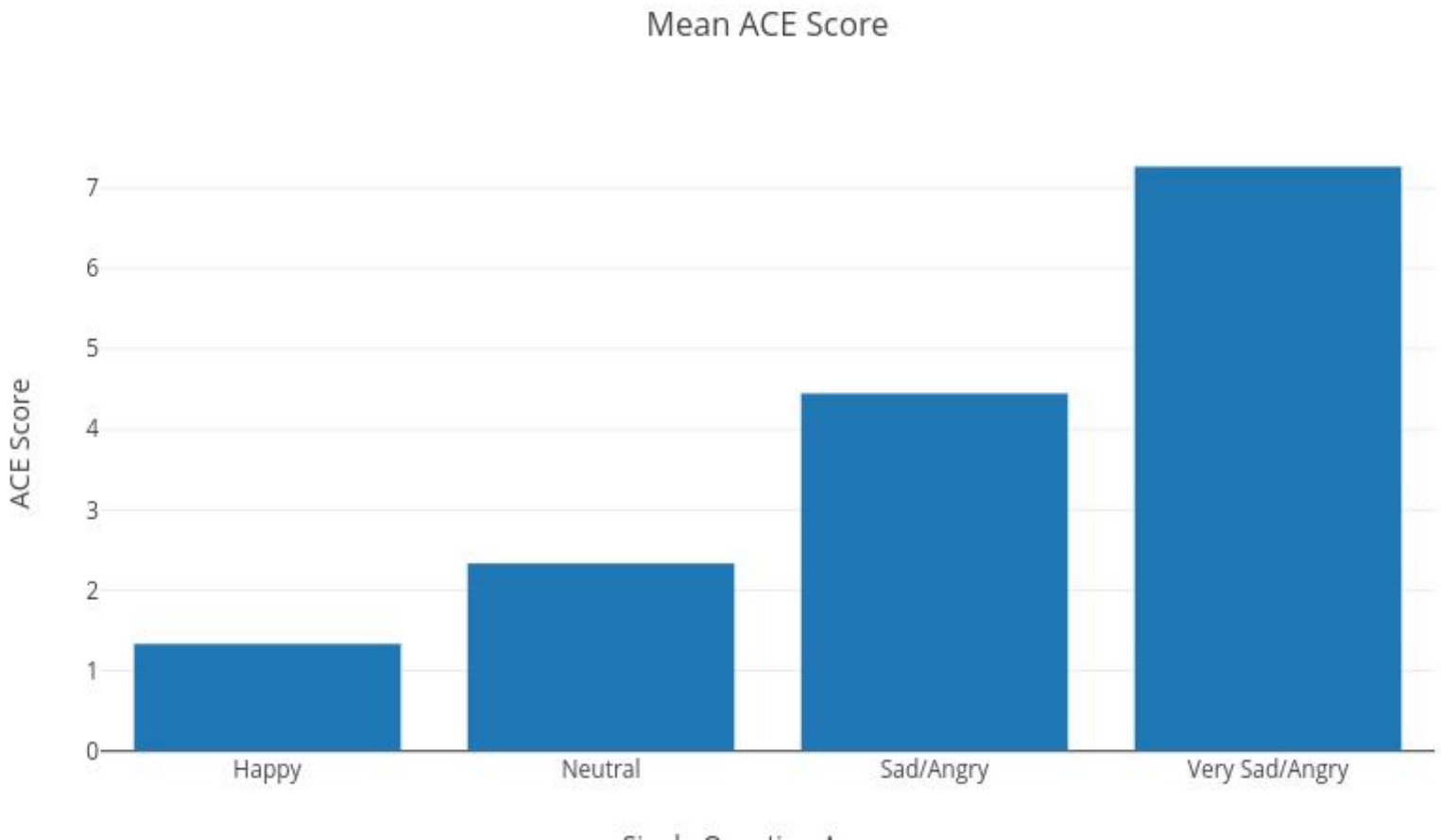
Current Stress

- Lack of “me” time
- Always caring for others

Childhood Stress

- Did you experience stress as a child?
- How much? (0-10 scale)
- Can you tell me more?
- Does it affect you now?

How would you feel if your child experienced your childhood?



Depression

- In most cases, depression is not obvious, accounting for the routine failure to diagnose in primary care.
- Patients whose depression presents somatically often describe their symptoms in vague terms and deny feeling depressed.
- Inquire about
  - sleep disruption
  - Fatigue
  - reduced ability to cope
  - loss of interest or pleasure in usual activities
  - decreased appetite
  - Tearfulness
  - suicidal thoughts or plans.

Post Traumatic Stress

- PTSD may present primarily with somatic symptoms.
- The traumatic event underlying the physical symptoms may be recent or many years in the past.
- Symptoms of PTSD include
  - distressing memories
  - strong reactions to triggers
  - feeling
    - anxiously watchful
    - emotionally numb
    - detached from the world
    - Irritable
    - nightmares or flashbacks.

Anxiety Disorders

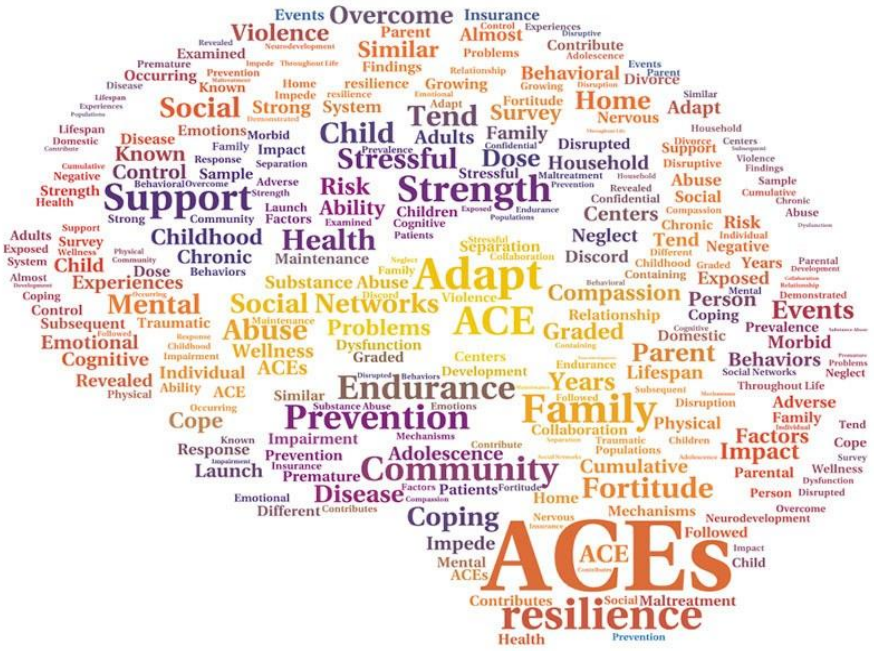
- Minimum of 6 six months of persistent, excessive anxiety or worry about common events that is difficult to control and interferes with performing usual tasks.
- May be accompanied by the physical symptoms of stress illness and
  - disrupted sleep
  - Fatigue
  - Restlessness
  - difficulty concentrating
  - irritability.

PCPs
Stress Evaluation

INPUT FROM STUDY

Screening Tools- Dr. Cleney

- PHQ-9
- GAD-7
- PC-PTSD
- ACES
- HSST



PHQ-9

	Benefit	Drawbacks	Recommendation
PHQ-9	Good screening tool	Doesn't always pick up MUS.	Use this as a screening and monitoring tool but can miss some MUS
	Starts discussion	Not as accurate w/ long term Depression	
	Monitor treatment progress accurately	Score often worsens initially w/ MUS treatment	
	Illustrates to patients physical symptoms of emotional problems		

GAD-7

	Benefit	Drawbacks	Recommendation
GAD-7	Good screening tool	Chronic anxiety patients sometimes underscore and minimize symptoms	Good screening and treatment monitoring tool for MUS
	Starts discussion		Often picks up current and childhood stress as well as GAD.
	Monitors treatment progress accurately		

ACEs

	Benefit	Drawbacks	Recommendation
ACEs	Excellent screen for identifying childhood trauma	Can miss some sources of childhood stress like bullying	Continued use of this without revision is recommended.
	Allows patient to open up by doing it on paper some things that are difficult to verbalize		
	Starts discussion		

Hidden Stress Screening Test

	Benefit	Drawbacks	Recommendation
HSST	Good screening /diagnostic tool	Patients can minimize symptoms	Consider revision of PTSD questions
	Helps frame discussion of what MUS is.	Did not prove to be an effective monitoring tool for treatment under 4 months.	Screen needs to be developed to objectively both diagnose and monitor treatment of MUS patients.
	Helps target approach to therapy.	Insufficient clarity of trauma vs PTSD DSM-V criteria	
	Often brings out childhood stress that is not in ACE's		
	Hand out included to give patients ways to deal with current stress on the spot		

Conference on
Practice Improvement

Thread: PCP stress assessment

Select: All None

Message Actions | Expand All | Collapse All

4 Posts in this Thread 0 Unread

Elizabeth Locke 1 year ago

PCP stress assessment

Generally it takes the majority of the visit to review all the patients physical complaints in a systematic manner to rule out a physical condition. Often they have already seen another provider for the symptoms also. It is at the end of the visit that I attempt to plant the seed of stress illness so there isnt much more time left to discuss this further. I think after opening the discussion of stress as a cause of the patients symptoms I would ask them return for a follow up visit to explore this more. I could then use the hidden stress and/or aces screen. Since the patient would be expecting to discuss stress more, the nurse could give these to the patient to be done before I go into the room.

Reply

Additional Physician BB Responses

- "I think that the initial step would be to perform an ACES and Hidden stress evaluation, then going off of those things could explore deeper whatever category seems to be the most affected. a second session may be needed to further go into detail about what stress/trauma they have experienced and they could be given a homework assignment of writing them down to bring with them the next time that they come in a couple of weeks. these visits ideally would be 30 minutes in length. also during the first visit discussing how chronic stress can affect the brain and create real physical symptoms that are experienced."

- "1) First would be for the clinician to have an awareness that the symptoms/pattern of symptoms may be a stress related illness
- 2) Introducing this idea to the patient and beginning questioning about current and past stressors, possibly giving the ACE
- 3) Follow up visit to further investigate and make a plan for treating stress and hopefully improving physical symptoms.
- 4) Follow up visits to see how it is going."

Stress Screening Protocol Developed

Listed below are the steps we developed to "diagnose"/ screen for stress illness listed very succinctly and clearly (thank you, Beth). However, now we need to discuss in further detail guidelines/ protocols and build out each bullet point providing information that will be useful for those not familiar with screening for stress illness. Please add your own contributions and comment on the posts of at least 2 of your peers.

1. Hone in on psychosocial issues
2. Affirm/validate physical symptoms
3. Review testing/evaluations to date
4. Offer stress illness as a cause
5. Ask permission to explore 5 types of stress: current, childhood(ACES), depression (PHQ9), PTSD (PCPTSD), anxiety (GAD7)
6. Review results and make follow up plan

Treatment

PHYSICIANS: ENGAGING WITH PATIENTS IN NEW WAYS

Dr. Clarke

RECOMMENDED TREATMENT PROTOCOL

Treatment of Current Stress

- List your stressors
  - Self-Care Time
  - Relaxation techniques
  - Mindfulness
  - Meditation

Treatment of Childhood Stress

- Acknowledge Their Heroism
- Buried Emotions need
  - To be uncovered & recognized
  - Talked/ written about
  - Normalized through “reading about”
  - Curable App Exercises and Facebook Support

Treatment of Depression, PTSD & Anxiety

- Medication

- Behavioral intervention
  - counseling?
  - Primary care/ BH support
    - Co-visits

PCP Comments

KEYS TO TREATING 5 TYPE OF STRESS

NEW WAY OF INTERACTING WITH PATIENTS USING MOTIVATIONAL INTERVIEWING

Key Behavioral Health Components of Training

MOTIVATIONAL INTERVIEWING TRAINING

MODELING

CO-VISITS

Spirit of Motivational Interviewing

- **Collaboration** between the practitioner and the patient
- **Evoking** or drawing out the patient‘s ideas about change
- Emphasizing the **autonomy** of the patient.
- Practicing **compassion** in the process.

OARS

- (Asking) **O**pen questions
- **A**ffirming
- **R**eflecting and
- **S**ummarizing
- **Plus**- Giving information and advice with permission

Four Fundamental Processes in MI

Engaging: The relational foundation

Listening; accurate empathy; striving to understand fully from the client's perspective without agenda; client-centered style; using OARS non-directively (to understand BOTH sides of the ambivalence or dilemma); avoiding righting reflex or "fixing".

Focusing: Guiding client to a target behavior that is important to them.

Helping client identify a target area about which s/he is ambivalent or struggling to make a change. Using agenda setting, bubble chart, asking the client what's important to him/her or what area of present behavior might get in the way of his/her goals. Being transparent about what the target is, once identified.

Evoking: Drawing out client's intrinsic motivation (reasons/importance for change) and their own ideas for change.

Drawing out client's *own* ideas and reasons for change; listening for and recognizing change talk; selectively reinforcing change talk; summarizing change talk (change talk bouquet). Avoiding expert trap. Using Elicit-Provide-Elicit and advice with permission only after asking the client his or her own ideas and reasons… ("What makes this change important to you?" "What makes you confident you can do it?", etc.)

Planning: The Bridge to Change (formerly called Phase II)

Consolidating commitment by selectively reinforcing commitment language; asking key questions to determine readiness for action planning; assisting with change plans; revisting change plans to determine need for more work in former stages and/or changes/additions to the plan, etc.

PCPs

Discussion of Treatment

INPUT FROM STUDY

Outcomes

AS A RESULT OF TRAINING AND OUR STUDY

What We Did Find

INITIALLY STRESS INCREASED

- psychosocial nature of the information disclosed
- Change in flow of the visit

- Online learning platform challenges

- Re-experience formal learning

OVER TIME STRESS DECREASED

- more engagement
- Became better equipped

- Found success with a new treatment model

- Learned how to managing flow of the visit
  - Saving time- not adding

Learning language and framework to address stress illness

Take Homes

- Significant Results:
  - The PCPs perception of the importance and confidence of diagnosing and treating MUS patients in primary care significantly increased as a result of training.
  - PCPs stress in treating MUS patient significantly decreased as a result of training

- PCP stress related to treating MUS patients diminishes as a result of
  - Time
    - In accessing and engaging in the training program
    - In practicing new skills with actual patients
- Treating MUS in primary care is
  - A learnable process
  - Achievable
  - A huge benefit to patients

Recommendations

- Create new ways to evaluate impact on patients and improved outcomes

- Develop ways to demonstrate reduction in total cost of care

Proliferate a training program for physicians in discussing, diagnosing, and treating MUS in primary and speciality care.

Conclusion

PCP Recommendations and Conclusion

What Worked- PCPs

- Face-to-face sessions had productive discussions and helped with understanding
- Book is an easy read
- Blackboard learning material helpful and not time intensive for an FP schedule
- Blackboard discussions with case presentations very helpful
- Co-visits very helpful for those that scheduled them.
- Peer interaction/hallway conversations/consultations helpful and kept up motivation to learn/ change

Challenges- PCPs

- Completing actual meeting time allotments due to nature of primary care
- Scheduling and Time constraints in schedule for scheduling co-visits and follow ups
- Barriers to asynchronous learning
  - Lack of familiarity with technology (Blackboard app used)
  - Minimal time needed to adequately complete weekly learning modules
  - Difficulty in acclimating back towards ongoing didactic learning

Conclusions from Physicians

- Couldn’t NOT see MUS- now see it everywhere!
- Medical community unaware of stress illness
- You can learn how to do this
- Helpful in managing your patients
- Helps your patient
- Learning to recognize is important
- Improve relationship, reduce testing, relieve stress
- Tool to help you deal with stress with your MUS patients on your

Conference on
Practice Improvement

Improved Patient Care

- Improved patient care
- Enhanced patient satisfaction
- Improved outcomes
- Reduced cost
  - Medical testing
  - ER/Urgent care visits
  - Referral to specialty care (multi-speciality)
  - Hospital admission/ readmissions
  - Medication

Questions?

Contact Information

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- drdave@stressillness.com

- Please feel free to contact us for any further questions, support or to inquire about the progress of the training program we a re establishing!