Implementing an Emotion-Focused Consultation Service to Examine Medically Unexplained Symptoms in the Emergency Department

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Abstract

Introduction: Providing an emotion-focused assessment service to explore emotional contributors to medically unexplained symptoms (MUS) is a culturally new concept within the traditional model of emergency medicine. We developed a multi-step approach to educate physicians and patients on how such a service might benefit them. Results: Patients reported high satisfaction with the service and more physicians referred greater numbers of patients. The institution supported the service, providing permanent funding, giving it an award and nominating it for a national quality award. Dealing directly with emotional contributors to symptom formation is a new approach to the emergency care of patients with MUS. This diagnostic and treatment innovation was accomplished successfully, with data supporting reductions in ED readmission and reductions in overall costs. The steps we took appear to have played a role in the service being both beneficial and well received by patients and physicians. Further study and replication of these methods is warranted.

Introduction

A typical model of emergency department care is one where patients present with subjectively alarming symptoms, which may require rapid intervention. Shortness of breath, chest-pain, abdominal pain, and headache—the major presenting complaints that we investigated in our pilot service—are frequent causes of ED presentation. They also happen to be symptoms with causes ranging from benign to catastrophic. Within current paradigms, patients are triaged by level of urgency when they present, using widely accepted, evidence-based criteria, to direct speed and intensity of investigation and intervention. Patients, whose symptoms are judged to be benign, medically unexplained, or anxiety driven are commonly given reassurance and then discharged. As reported by Abbass et al [1], for at least some of these patients, unless underlying factors are explored and dealt with definitively, readmission to the ED is common, coupled with high costs and frustration on the part of treating doctors and patients alike.

Somatization or the translation of emotions into the development or worsening of somatic problems or complaints [2, 3] accounts for a large proportion of these ED visits [4, 5]. We have previously described (See page 35 of this issue. ed.) the patterns of unconscious anxiety

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and various defenses against this anxiety, which translate into common ED presentations (6). We have also described how a pilot service using a brief treatment called Intensive Short-term Dynamic Psychotherapy (ISTDP) led to both decreased ED readmission rates, decreased health-care costs overall, and was viewed as satisfying by patients and referring physicians [1, 6].

In setting up this pilot study, we realized that ED physicians might be reluctant to consider emotional factors in symptom-formation, in part because of medical education deficits in this relatively new area of science. Patients may also be reluctant, perhaps feeling that their urgent symptoms are being dismissed. Furthermore, the traditional role of mental health in the ED is oriented to behavioral emergencies: suicidality, homicidality, agitation, and functional decline due to acute decompensation of the mental state via psychosis, mania or depression. Exploration of emotional factors in physical symptom formation has not historically been within the purview of psychiatric emergency services.

Here, we discuss the specific steps undertaken at the QE II Health Sciences Centre to provide emergency physicians with the skills to detect whether emotional factors might be playing a role in symptom formation, how to engage the patient in a non-threatening discussion of emotional factors of their symptomatology, and how our service approached patients referred for assessment, including patients who initially felt threatened or dismissed by the referral.

I. Methods

1. Diagnosing Somatization in the ED Patient

A key element we helped the ED physician understand is how we orient an ED patient to the evaluative interview of ISTDP, which is called a trial therapy [1, 2, 3] . It is important to remember that these patients presented to a hospital for a physical evaluation and not to a psychologist for emotional assistance: thus, an interviewer has to establish a collaboration to examine whether or not emotional factors are producing or worsening his or her presenting physical complaints. Patients coming to this interview can arrive one of the following ways:

A. Ready to focus on emotional factors

Patients ready to focus on emotional processes arrive with active unconscious anxiety in the form of striated “anxiety with hand clenching and sighing, or anxiety in smooth muscle with GI upset for example. These are signs of receptivity and readiness to examine emotional factors. Other signs include verbal statements of interest in emotional contributors.

B. Consciously Defending

These patients are guarded and wary about interacting with the therapist. He or she isn’t yet a patient (or client) to work with. The nature of the interview, goals and methods need be reviewed to see if he or she is willing to examine possible emotional factors. In our experience it is rare for a person to decide not to engage in the interview once they have arrived in the office and been explained the process.

C. Unconsciously Defending

Such a person is typically tense and intellectualizing, detaching, defying, complying or using one or another unconscious defense mechanism. This is a marker of mobi-

lized unconscious emotions, which are being avoided unconsciously by whatever set of habitual behaviors that were learned over the lifetime. This is dealt with through a range of interventions central to ISTDP technique that include clarification of the defenses, turning the patient against the defenses and challenging the defenses [(7)].

D. Confused

This patient arrives but does not have any idea what he or she is doing in the office. This may be a failure of the referring professional to explain (or offer the pamphlet) or is a product of low psychological mindedness in the patient. It may also be that in this patient's case, there is no link between the symptoms and emotional factors. Such a person requires a clear explanation about the interview, and perhaps further explanation of the concepts of unconscious, emotions and anxiety about emotions.

E. Combinations of the above

A patient may arrive with more than one of these states of mind. The priority is as follows: First, a conscious understanding of the process must be provided. Second, conscious defenses must be handled by conversation and decision making. Third, unconscious defenses must be addressed. Finally, unconscious anxiety and emotions can be examined. Then, the patient and interviewer can begin to assess whether or not there are emotional contributors to the symptoms in question.

2. Actively Exploring Emotions Interviewing

Examination of the emotional system progresses from observation to active exploration, in concert with the patient. When meeting with the patient one observes the patient upon coming into the office for the presence of visible unconscious anxiety. Then, in the context of a supportive therapeutic relationship, one may explore emotionally charged situations that exacerbate or generate symptoms. One may also ask in what way strong emotions like anger affect the patient's physical problems. Asking about specific recent events and feelings that were triggered leading to the ED visits usually mobilizes emotions, giving the interviewer and the patient a direct look at how emotions affect him or her physically. If a patient is anxious in the office, the best place to focus is on the feelings that generate the anxiety during the interview.

3. Managing Excess Anxiety

If the patient becomes anxious when focusing on emotions, one may help him or her relax by asking the patient to intellectualize about the specific bodily anxiety symptoms. This reduces the anxiety by using the defense of intellectualization. Alternatively one may change topics or areas of focus temporarily.

4. Interpretation of Responses

In a previous videotape, case-based study we found that during the trial therapy, somatic symptoms could briefly increase or decrease, disappear, or might not change at all. Each of these responses has diagnostic and etiological implications in the patient with physical symptoms. These interpretations are described in Table 1.

Table 1. Interpretation of responses to emotionally focused assessment

Response	Interpretation and Response	Beware of
Response 4a: Symptoms go up with emotional focus then down after focusing away from emotions	The diagnosis is likely somatization. Prescribe emotion-focused psychotherapy and monitor for gradual symptom removal	False positives due to coincidental symptom changes in interview Health problems unrelated to the somatization could always be present
Response 4b: Symptoms are improved or removed by emotional focus or emotional experience in the office	The diagnosis is (was) somatization of those emotions. Follow-up to see if gains are maintained	
Response 4c: No change in symptoms	Somatization is unlikely to be the cause of the symptoms. Look for other physical causes.	False negatives due to high defenses, sedation, lack of cooperation, inadequate focus by the therapist
Response 4d: Unclear response	May or may not be an emotion-based component in the symptoms. Repeat test, consider other diagnostic tests or referral for emotion-focused diagnostic testing	

Table 1 outlines the response patterns seen in screening patients with the ISTDP method:

4a. Somatic symptoms varied with emotional mobilization, both increasing and decreasing with emotion activation. For example, chest pain increases with a rise in unconscious anxiety with sighing respirations and this varies with the amount of reported chest pain. This suggests somatization was a contributor to the symptoms. Such patients would be directly provided ISTDP treatment.

4b. Symptoms were removed or markedly diminished with emotional processes in the interview: for example, a patient with a recurrent headache comes in the interview with a headache which abates directly when the emotions are experienced [3]. This finding strongly suggests emotional causation or at least strong emotional contribution to symptoms that have now abated. These patients would also be offered a course of ISTDP.

4c. No change is seen. In this case there is no symptom variance with emotional mobilization or experiencing. This finding may suggest emotional processes are unlikely to be contributors and that additional medical testing is warranted. An example of this was a person with recent onset confusion: After additional medical review it was found she had central nervous system effects from an anti-malarial drug, which abated when it was stopped. In cases with no change and who already had extensive medical testing, a brief series of exploratory psychotherapeutic sessions may be warranted to see if symptoms may abate with more treatment.

4d. An unclear response may be derived where no conclusions can be drawn. This finding suggests the interview should be repeated or a brief series of sessions be provided to further attempt to evaluate emotional contributors.

Caveats for each of these interpretations include false positives and false negatives. Unconscious anxiety can be present comorbidly with medical conditions. Some conditions can be worsened by, but not be caused by, unconscious anxiety. Responses could be coincidental, although minute-to-minute changes in chronic symptoms are less likely to be by pure chance. For these reasons, repeated mobilization within the assessment interview is suggested to confirm any positive findings.

5. Review and Planning of Active Emotional Interviewing

This interview process is concluded by reviewing the findings with the patient in the same way one would the findings on any psychological or medical test. Management options would depend on the findings and may include another interview, further medical investigations, referral for psychotherapeutic treatment or follow-up to see his or her response to the interview itself. This review and planning process is illustrated in the companion article to this (6) and in a description by Patricia Coughlin [8].

Within the limitations of this assessment method, the clinical utility of this assessment method has rendered it our core diagnostic and treatment instrument for MUS in all medical, surgical and ED patients. In our institution, we use this approach to screen patients before they receive brain implants for idiopathic tremor, electronic stimulators for bladder dysfunction and electroconvulsive therapy for a range of psychiatric presentations [9]."We co-screen patients with neurology who are being assessed for pseudoseizures and consult to general surgery prior to specific procedures in cases where somatization is suspect. All of these assessments are provided as urgent consultations with the same preparatory explanation as we provide ED patients.

II. Adaptation to the Emergency Department: Changing the Treatment Culture of the ED

In the pilot study, we introduced this technology to a new setting—that of a busy urban emergency department. This was achieved through the following processes:

First, we established working relationships between our clinicians and some emergency physicians already interested in the area of somatoform disorders. This relationship was facilitated by the fact that Doctor Abbass practiced as an emergency physician in the hospital some years before.

Second, we provided videotape-based education workshops of 1–2 hours to the emergency staff. The education sessions covered the following key points. First, we reviewed the basic metapsychology underpinning the evaluation we use [2, 3]. We showed videotape to illustrate the difference between emotions, such as rage, and the somatic patterns of anxiety when rage is mobilized. Then we covered how to approach the ED patient about referring to the service including the notion that we do not assume psychological causation. We also reviewed the patient information pamphlet we prepared. This was a simple information piece to give to patients and explain the purpose of referral. It outlined, that the purpose was to see "whether or not" emotional factors were contributing to symptoms. In addition, we covered how emotional reactions in the physician could blur recognition of somatization or interrupt the treatment process [10, 11]. These workshops relied on videotape of actual cases and allowed case discussion with staff. We presented the literature and provided copies of relevant articles. Finally, we reviewed how to make referrals for ISTDP evaluations.

Third, we introduced rapid access referrals to the service where emergency patients were seen in less than 2 weeks when possible and made ourselves available by phone as needed.

Fourth, we showed videotapes of emergency-referred cases we had seen to the referring physician to illustrate what we did and the outcome.

Fifth, we made literature readily available to emergency physicians and other staff, including articles on the interview methods we used and outcome research.

Finally, we provided a month of on-site consultation / liaison with emergency physicians. This on-site consultation was provided by a senior ISTDP trainee and resident in psychiatry (RT). In this period brief, on-site liaison was provided to help emergency physicians learn who may benefit from referral to the service and to explain what we do.

The central philosophy in our consultation/liaison and education was as follows: we never assume that emotional factors are present, but we also do not assume they are absent. Rather, we do a direct diagnostic evaluation through emotional mobilization coupled with close observation of the responses to this process and see if we can make a determination on causation. Another concept that was helpful is the notion that nearly every illness is made worse by stress. This is why we called our assessment a “Diagnostic Interview for Stress Factors” and explained this to each patient. By using this concept we never lost sight of the possibility that a medical condition could be evolving or subclinical: we made medical referrals on a few occasions when medically warranted. This philosophy made the service acceptable to physicians hesitant to send patients for emotion-based assessment. Otherwise, they may have feared the patient would be seen and told the problems are “in the patient’s head” as opposed to actual end organ phenomena with cause to be determined.

Extending education on this evaluative approach to the university-hospital specialty medical departments, to undergraduate medicine and to postgraduate medicine all aided in the development of ISTDP services in this ED over a 10 year period. Over these years we had provided over a dozen presentations to medical-surgical specialty grand rounds. We provided annual half days of videotape training to all junior surgical residents, to all residents as a group, and to all family medicine residents [(12)]. Annual presentations to undergraduate medicine has now been converted to a full week of curriculum on “Emotions and Health” in second year medicine. By the time new emergency physicians were recruited over the past 10 years, all local graduates had seen some of the materials and videotapes demonstrations. This familiarity helped this service to take hold and be supported widely in the institution.

Results

We previously reported patient self-reported satisfaction, physician verbal reports of satisfaction and a high rate of referrals from more ED physicians as a response to the pilot study [(1)]. Based on these responses, we were awarded a $50,000 (USF) “Innovation Grant” to further study and implement this diagnostic and treatment service in the ED in 2009. The funds were used to support a fulltime equivalent psychologist position in the ED. This position was shared between two senior psychologists (SGH & IL) with experience and training in ISTDP. They worked collaboratively and provided liaison and ISTDP services in the ED.

Although we did not collect written feedback from ED physicians, verbal feedback continued to be very positive: fourteen of these physicians referred over 50 patients to the service over a 5 month period. Patients rated the service highly with an average self- reported satisfaction level at the 8.7 out of 10 level on a Likert Scale. These are improvements over the previous pilot and suggest assimilation and acceptance of the service both among referring emergency physicians and, therefore, patients themselves.

Since utilizing this Innovation Grant, support in the Institution has been such that we have been provided funding for 1.2 full time equivalent psychologist positions in the ED.

The service was awarded an institutional "Quality Award 2010" and was nominated as a national "Leading Practice" by Accreditation Canada in 2010.

Conclusion

Medically unexplained symptoms are common. Emotion-focused therapies, such as ISTDP, can play a role in the diagnosis and treatment of emotional factors underlying symptom formation, where such factors exist in a given patient. The prevailing model of care in EDs had been triage, exclusion of ominous causes, and reassurance in cases where no medical or surgical therapy was appropriate. Our intention was to modify that model to include focused psychodiagnostic evaluation as a third modality, one that could be made available rapidly for diagnostic and therapeutic purposes. Having no precedent in the Health Sciences Centre, we developed the method described above to facilitate implementation of our service on a pilot basis into a busy urban ED. Extensive educational ground work in the university and hospital facilitated this cultural shift.

The successful implementation of a service to explore emotional factors in medically unexplained symptom formation can be concluded from patient and physician satisfaction, reduction in ED readmission rates, and net reduction in health costs related to ED use. What is less clear is whether our specific approach to physicians and patients played a role in that success. While we would argue from converging evidence that it did, replication of this implementation method in other centers would be necessary to offer independent validation of the claim. Furthermore, it may be possible to implement such a service with fewer steps, in a shorter time scale, but just as successfully. These remain open questions. While we are planning formal evaluation and further study of this service, we hope that medical and psychological colleagues will take up the challenge to bring and research such services in this important area of clinical need.

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