By David Clarke, MD

An Approach to Severe or Persistent Functional Symptoms

Functional symptoms which are severe, persistent or both are a common and often frustrating clinical problem in adults. Recent literature has documented a frequent association of these symptoms with a history of abuse in childhood or other source of chronic emotional stress. Based on the author's experience in an office-based practice, this article describes a practical approach to evaluating and treating these patients and reviews some typical personality traits of adult survivors of child abuse.

Introduction

Functional symptoms which are either severe, persistent or both are a common clinical problem in adults. These complaints are often seen in patients suffering from chronic emotional stress. For example, recent reports have described an association between functional symptoms in adults and a history of abuse when they were children.[1,2,3,4,5] An approach to the diagnosis and treatment of functionally ill patients will be described.

Common Characteristics

The ideas presented are intended for practical application in a primary care or referral setting. They were developed by the author based on literature review, collaboration with several mental health professionals and detailed interviews with well over 1000 patients (since 1983) referred to a gastroenterology practice. These patients shared three general characteristics. First, no organic etiology for their symptoms was identified after diagnostic evaluation. Second, there was a history of chronic emotional stress and frequently a history of events in childhood that, as a common denominator, had a negative impact on the patient's self-esteem. This may have included physical, sexual or verbal abuse, physical or emotional neglect, parental abuse of drugs or alcohol or recurring violence in the home. Third, these patients achieved resolution of symptoms with counseling, support groups, classes or books directed at the source of chronic stress or childhood issues.

Case 1 illustrates many typical features of this group.

Case 1

A 36-year-old white female was referred from a University Gastroenterology department with a two year history of having bowel movements only once every two to six weeks. This habit persisted despite daily ingestion of approximately double the usual dose of milk of magnesia, bisacodyl, docusate and fiber supplements. An extensive evaluation had been entirely normal. She denied any emotional stress but was then asked about stress during childhood. She gave a history of penile-vaginal intercourse with her father on a weekly basis from age 4 to age 11. Asked again about stressful events at the time of onset of her illness she reported that the opposite had occurred. Just before her symptoms began she had quit her job as a part-time bank teller because of harassment (non-sexual) from her supervisor. She was quite happy at her current bank and was also happily married, had two healthy children and was financially secure. The patient was referred for counseling for the sexual abuse. Her bowel habits returned to normal in about two months.

Diagnosis

The diagnostic evaluation of these patients depends on the nature and severity of their symptoms and will vary by individual. Contrary to common practice and as recommended by Barbour,[6] it can be very helpful to include emotional stress in your earliest discussions of possible etiologies. When clinicians point out that emotional stress is capable of causing symptoms that are just as 'real' as symptoms caused by, say, tumors or inflammation, patients will appreciate your thoroughness. This approach enables the evaluation for sources of stress to proceed concurrently with the workup for an organic etiology, possibly over several visits.

Begin by ruling out significant current sources of emotional stress. These include problems within the family, domestic violence, problems at work, chronically insufficient personal time, and any source of substantial anxiety. Occasionally a major negative life event will be found to have coincided with the onset of symptoms. The next step is inquiry about vegetative symptoms of depression such as early morning awakening or other sleep disruption, persistent fatigue, change in appetite, spontaneous tearfulness, anhedonia and suicidal ideation.

Follow this by inquiring about stress in childhood. It is diagnostically and therapeutically helpful to elicit as detailed a history of childhood stress as time and the patient's comfort level will allow. Non-threatening questions such as "Were you under stress as a child?", "Can you tell me more about what went on?", "How often did that happen?" are most useful. It is important to elicit a history of any childhood stress that produces a lowered self-esteem in the child. Significant functional symptoms can occur in adults in the absence of what is commonly considered abusive treatment if childhood self-esteem was substantially and adversely impacted. Cases 2 and 3 are examples.

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Case 2

A 31-year-old white female was admitted for diarrhea and orthostatic vital sign changes. She reported that during the 18 months prior to admission she experienced 5-10 non-bloody bowel movements per day on 3-4 days per week associated with a documented 81 lb weight loss to 117 lb. On the remaining 3-4 days per week she was asymptomatic. An extensive evaluation did not determine an etiology. The patient denied significant current stress and any physical or sexual abuse in childhood or later. She had some symptoms of depression. She also recalled that it was her father's habit, on a daily basis from her earliest years, to spend most of the evening meal discussing his children's flaws and recommending methods for improving. This practice continued less regularly during her adult years. The patient recalled "never being able to please him." After discussion of these issues she felt a great sense of relief, became asymptomatic for the next four months (but was then lost to follow-up) and regained 15 lb in three weeks.

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Case 3

A 54-year-old white female was admitted for uncontrollable nausea, vomiting and vertigo. She reported a 15 year history of episodic attacks of these symptoms 6-10 times annually. She had been evaluated by "every GI, Neurologist and ENT" at a University Hospital and by many other physicians in her community as well. There was no history of significant current stress, depression or physical or sexual abuse in childhood or later. However she did recall growing up "like Cinderella but without the prince" with very poor treatment by her mother after the mother divorced and remarried when she was age two. She reported as well that driving through a particular town (25 miles from her home) "always" led to one of her attacks. Further questioning revealed that the only occasion that led her to pass through that town was while on her way to visit her mother. Driving the same distance in the opposite direction never produced an attack. After this revelation she became and remained asymptomatic.

Typical Findings in Adult Survivors of Child Abuse

The amount of time you devote to a patient's childhood stress history will depend on your index of suspicion regarding its relevance. It has been my experience that several findings in the history of the patient's teen/adult years are characteristic of adult survivors of child abuse. The more of these that you identify in reviewing records or in taking the history, the higher will be your index of suspicion that you are treating a child abuse survivor. These include a history of:

1. Early adult personal relationships in which the patient was treated poorly.
2. Prior negative medical evaluations.
3. Prior mental health treatment.
4. Suicide attempt(s) or self-mutilation.
5. Abuse of drugs and/or alcohol.
6. Smoking, particularly those who do not wish to quit.
7. Anorexia nervosa or bulimia.
8. Concerns about ability to appropriately discipline their children.
9. Feeling that the patient's life is better than ever but that something could go terribly wrong at any moment.
10. Belief that they are not as capable as their peers believe them to be.
11. Perfectionism.
12. Caring for problems of others so much they neglect their own problems.
13. Outbursts of anger that seem to have insufficient cause.
14. A major positive life event just prior to the onset of symptoms.

When the history is positive for significant childhood emotional stress in a patient with a negative medical evaluation it is reasonable to recommend that the childhood issues be addressed as an adjunct to planned medical therapy. This process is described in the next section.

Treatment

Begin with a simplified explanation of how symptoms could be linked to stress. Despite our poor understanding of the physiologic basis of these symptoms patients find this very helpful. A typical discussion that patients across the spectrum of educational backgrounds can comprehend is as follows:

"There is an area in your brain that manages stress. When it has too much to deal with it sends out nerve impulses to relieve the overload. These nerve impulses go to various parts of your body and cause symptoms. The best way to confirm that this is happening is to reduce the stress and then see if your symptoms improve."

Patients who have symptoms of depression appreciate the following addendum:

"If the stress manager in your brain is working too hard it may use too much of its chemical supply. This can cause trouble sleeping, persistent fatigue, change in appetite, loss of interest in activities you enjoy and even depression and suicidal thoughts. There are

medications available that are neither addictive nor tranquilizing that can restore those chemicals to the levels that nature intended. Using these medications is therefore much like a diabetic using insulin."

Supported by this information my patients have been able to focus on reducing sources of stress. When childhood issues are present, useful treatment resources developed for "Adult Children of Dysfunctional Families" are now widely available. They include self-help books,[7] support groups (through Al-Anon or the patient's church), educational classes and mental health professionals with specialized interest and training. A knowledgeable social worker can be invaluable in triaging patients among these resources.

In my experience, the combination of the discussion described above, symptomatic treatment, antidepressant medication where indicated and addressing childhood issues, if any, generally produces a definite improvement in symptoms at the initial follow-up visit. Complete resolution of symptoms generally takes a few months to a few years. Often there are relapses and remissions superimposed on steady general improvement.

A very small number of patients may acknowledge the importance of the childhood issues but be psychologically incapable of addressing them immediately. Even these patients generally experience some alleviation of their symptoms after discussion. Other patients will hear and appreciate your recommendations but state that they do not believe their admittedly significant childhood issues are a factor in their illness. It has been my experience that in most of these cases the patient's perception is correct.

Common Themes

Detailed interviews with over 1000 adult survivors of child abuse who presented with functional symptoms revealed that they often share certain personality characteristics. Familiarity with these is a useful background for clinicians who work with them.

As children many of these patients responded to the abuse or other trauma with hard work in school and at home. They were perpetually "on their best behavior." Many took on parental roles with respect to cooking, cleaning and other household duties. As adults these qualities made them ideal employees, colleagues and friends though often they would take on so much that they had little time for themselves.

As young adults, low self-esteem led them away from mutually supportive personal relationships and toward individuals whose treatment of them was more consistent with what they had experienced as children. As a result, a history of marriage to an abusive and/or alcoholic spouse or spouses is common.

As their hard work results in worldly success, however, self-esteem begins to improve which often leads to a positive, stable long-term personal relationship. Ironically this development is often very stressful because it challenges long-held views of their low value and creates anxiety about whether such a relationship can last. It is common for functional symptoms to appear soon after the start of the patient's first relationship with a supportive partner. In a variation on this theme, Case 1's symptoms began when she developed enough self-esteem to end the only negative relationship in her life, the one with her supervisor.

Mistreated children typically suspect that their abuse is partially deserved. But as self-esteem strengthens in the adult years their early experiences will increasingly be viewed as inappropriate. Anger, often unexpressed, about this treatment becomes more difficult to ignore. When a parent or other loved one was the perpetrator, the anger is often suppressed. Surprisingly to many, this suppression is commonly due to a desire for a healthy, positive relationship with that individual. These antagonistic emotions are difficult to resolve without expert assistance. The next case illustrates.

Case 4

An 83-year-old white female had a 25 year history of abdominal cramps, bloating and alternating constipation and diarrhea. An extensive evaluation over the years had been negative. From her earliest memories she recalled approximately weekly beatings with strap, baseball bat, or two-by-four by her father. She married at age 15 in order to leave this situation and was unhappily married for the next 63 years until her husband died. When her father developed prostate cancer she moved out of state (late in her sixth decade) and cared for him in his home for 18 months until he died. She and her father never discussed the physical abuse. The patient recalled hoping that her father would express affection for her and/or remorse for his abuse of her but this did not occur. Her gastrointestinal symptoms began soon after he died and she had returned home. With counseling her symptoms improved significantly although they did not completely resolve.

These common themes should be kept in mind when listening to patients describe themselves and their lives. The ability to recognize, understand, and respond to a survivor of child abuse will improve significantly.

Conclusion

This approach has favorably altered the course of patients who had previously frustrated the diagnostic and/or therapeutic efforts of one or more clini-

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cians. However, the ideas expressed here are based on the experience of one individual with a selected group of patients. They have not been tested against a control group. No firm conclusion is possible regarding the success of the approach in other settings. Nevertheless the concepts presented may aid others in developing their expertise with this very treatable group of patients. ❖

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"You must give birth to your images. They are the future waiting to be born."
Rainier Maria Rilke, Letters To A Young Poet.