Cognitive Re-Orientation in the MUS Patient

It is essential to first learn the patient's understanding of their condition, their explanatory model; e.g., their beliefs and expectations. These often are at odds with the clinician's diagnostic evaluation and re-orientation (re-attribution) is necessary, usually accomplished easily as patients engage in treatment. For example, some chronic MUS patients believe that every symptom means an underlying disease needing investigation, while others believe each symptom suggests a life-threatening problem. One respectfully addresses and effects changes of these thoughts, relying on the patient-centered approach to do this. We do the following for a new, healthier understanding of the symptoms:

1) Provide data that ominous conditions, especially those they worried about have not been found (e.g., multiple sclerosis, cancer, AIDS).

2) Indicate that consultation, further testing, and surgery are not needed and that the doctor will follow-up closely for subsequent evidence of organic diseases.

3) State emphatically that the problem is 'real' and physical and not 'in my head.'

4) Provide a benign physical diagnosis and its mechanism (e.g., chronic muscle strain; altered brain chemicals); using common names such as fibromyalgia or irritable bowel syndrome is appropriate.

5) Confidently reassure the patient that the clinician has seen many such cases of this common problem and is sure of the diagnosis.

6) Clearly state that depression is a key part of the problem and needs to be treated. It is critical, though, to volunteer (if not asked) that the patient is not a 'psych case,' often needing to de-stigmatize by stating that most people with their degree of suffering would be depressed.

7) Equally clearly, indicate that opioids, tranquilizers, and sleeping pills make both the depression and the pain worse and will need, over time, to be reduced or even discontinued – and that the clinician will provide them with more effective pain medications and treatment.

8) Volunteer that cure is unlikely but convey hope that the treatment package can achieve their goals and help them live a better life.

9) While the above approach may require repetition, it usually is effective in re-orienting patients from their unhealthy beliefs over the first 1-4 weeks of treatment. When it is not, the clinician can have the

patient keep a diary recounting the specific symptoms as well as the personal, cognitive, and emotional concomitants. This helps the patient recognize the associations and can foster change; however, such patients may require referral to a specialist for more intensive CBT if this focus interferes with the rest of treatment.