The Worried Well in Primary Care: Strategies for Management

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Objectives

Following this presentation, the participants will be able to identify 3 characteristics of “worried well” or patients with medically unexplained symptoms (MUS).

Participants will verbalize three ineffective methods for dealing with worried well and those with medically unexplained symptoms and to understand why these tactics do not work.

Participants will come away from this presentation with three effective strategies to utilize in practice in working with the “worried well” and patients with medically unexplained symptoms.

Terms Used

- Worried Well—frequent office visits, vague complaints or symptoms
- MUS—medically unexplained symptoms
- High utilization patients
- Somatoform disorders—mental/emotional concerns manifesting as physical symptoms (rarely used term)
- Somatic Symptom Disorder (new DSM-V term)
**Extent of the Problem**

- True percentage is unknown as many go unrecognized.
- Estimated prevalence of MUS in primary care is 25-75%; predominant c/o is pain.
- Among all new symptoms in primary care only 16% have an organic basis. (Kroenke, 2006)
- In current medical model system, MUS can only be diagnosed by excluding organic diseases.

**Differential Diagnosis**

- Rare organic diseases such as Wilson's disease.
- Lyme disease or other tickborne illness.
- Multiple sclerosis or other disease with vague presentation.
- Porphyria.
- Factitious disorder (e.g., Munchausen Syndrome).
- Co-occurring organic and MUS - e.g., recent MI, now has daily chest pain; studies negative.

**Provider Perspective**

- “difficult patient”
- Never satisfied.
- Frustrating to encounter.
- Avoidance behavior.
- Refer to specialists.
- “Frequent Flyers”
- Medicolegal concerns.
- Concern about patient dependence.
Profile of Patient

- Heterogeneous with some characteristics in common:
  - Many have a history of abuse or family dysfunction
  - Seek explanation and emotional support
  - Psychosocial agendas
  - Frequent visits
  - Dissatisfaction with care
  - Health anxiety
  - Mistrust of health care system

Profile of Patient

- More women than men
- Most common complaints:
  - Musculoskeletal
  - Abdominal
  - Headache
  - Dermatological
  - Cardiopulmonary
  - Miscellaneous

In Their Own Words: Patients

- Several small qualitative studies done, one quantitative one on why patients worry:
  - Uncertainty, perceive their problem as serious
  - Concerned about loss of function, loss of control
  - Want an explanation; some may not trust this—mistrust of healthcare system
  - Patient’s explanatory model of the symptom or illness
### Categories of Reasons for Worry
#### Pre/Post Visit
- Nature of the complaint
- Pain
- Complaint still present
- No explanation given by provider
- Bodily damage or dysfunction
- Ability to function
- Psychological consequences
- Death
- Inadequate treatment
- Mistrust in healthcare
- Negative prognosis of the complaint


### In Their Own Words: Patients
- Part of a larger, longitudinal, quantitative study
- Selection of participants based on high utilization
- Interview with open ended questions, followed by directed questions:
  - explanatory models
  - locus of control
  - health-seeking behaviors
  - Relationships
  - expectations for the future
  - childhood memories and any history of abuse

### In Their Own Words: Findings
- 3 categories of high-utilizers:
  - Coping—insight into problem, optimistic outlook but still lots of visits
  - Classic—no insight, “entitled”, should be excused from work and social obligations due to symptom
  - Worried—health anxiety, displaced symptoms
  - History of abuse or family dysfunction in all three groups

*Dwamena, F.C., Lyles, J.C., Frankel, R.M., & Smith, R.In their own words qualitative study of high-utilising primary care patients with medically unexplained symptoms. BMC Family Practice 2009; 10:67*
In Their Own Words: Findings
Themes divided into 3 areas:
- Experiences
  - Impact of childhood trauma, adult abuse, or family patterns of dysfunction or distress
- Perceptions
  - Entitlements, health anxiety, psychological explanations and insights
- Behaviors
  - Symptom focus, achievement, action, altruism, expressing dissatisfaction with health care

In Their Own Words: Providers
- Disconnect between medical model of symptom and diagnosis and psychosocial model of patient, seeking emotional support, listening, and validation.
- Physicians feel unprepared to treat patients with MUS, try reassurance that tests are negative.
- Unsure if patient belongs in primary care or psychiatric service

What Do NPs Offer to Worried Well?
- NPs are educated in the biopsychosocial model of health and illness—holistic
- Therapeutic communication and active listening is taught at the foundational level in nursing
- Focus on treating the patient’s response to illness as well as the illness itself
Sir William Osler (1849-1919) said, “It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has”

Active engagement of the patient in the plan of care

Importance of patient-practitioner relationship

Listen to the patient—broaden your questions beyond the symptom... “Is there anything else going on in your life that is different?”

“What do you think is causing your problem?” Have you given it any thought? This can be very insightful— you may learn about the patient’s explanatory model of the illness OR they may just respond rather sharply, “That’s why I came to see you”.

Strategies for Management

- Same provider when possible
- Regularly scheduled follow up to avoid the “crisis” visits
- Avoid labeling it as a psych problem
- Cognitive behavioral therapy model is very effective for some cases but difficult to implement in primary care unless extra time is allotted for the visit

Strategies for Management

- Screen for anxiety/depression and treat with SSRI if indicated.
- Consider cultural factors
- Work with patient on shared treatment plan—may involve structured activity by patient—exercise, meditation, visualization, support group, assignments
Successful model in an HMO using family nurse practitioners to manage complex, high utilizing patients.

Nurse practitioners received training in cognitive behavioral therapy, were assigned to specific patients and provided all primary care over a year.

Extra time built in, visits at monthly intervals with phone contact in between.

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**NURSing the patient**—when the patient expresses an emotion, try to: Name it; Understand it; Respect it; Support it.

Reattribution of the symptom is a therapy that connects mind and body and broadens the treatment for a somatic complaint.

Integrative health practice is ideal; team approach.

Still many questions about whether MUS belong in primary care or mental health.

Remember to care for yourself as well.