Ethical Psychotherapeutic Management of Patients with Medically Unexplained Symptoms: The Risk of Misdiagnosis and Harm

Diane O'Leary and Keith Geraghty

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Abstract and Keywords

Management of medically unexplained symptoms (MUS) is undergoing a period of change. We see this in the recent breakdown of consensus on mental health management of quintessential medically unexplained conditions (like myalgic encephalomyelitis/chronic fatigue syndrome), and in recent work in bioethics suggesting that the issue of biological versus mental health management of MUS is fundamentally an ethical matter. For these reasons, it is important to think carefully about ethical aspects of MUS management in psychotherapeutic settings. In the first part of this chapter, the authors show how ambiguity in the term “MUS” leads to routine conflation of diagnostic uncertainty with psychological diagnosis for unexplained symptoms in medical settings. The second part of the chapter explores evidence suggesting that substantial harm results from a failure to draw that distinction in medical settings, and clarifies the psychotherapist’s obligations to avoid those harms. The authors then explore the risk for psychological harms when psychotherapists conflate diagnostic uncertainty with psychological diagnosis. Finally, they consider challenges to informed consent in psychotherapy for MUS. The chapter concludes with principles for ethical psychotherapeutic management of MUS.

Keywords: medically unexplained symptoms (MUS), treatment, psychotherapy, CBT, misdiagnosis

Introduction

Management of medically unexplained symptoms (MUS) is undergoing a period of dramatic change, and we see this most clearly in the realm of contested conditions. In 2015, the US Institute of Medicine (now Academy of Medicine) announced its conclusion that while medical and mental health providers have managed myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) as a condition caused by psychological distress for decades, doing so has been a mistake (Institute of Medicine 2015). ME/CFS, they concluded, is a serious biological disease that requires biological medical care, and this conclusion has been emphatically embraced by all US governmental health authorities, including the National Institutes of Health (Green et al. 2015), the Department of Health and Human Services (Chronic Fatigue Syndrome Advisory Committee 2015), and the Association for Research and Healthcare Quality (AHRQ 2016). A similar shift in professional consensus has occurred with long-term Lyme disease. While long-term Lyme is very often managed as a psychological condition (as recommended at this time by the US Centers for Disease Control 2018), the World Health Organization recently acknowledged the biological reality of several forms of persistent Lyme with new medical diagnostic codes for ICD-11, suggesting that at least some forms of chronic Lyme do require biological medical care after all (WHO 2018).

Because ME/CFS and chronic Lyme disease are quintessential examples of MUS, the dissolution of professional consensus on psychological management of these conditions has powerful implications for MUS management in mental health settings. Recent work in bioethics has suggested, moreover, that the issue of biological versus mental health management of MUS is fundamentally an ethical matter (Blease et al. 2017; O’Leary 2018a; Sankary and Ford 2018; Schwab 2018; O’Leary 2019). For these reasons, it is important to think carefully about ethical aspects of MUS management in psychotherapeutic settings, particularly when it comes to the question of biological medical care vs. mental health care.

In the first part of this chapter, we explore the concept of MUS, focusing on ambiguity in everyday usage of the term. We show how diagnostic uncertainty and psychological diagnosis for unexplained symptoms are routinely conflated in medical settings, a practice that violates scientific standards for clarity and ethical standards that protect access to medical care for patients who need it. In the second section, we explore evidence suggesting that substantial medical harms result from a failure to distinguish diagnostic uncertainty from psychological diagnoses, and we consider the psychotherapist’s responsibility to avoid those harms. In the third section, we explore the risk for psychological harms when psychotherapists conflate diagnostic uncertainty with psychological diagnosis. Lastly, we consider informed consent in psychotherapy for MUS. We conclude by organizing principles for ethical psychotherapeutic management of MUS.

The many naming iterations for MUS (Jimenez and Mayer 2015) have long complicated this area of practice. MUS are broadly labeled at this time as “functional disorders,” “psychogenic disorders,” or “psychosomatic symptoms,” terms that carry distinct individual shadings, and alternatives to these labels have proliferated at an astonishing rate in recent years. Though “MUS” remains in common usage, the American Psychiatric Association explicitly rejected use of the term in 2013, when it replaced “somatization” with “somatic symptom disorder” in DSM-5. In 2018, the World Health Organization (WHO) chose to replace somatization with “bodily distress disorder” in the new general edition of the International Classification of Diseases (ICD-11) (Gureje and Reed 2016), while a different construct, “bodily stress syndrome,” has been recommended to fill the parallel slot in the new ICD for primary care (Goldberg et al. 2016). Given these many ways of characterizing MUS, it remains unclear how diagnostic practice in this area will change in the com-ing years. In this chapter we use the term “MUS” in the broadest possible sense, in a way intended to be relevant for the whole range of alternative labels.

Diagnostic Uncertainty versus Diagnosis of Psychological Causes

Most lay patients assume that they will receive a diagnosis when they present to a medical doctor with bodily symptoms. The fields of psychotherapy and bioethics generally assume that medical care involves presentation, diagnosis, and treatment of symptoms—but that picture is very often mistaken.

Estimates of the prevalence of MUS vary widely, ranging from 11 percent (Johansen and Risor 2016; Swanson et al. 2010), to 86 percent (Kroenke and Mangelsdorff 1989) of outpatient cases. Generally, practice and policy guidelines accept an estimate in the middle of that range. The “Up to Date” (www.uptodate.com) research summary system states, for example, that “more than 50%” (Greenberg 2017) of outpatient cases involve medically unexplained symptoms, while the UK’s Joint Commissioning Panel for Mental Health states that “on average, 52% of patients accessing outpatient services have MUS” (JCPMH 2017: 6). In everyday medical understanding then, cases lacking diagnostic clarity are the rule much of the time, and not the exception. They are the norm, or at least they are understood to occur roughly as often as cases where a diagnosis is established.

The wide range of prevalence estimates for MUS arises from confounding ambiguity in professional use of the term (Jutel 2010; O’Leary 2018a). In some contexts, providers and researchers understand “MUS” very broadly (Jackson and Passamonti 2005; Kroenke et al. 1994; Steinbrecher et al. 2011) as a term that captures all symptoms that lack biological explanations. In this sense, when a health professional states that a patient has MUS, she is understood to mean simply that the cause of symptoms remains uncertain. The term “MUS” in this broad sense, can name every kind of symptom that might lead to diagnostic uncertainty, including benign self-limiting biological symptoms, rare disorders, contested conditions, everyday medical conditions that present in unusual ways, more serious medical conditions that are typically diagnostically challenging (such as autoimmune diseases), very serious medical conditions that have not yet made their seriousness apparent, and symptoms with primarily psychological causes (O’Leary 2018b).

In medical and mental health contexts, however, professionals very often use the term “MUS” in a more restricted sense where it is understood to name only the subset of unexplained symptoms that have psychological causes (Canavera et al. 2018; Johansen and Risor 2016; Kanaan 2018; Oyama et al. 2007; Swanson et al. 2010). Based on this more restricted sense of the term, the current ICD-10 for primary care classifies MUS in the section on psychiatric disorders (as “unexplained somatic symptoms”). Similarly, based on the restricted sense of the term, both the *Oxford Textbook of Medicine* (Sharpe 2010) and the Up to Date review system classify MUS as a psychiatric condition.

Mental health practitioners should recognize that because the term "MUS" can mean either the very large group of symptoms with uncertain causes or the smaller group with psychological causes, it is actually difficult for a medical provider to note for the record that a patient suffers from symptoms with uncertain causes. As a matter of peculiar professional fact, there is no term that names diagnostic uncertainty without also naming psychological diagnosis.

Moreover, this terminological ambiguity makes it difficult for medical providers to find information to help them determine when symptoms with uncertain causes can safely be confirmed as psychological disorders that do not require biomedical management. If a physician looks for this sort of guidance in *Macleod's Clinical Examination* handbook, for example, she finds:

> MUS cause similar levels of disability to those resulting from disease and are often associated with emotional distress. If such patients are not managed effectively, fruitless investigations and harm from unnecessary drugs and procedures may result. (Snadden et al. 2013: 27)

This entry clearly assumes that MUS do not, or cannot, be caused by disease, and that assumption confounds physicians' effort to manage diagnostic uncertainty carefully. Similar suggestions arise in the *Oxford Textbook of Medicine*, where providers in search of guidance for managing diagnostic uncertainty are encouraged to "seek specific treatable psychiatric syndromes" and "consider prescribing antidepressant drugs" (Sharpe 2010: 5299).

Once we become aware of ambiguity in usage of the term "MUS," we see that medical guidance for management of MUS is often terribly unclear. When we read, for example, the common suggestion that roughly half of symptoms in outpatient settings are medically unexplained, it's unclear whether we should conclude that in half of cases diagnosis is uncertain, or that in half of cases symptoms have psychological causes. While the ambiguity of "MUS" makes it difficult to pin down a definitive answer to that question, it's not difficult to see that the two claims are very different, that they require different forms of verification and radically different responses in patient management and health policy.

It is helpful to track an example that slips from the broad use of "MUS" to the specific use in a way that leads to problematic clinical recommendations. Salkovskis et al. (2016) write:

> Medically unexplained symptoms (MUS) are an extremely common source of distress and disability for service users attending both primary and secondary health care settings. Those experiencing such problems represent not only a substantial pool of unresolved distress and disability but are also a considerable drain on health care resources, which are deployed to no effect or may even worsen their

> problems in such cases. These patients gain little benefit from current medical treatments, which by definition will be misdirected. (Salkovskis et al. 2016: 172)

If we understand "MUS" in the broad sense that names all symptoms with uncertain diagnosis, we'll find the first two of these sentences to be sensible. Diagnostic clarity is very often elusive and it is often true that where diagnosis remains uncertain, healthcare resources are "deployed to no effect." The final sentence states, however, that medical treatments will be misdirected "by definition" in patients with MUS. While this is reasonable if we construe MUS in the specific sense, it is both false and decidedly dangerous if we continue to construe the term in the broad sense. In fact, for patients whose diagnoses remain uncertain, the most important feature of continued care is attention to the possibility that medical treatment might be needed.

As is so often the case in medical settings, the ambiguity of "MUS" in mental health settings invites practitioners to assume that biomedical treatment cannot be beneficial for any client with MUS. That assumption is clearly mistaken, and it carries considerable risk for every client whose symptoms have been characterized by diagnostic uncertainty, rather than psychological diagnosis.

On the level of ethics, the principle of beneficence demands that patients in need of biomedical care do receive it from their doctors. Indeed, it is hard to make sense of what medical practice amounts to without the basic form of beneficence that demands doctors' continual commitment to meeting biomedical need with biomedical care. When medical providers conflate diagnostic uncertainty with diagnosis of psychological causes they direct the course of patient care down the mental health track without first determining whether it is safe to do so. In this way, they risk obstructing access to biomedical care for patients in need, violating the duty of beneficence that fundamentally defines the roles of patient and doctor.

Mental health care is not defined by biomedical beneficence, but mental health practitioners do have obligations that pertain to biomedical risk, and it's important to be clear about those in every case where MUS are managed in a psychotherapeutic setting. In addition, mental health providers have a clear duty to avoid causing psychological harm. In cases where clients with MUS do suffer from undiagnosed medical conditions, psychotherapy that assumes psychological causation might well be damaging or, at best, compromised in efficacy. In the following two sections we explore psychotherapists' obligations with clients who suffer from MUS, with emphasis on the potential for medical and psychological harm.

First Do No Harm: Medical Risk and MUS

Psychotherapeutic management of MUS has become more standardized in recent years, so much so that the UK has developed a program to integrate psychotherapy services for MUS into general practice settings (National Collaborating Center for Mental Health & National Institute for Health and Care Excellence 2018); a suggestion other countries have also explored (Cooper et al. 2017; Derksen 2009; Holmqvist et al. 2013). Organizational arrangements of this kind seem to suggest that patients with MUS will generally benefit by turning away from medical management of symptoms in favor of mental health management, but is it safe for psychotherapists to embrace that idea? Should psychotherapists accept without question that MUS clients will generally benefit by ending further medical care in favor of mental health care? No, for three reasons.

First, given ambiguity in the term “MUS,” it is not merely easy for a physician to assume without further exploration that symptoms with uncertain causes are symptoms with psychological causes. As a matter of professional fact, it requires considerable effort for a physician to avoid conflating those two distinct symptom groups. As a result, based on referral, psychotherapists cannot determine whether MUS patients suffer from undiagnosed biomedical conditions or psychological conditions. Second, physicians are often poorly trained in mental health conditions, and negative attitudes toward patients with MUS can leave them eager to shift these patients out of the exam room into mental health services. It is not ideal for psychotherapists to be left with responsibility for determining whether patients have been hastily referred, though it is clear they must remain vigilant about the possibility. When possible it seems the best course of action to develop relationships with referring physicians so that tactful discussion might help clarify what is and is not known about clients’ needs.

Third, while it is commonly suggested that research has established a low rate of error with diagnosis of psychological causes for unexplained symptoms, on closer inspection it is clear this is not the case. Studies cited to support that conclusion (de Gusmao et al. 2014; Schuepbach et al. 2002; Skovenborg and Schroder 2014; Stone et al. 2005) determine how often patients with psychosomatic diagnosis “are subsequently given a disease diagnosis that, in hindsight, explained their original symptoms” (Stone et al. 2005: 989). As a matter of basic scientific method, that process can tell us a lot about the rate at which doctors are willing to overturn a diagnosis of psychological causes, but it tells us nothing at all about the actual rate of error. To determine that, researchers would need to directly and diligently search for cases where medical conditions have been mistakenly attributed to psychological causes (O’Leary 2018b).

Pressing as it is for mental health providers to know how often physicians mistakenly attribute unexplained symptoms to psychological causes, the field of psychosomatic medicine has not pursued research studies that can establish error rates of that kind (Eichner 2016; O’Leary 2018a). While a search for “cancer, diagnostic error” yields more than 26,000 research papers at the National Library of Health for example, “somatoform disorder diagnostic error” yields roughly 175—and the majority of those focus on mistaken medical diagnosis for symptoms with psychological causes. Medical practice guidelines commonly suggest that physicians rarely attribute symptoms to psychological causes in error, but there exist no focused research studies that support this suggestion (O’Leary 2018c).

Patient organizations have expressed increasingly vocal concern about error in diagnosis of psychological causes, and they've established substantial evidence to support that concern. The American Autoimmune-Related Disease Association (AARDA) for example, found that 52 percent of patients surveyed with autoimmune disease report that they've been denied biomedical care in the past based on mistaken attribution of symptoms to psychological causes (AARDA 2014). Moreover, the European Organisation for Rare Diseases (EURORDIS), has established a tie between diagnostic delay for rare disease patients and mistaken attribution of symptoms to psychological causes (Kole and Faurisson 2009). Their research determined that with eight rare diseases studied, mistaken diagnosis of psychological causes led to delays in rare disease diagnosis that were 2.5 to 7 times as long as delays caused by medical misdiagnosis.

Rare disorders, it is important to note, are anything but rare. In the United States, there are roughly 30 million people with rare disorders according to the National Institutes of Health (NIH Office of Rare Disease Research 2017); roughly the same number who suffer from diabetes (National Center for Chronic Disease Prevention and Health Promotion 2017). That reality alone, lends strong support to skepticism in cases where patients with MUS are referred for psychotherapy. Because rare disorders are actually common as a group, and because it is impossible for a physician to be familiar with even a small portion of them, it is impossible for physicians to safely rule out rare disease before making referrals for mental health care.

When psychotherapists do maintain skepticism about the wisdom of forgoing medical care in cases of MUS, they are forced to reckon with the ethical principle of non-maleficence, the imperative to "do no harm." How should we understand that imperative when it comes to the possibility that medical harm might arise from a psychotherapist's mistaken attribution of symptoms to psychological causes?

First, the psychotherapist should not expect to resolve the question of biomedical versus psychological causes for symptoms in cases of MUS. Skepticism is warranted in every case where MUS patients are referred for mental health care and psychotherapists should acknowledge that they lack the medical expertise to resolve that question. It is very commonly suggested that psychological causes for symptoms are more likely in patients who suffer from comorbid mental health disorders (Sharpe 2010) but the psychotherapist must recognize that this reasoning is confused. The presence of mental illness does not make any person less likely to suffer from a biomedical condition. On the contrary, mental illness increases the likelihood of biomedical illness (Lavtoo et al. 2013; Mouko and Sullivan 2017; Osborn 2001). Uncomfortable as uncertainty may be, it is not possible for the psychotherapist to reliably resolve the question of biomedical versus psychological causes for MUS.

Second, because a client referred for psychotherapeutic management of MUS might well be in need of biomedical care, a psychotherapist is obligated to proceed with substantial caution when it comes to discouraging clients from continued pursuit of biomedical care. The challenge here is in balancing the potential for harm from mistaken rejection of biomedical care against the potential for harm from pursuit of unnecessary biomedical care. Research shows that continued medical investigation makes it more difficult for clients to address the source of the problem when symptoms are caused by psychological distress (Page and Wessely 2003). Diagnostic tests and trial treatments, moreover, create risks of their own, and they waste valuable resources that could be put to more productive use. In addition, medical investigation often results in findings of uncertain significance and in cases of MUS, these findings can lead to overdiagnosis and overtreatment (Arnold and Kerridge 2018).

To balance these competing risks, clinicians should weigh their comparative seriousness. First, the risk of untreated disease may demand greater caution than the risk of untreated mental illness. This is certainly the case in clients whose only marker for mental illness is MUS, and there is no case where the presence of mental illness decreases the likelihood of disease. Second, risks from tests and trial treatments, and overdiagnosis and overtreatment, immediately pale in every case where those efforts confirm the presence of disease—and every case of MUS is a case where that confirmation remains possible.

Perhaps ME/CFS offers the most informative model for ethical balance with these competing risks. For decades, psychological causes for ME/CFS were so uniformly accepted in medicine and mental health that it seemed absurd for psychotherapists to doubt the wisdom of advising clients to abandon biomedical management of their condition. If the US Academy of Medicine, National Institutes of Health and Agency for Healthcare and Research Quality are correct, that advice has been misguided. According to these formidable authorities, in the last three decades many millions of patients with serious biological disease have been wrongly advised by physicians and psychotherapists to abandon their insistence on biomedical care. Even if the new US position turns out to be incorrect, it does establish the presence of medical risk even in cases where it seems absurd to imagine that disease is possible (Chronic Fatigue Syndrome Advisory Committee 2015; Green et al. 2015; National Institutes of Health Autoimmune Diseases Coordinating Committee 2005).

Difficult as it is for any professional to work with uncertainty, to proceed based on uncertainty, and to expect continued uncertainty, this is the nature of the task with clients who suffer from MUS. It is rarely possible for a psychotherapist to safely ignore the possibility of disease in clients with MUS, and this reality should form the foundation for ethical management.

Do No Harm: Psychological Risk and MUS

As we’ve noted, ambiguity in the term “MUS” means that physicians’ search for information about managing diagnostic uncertainty actually leads to information about cases of psychological diagnosis. The same is true in mental health. There exists no term in psychotherapy that names clients who suffer from undiagnosed symptoms without also implying that symptoms have psychological causes. As a result, in mental health as in medicine, providers can find little guidance for managing clients struggling with undiagnosed symptoms. This is no small problem—because routine psychotherapeutic management of MUS can be psychologically harmful for clients who suffer from undiagnosed medical conditions.

In a review article on management of MUS with CBT (Mobini 2015) we find this broad overview of goals:

> CBT aims to help patients manage their symptoms by enabling them to understand links between their symptoms, worries, feelings and behaviour. Patients are taught some cognitive and behavioural skills, so they can manage their bodily symptoms. (Mobini 2015: 1)

It has been suggested, moreover, that the benefits of CBT arise from “its focus on facilitating … self-responsibility of the patient” (Kleinstauber et al. 2011: 156), and this aspect of CBT management has particular ethical importance. Broadly speaking, CBT is thought to treat MUS by shifting the focus of the recovery process from biomedical action to personal action, so that the patient looks to herself, rather than to her doctors, to facilitate improvement.

What happens when a psychotherapist proceeds with CBT in this form with a client who suffers from undiagnosed symptoms caused by a biomedical disease? How would a client with, say, systemic lupus, respond if mistakenly referred for psychotherapy with a provider who is not careful about distinguishing undiagnosed symptoms from those with psychological causes? Lupus is a common autoimmune condition and it is important to note, again, that 52 percent of patients who suffer from autoimmune disease report having been denied medical care based on mistaken attribution of symptoms to psychological causes (AARDA 2014). It takes six years on average for lupus to be diagnosed in the USA (Al Sawah et al. 2015) and seven years in the UK (Lupus UK 2017). It seems reasonable to imagine that during those years, patients with lupus are often characterized as suffering from MUS and are often referred for psychotherapy.

When CBT “helps” the lupus patient to “manage” her symptoms by understanding their link to her feelings and behavior, it directs her to do something that is not humanly possible. In encouraging her to shift responsibility for improvement from her doctors to herself, CBT can lead the client down a track where she is doomed to psychological failure, both in her own eyes and in the eyes of her therapist. More than that, when psychotherapists suggest to biomedical patients that their conditions can improve only through their own psychological change, they teach clients to cultivate patterns of doubt about basic forms of self-perception that have actually been entirely reliable—so clients are taught to question their mental resilience in a way that could actually damage resilience. Though at this time there exists no research that explores psychological harms caused by CBT for MUS in patients who actually suffer from biomedical conditions—and that is an oversight that surely needs to be remedied—it is not difficult to see that it is harmful to place psychological responsibility for symptom improvement on clients who suffer from biological disease.

The same is true for other forms of psychotherapy that assume all MUS have psychological causes. “Intensive short term dynamic psychotherapy” (ISTDP), for example:

> focuses on the bodily experience of emotions and how emotions can convert into bodily symptoms. Specifically, ISTDP seeks to interrupt the buildup of physical symptoms by helping patients tolerate their anxiety, recognize and feel their emotions, develop healthier means of emotional expression and enhance self-care, all of which counteract destructive health-related behaviors. (Cooper et al. 2017: 112)

When clients’ symptoms are not “means of emotional expression” but are caused by biomedical diseases over which they have no control, ISTDP, like CBT, will be psychologically harmful. When US physician Nancy Klimas embarked on research to establish that ME/CFS patients experience exacerbated symptoms in response to trauma, she discovered evidence that they suffer from trauma as a result of “exposure to a health-care situation that was demoralizing and demeaning” (Weir 2014). Klimas has directly noted that when treatment for genuine disease attempts “to put it back on the patient” (Weir 2014) trauma results for the patient that violates the ethical imperative to do no harm.

Ethically speaking, risk of harm from standard forms of psychotherapeutic management of MUS cannot be justified by their potential benefits, because the portion of patients referred for psychotherapy in error remains unclear and might well be high. Both lupus and ME/CFS serve as meaningful cautionary tales in this regard. The psychotherapist can meet the obligation to avoid psychological harm with MUS clients by avoiding a prescriptive program of psychotherapeutic management that assumes psychological causes for medically unexplained symptoms.

Informed Consent, Care Access and Social Concerns

It is important to note that in countries with and without a national health service, patients with MUS are sometimes informed that continuation of medical or disability benefits depends upon their willingness to engage in psychotherapy (Rafik 2009). This situation is unique in medicine and mental health, and the features that make it unique are chiefly ethical.

As established by Beauchamp and Childress (2009), informed consent requires not only informedness and competence, but also voluntariness. While it is clear that the presence of MUS in no way challenges a patient’s competence to make medical or mental health decisions, it remains unclear whether consent to psychotherapy can be voluntary under threat of loss of healthcare or disability benefits. In clients who suffer from serious, persistent unexplained symptoms (regardless of whether those symptoms do or do not have psychological causes), a threat to healthcare or disability benefits is very grave indeed, and it is difficult to see how any client fearful of that outcome could meet the voluntariness requirement. While it is not the psychotherapist who places the client in such an ethically compromised position, when clients do pursue psychotherapy based on fear of this kind, the psychotherapist must recognize that standards for informed consent have been compromised and that these challenges would be disturbing for any reasonable client, regardless of diagnosis.

Perhaps more importantly, like doctors and psychotherapists, insurers and health policy makers often conflate diagnostic uncertainty with diagnosis of psychological causes for symptoms—and when they do they take the same unethical risks of medical and psychological harm. It is not the psychotherapist's responsibility to avoid or resolve ethical problems created by insurers or policy makers but again, it is not possible to manage a case of MUS ethically without awareness of this problem.

In cases where clients suffer from symptoms that do have unrecognized biomedical causes, a demand for psychotherapy from insurers or national health services is made in error. Patients in need of biomedical care do not receive it, and patients who do not need mental health care pursue it under threat. Every patient with MUS could be such a patient, and it is the psychotherapist's responsibility to recognize that. As with physicians' referrals, it is certainly easier to assume that insurers and health policy makers are correct in their determinations of who requires psychotherapy but, as with physicians' referrals, the psychotherapist can avoid potential harms only by maintaining skepticism about that conclusion.

Conclusions: Ethical Psychotherapeutic Management of MUS

Confusion in use of the term "MUS" in medicine encourages physicians to ignore the vital distinction between diagnostic uncertainty and a diagnosis of psychological causes for unexplained symptoms. Ethically speaking, that conflation risks obstructing access to medical care for patients in need, and in the context of bioethics, that risk could not strike more directly at the roles that define the enterprise of healthcare. For these reasons, ethical management of MUS in psychotherapeutic settings is based on awareness of the difference between undiagnosed symptoms and those with psychological causes, and recognition of physicians' tendency to ignore that difference when referring patients for psychotherapy.

It is very important to note that these principles in no way suggest that ethical psychotherapy for MUS is impossible. CBT, for example, is productive for clients with chronic medical conditions such as cancer (Daniels 2015), heart disease (Gulliksson et al. 2011), and diabetes (Safren et al. 2014). The difference is that while CBT for MUS aims for that shift toward clients' psychological responsibility for improvement, CBT for chronic medical conditions focuses instead on developing productive responses to the challenges of disease. Along those same lines, clients with MUS can certainly benefit from therapeutic recognition of the challenges involved in living with undiagnosed symptoms, and therapeutic support in coping with those challenges. What is important is that risk of harm cannot be avoided if the therapist understands any form of psychotherapy for MUS as a method for leading clients to recognize a psychological source of the problem. The principles that should guide practice in this area are listed in Table 1.

Table 1: Five core principles for ethical management of patients with MUS
1. Based on the ethical obligation to do no harm and the potential for physical harm when medical conditions are mistakenly attributed to psychological causes, psychotherapists should not expect to resolve the question of medical versus psychological causes for symptoms in cases of MUS.
2. Based on the ethical duty to avoid physical harm, the psychotherapist has a duty to proceed with great caution when it comes to discouraging clients with MUS from continued pursuit of medical care.
3. Based on the ethical obligation not to cause psychological harm, in every case where possibility of medical illness remains, however small, the psychotherapist has an obligation to avoid programs of psychotherapeutic management that assume MUS have psychological causes. It is not ethical to encourage clients who suffer from disease to take psychological responsibility for improving their health.
4. In cases where clients concede to psychotherapy based on fear of losing healthcare or disability benefits, the psychotherapist has an ethical obligation to recognize a challenge to informed consent and to maintain skepticism about the wisdom of the demand for psychotherapy on the part of insurers or health policy makers.
5. Clients with MUS can benefit from general therapeutic support for coping with uncertainty, and from forms of CBT for chronic illness that do not encourage clients to take personal responsibility for improving disease.

“Uncertainty is the constant companion of medical practice,” notes bioethicist Abraham Schwab (2018: 37), and as long as that is the case in medicine, it must be the case in psychotherapy for MUS:

> Whenever a practitioner considers a psychogenic diagnosis there is an as-yet unquantified risk of a false positive — a psychogenic diagnosis for symptoms that have biological causes. In cases of MUS, practitioners will not be able to avoid this risk. Because the robust support for a psychogenic diagnosis will always be lack-

> ing, the diagnosis is always provisional in a more fundamental way than most other diagnoses in medical practice. (Schwab 2018: 37)

Sociologist Chloë Atkins (2018) has suggested that "the culture of medicine needs to evolve" so that patient and provider are continually aware "of the possibility that [the] doctor may not be able to discern exactly what is wrong" (Atkins 2018: 21). The same is true of the culture of psychotherapy, and this is nowhere more the case than it is in the context of MUS. In this sense, ethical psychotherapeutic management of MUS begins and ends with truthfulness. Both provider and client will find uncertainty to be an uncomfortable starting point for therapy, but discomfort in psychotherapy has no more power to change reality than discomfort in the psyche. "Practitioners should incorporate strategies for communicating about uncertainty" (Schwab 2018: 37) and, on a personal level, for grappling with uncertainty as a starting point for care.

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Diane O'Leary

University of Maryland University College, Department of Philosophy

Keith Geraghty

University of Manchester, Department of Population Health