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SOLVING MEDICAL MYSTERIES: HIDDEN STRESSES AND UNEXPLAINED SYMPTOMS

REŠEVANJE MEDICINSKIH UGANK: PRIKRITI STRES IN NEPOJASNJENI SIMPTOMI

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Editorial

ABSTRACT

Medically unexplained symptoms and chronic functional syndromes are common but few healthcare professionals have had formal training about their connection to psychosocial issues. A systematic approach to diagnosis and treatment based on experience with over 7000 of these patients is described. Outcomes improve with assessment for and treatment of current life stresses, the prolonged impact of adversity in childhood and somatic presentations of depression, post-traumatic stress, and anxiety disorders.

Keywords:
medically unexplained symptoms, chronic functional syndromes, bodily distress syndrome, psychophysiologic disorders

IZVLEČEK

Kljub pogostosti medicinsko nepojasnjenih simptomov in kroničnih funkcionalnih sindromov so le nekateri zdravstveni strokovnjaki formalno usposobljeni za prepoznavanje njihove povezave s psihosocialnimi težavami. Članek opisuje sistematični pristop k postavljanju diagnoze in zdravljenja glede na izkušnje z več kot 7000 pacienti. Rezultati se izboljšajo z ovrednotenjem in zdravljenjem trenutnega stresa v življenju pacienta, podaljšanega vpliva tegob iz otroštva ter somatskih prikazov depresije, posttravmatskega stresa ter anksioznih motenj.

Ključne besede:
medicinsko nepojasnjeni simptomi, kronični funkcionalni sindromi, sindrom telesne stiske, psihofiziološke motnje

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1 PSYCHOPHYSIOLOGIC DISORDERS

In primary care, 25-33% of patients suffer from illness not fully explained by diagnostic tests. In these patients, pain or other symptoms (often more than one) can affect almost any structure, organ system or body region. There is growing evidence from controlled trials that addressing psychosocial problems in this population leads to significantly improved outcomes. However, few healthcare professionals have had formal training about the link to stressful issues. Clinicians who are familiar with these connections can achieve much better outcome for their patients.

Psychosocial issues encountered during experience with over 7000 of these patients are described below. These include current life stresses, the prolonged impact of adversity in childhood and primarily somatic presentations of depression, post-traumatic stress, and anxiety disorders. Although many people are reluctant to consider stress as a cause of physical symptoms, they can be reassured by the concept that "tension headaches" can occur in other places in the body.

A new term for stress-related illness is Psychophysiologic Disorders (PPD). This reflects growing evidence that chronic stress can alter nerve pathways in the brain. However, the phrase Stress-Related Illness remains preferred when communicating with patients.

2 THE STRESS EVALUATION

There are five major types of stress to look for in patients with diagnostically unexplained symptoms. Suspicion of a link between any of these and the patient's condition is stronger if a stress occurred just before symptoms began or is linked to flares of symptoms. You might also listen for clues that symptoms are highly unlikely to have an organic or structural cause. For example, one of my patients was a 40 year-old man who had abdominal pain only while driving to work but not when driving home or on days off work. (His job became stressful shortly before the pain started.)

2.1 Part I. Current Stresses

Almost any source of ongoing life stress is capable of causing physical symptoms. Listen for evidence of a personal crisis, issues with religious faith, problems with a spouse or partner, Lesbian/Gay/Bisexual/Transgender concerns, difficulty with children or parents, workplace stress, financial problems or a dilemma involving a friend or neighbour. Be alert for stressful events that link chronologically to symptom flares.

Another common theme in this category is a lack of self-care skills. Good questions that loved ones can help answer are:

- Do you care for those close to you but have difficulty finding time for yourself?
- What do you do for enjoyment and how often?

For many of these patients, their only relief from endless obligations is when symptoms force them to rest. Most of them suffered a challenging childhood that diverted them from attending to their own needs. They were left with little experience taking time for personal fulfilment and recreation.

2.2 Part II. Adverse Childhood Experiences (ACEs)

About 2/3 of adults have experienced at least one ACE and 1/6 have experienced at least four. ACEs increase the risk for many types of poor health outcome including PPD, which can begin during childhood, adolescence or well into mid-life. Symptoms can be mild or severe, single or multiple, and can persist for years or even decades. Most patients are grateful for inquiry with the following sequence of questions:

1. Were you under stress as a child?
2. If so, can you tell me a little about what happened to you?
3. If you learned that a child you care about was growing up exactly as you did, how would that make you feel? (Patients tend to minimize the adversity they suffered, but this question can help them to a more accurate assessment.)
4. Are you still interacting with a person who was stressful for you as a child? (If so, it is often essential to change the nature of the encounters or set boundaries that limit them.)

After each question, listen for mistreatment capable of causing enduring harm to self-esteem and/or anger, shame, fear, grief or guilt. This suffering often proves to be the source of unresolved emotions that are then expressed somatically. This is the fundamental cause of PPD in ACE survivors. Common forms of childhood mistreatment in this population include abuse, neglect, lack of praise or emotional support, excessive responsibilities, bullying by peers and parental violence or substance abuse.

Many PPD patients experience three overlapping stages in recovering from ACEs. You may detect evidence for this in your conversations with ACE survivors.

Stage One. Characterized by personality traits that developed in response to ACEs including poor self-esteem, stressful personal relationships, perfectionism, detrimental levels of self-sacrifice and increased

vigilance. Anxiety and depression often are present. Also common are behaviours that support coping such as eating disorders, addictions (alcohol, drugs, nicotine, exercise, work, sex, gambling, shopping), and self-injury. Positive characteristics include reliability, attending to details, a capacity for hard work and compassion for others in need.

Stage Two. Negative traits from Stage One diminish and the positive traits generate supportive feedback from friends and colleagues. This leads to steady growth in self-esteem. Many eventually recognize they deserve to be treated far better than they were as children. For the first time they feel worthy of mutually supportive relationships.

Stage Three. Reduced stress, improved self-esteem and feeling worthy of better treatment contrasts with and generates emotion about adversity suffered as a child. But because of years spent suppressing emotional reactions, many lack conscious awareness of anger, shame, fear, grief or guilt even when an ACE perpetrator is still active in the patient's life. The result is that emotion is expressed somatically (causing symptoms) rather than verbally or via behaviour. (It is not uncommon for symptom onset to coincide with the first supportive relationship, referred to as the Good Partner/Bad Illness syndrome).

It is remarkable how frequently ACE survivors are unaware of emotions powerful enough to cause physical symptoms.

2.3 Part III. Depression

In primary care, patients with depression typically present not with their mood disorder but rather with one or more body symptoms. Many do not feel depressed though they might admit to feeling stressed or frustrated. A vague, non-specific description of the symptoms and desperation to find relief are clues to depression. Confirmation usually follows from inquiry into early morning awakening, anhedonia, fatigue, anorexia, tearfulness, thoughts of self-harm, and loss of hope for the future.

2.4 Part IV. Post-Traumatic Stress

Routinely ask about traumatic, terrifying or horrifying life events. The link to PPD is clear when symptoms begin soon after the trauma, especially when accompanied by typical manifestations of Post-Traumatic Stress such as flashbacks, nightmares, avoidance of reminders of the trauma, emotional numbness, and increased vigilance.

PPD that begins long after the trauma is more challenging to diagnose and is not rare. Symptoms usually follow a triggering event linked to the trauma.

2.5 Part V. Anxiety Disorders

The prevalence of Generalized Anxiety Disorder (GAD) in primary care is 7-8% and most complain of physical symptoms rather than worry or fear. A clue to GAD is that somatic symptoms tend to be significantly less severe at times when the patient feels safe. Most GAD patients will admit to excessive worry about minor matters if asked specifically.

3 CONCLUSION

Millions of patients suffer from PPD. Physicians (with support from colleagues in mental health) who address the psychosocial issues described above can significantly improve their patients' outcomes.

CONFLICTS OF INTEREST

The authors declare that no conflicts of interest exist.

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