



GP Updates in Mental Health

Practical measures with your patients with medically unexplained 'functional' symptoms

Dr Sarah J Brown

Consultant Liaison Psychiatrist

RVI, Newcastle



Terminology

- Somatisation
- Conversion
- Dissociation
- Functional symptoms
- Medically unexplained symptoms MUS
- Medically unexplained physical symptoms MUPS
- Persistent physical symptoms PPS
- Hypochondriasis
- Hysteria



Functional symptoms

- Symptoms may not be related to a defined anatomical structure but to physical or psychosocial function
- **People prefer this term** (Stone, J., Wojcik, W., Durrance, D., Carson, A., Lewis, S., MacKenzie, L., Warlow, C.P., Sharpe, M. **What should we say to patients with symptoms unexplained by disease? The "number needed to offend"**. BMJ 2002;325;1449-1450



Common recognisable syndromes

- Fibromyalgia
- Irritable Bowel Syndrome
- Chronic Fatigue Syndrome
- Temporomandibular Joint (TMJ) dysfunction
- Atypical facial pain
- Non-Cardiac chest pain
- Hyperventilation
- Chronic Cough
- Loin Pain haematuria syndrome
- Functional Weakness / Movement Disorder
- Dissociative (Non-epileptic) Attacks
- Chronic pelvic pain/ Dysmenorrhoea



so·ma·ti·za·tion *noun* \,sō-mə-tə-'zā-shən

- conversion of a mental state (as depression or anxiety) into physical symptoms; *also* : the existence of physical bodily complaints in the absence of a known medical condition (Merriam-Webster online medical dictionary)
- “The presentation of bodily complaints assumed to arise from psychological disturbance” (Bass & Murphy, 1996)
- A process, not a diagnosis itself



Functions of somatisation

- Allows patient to occupy sick role while psychologically unwell
- Blame-avoidance – patient in role of victim
- Reducing blame minimises stigma for being emotionally unwell or ‘weak’
- The Doctor may become ‘blamed’ for not curing the patient

Goldberg D (1988)



Clinical impact

- 1 in 5 new consultations in primary care may be for somatic symptoms where no specific cause is found (Bridges, K.W. and Goldberg, D.P. (1985) Somatic Presentation of DSM-III Psychiatric Disorders in Primary Care. *Journal of Psychosomatic Research* 29:563-9)
- Up to 30% of primary care consultations no physical cause found for symptoms, rising to 52% in secondary care settings
Nimnuan, C., Hotopf, M. and Wessely, S. (2001) Medically unexplained symptoms: an epidemiological study in seven specialities. *Journal of Psychosomatic Research*, 51: 361-7



Consequences (Katon et al, 1984, 1991)

- Unnecessary and expensive lab tests
- Repeated hospitalisations
- Iatrogenic illnesses eg polysurgery
- Prescribed drug misuse
- Poor Dr-Patient relationship
- Secondary impact on family and social network
- Disability and loss of earnings
- Dependence on health care system for social support



Economics

- Up to 33,000 negative laparotomies per year in UK, many for non-specific abdominal pain (Raheja et al, 1991)
- Medically unexplained symptoms can cause direct excess treatment costs per patient estimated up to 5,353 USD annually. (Konopka, A. Economics of Medically Unexplained Symptoms: A Systematic Review of the Literature (2012) Psychother Psychosom 81:265–275).



Most frequent psychiatric associations

- Adjustment disorder (esp in primary care)
- Mood disorder (9-48%)
- Anxiety disorder
- Somatoform disorders (11-34%)
- Dissociative disorders
- Schizophrenia and related disorders
- Substance related disorders
- Factitious disorder
- Malingering



Treatment approaches

- A careful, chronological assessment
- Reframing the problem
- Help the patient to make links
- Reattribution of symptoms
- Management of any underlying disorder
- Cognitive behavioural therapy (CBT)



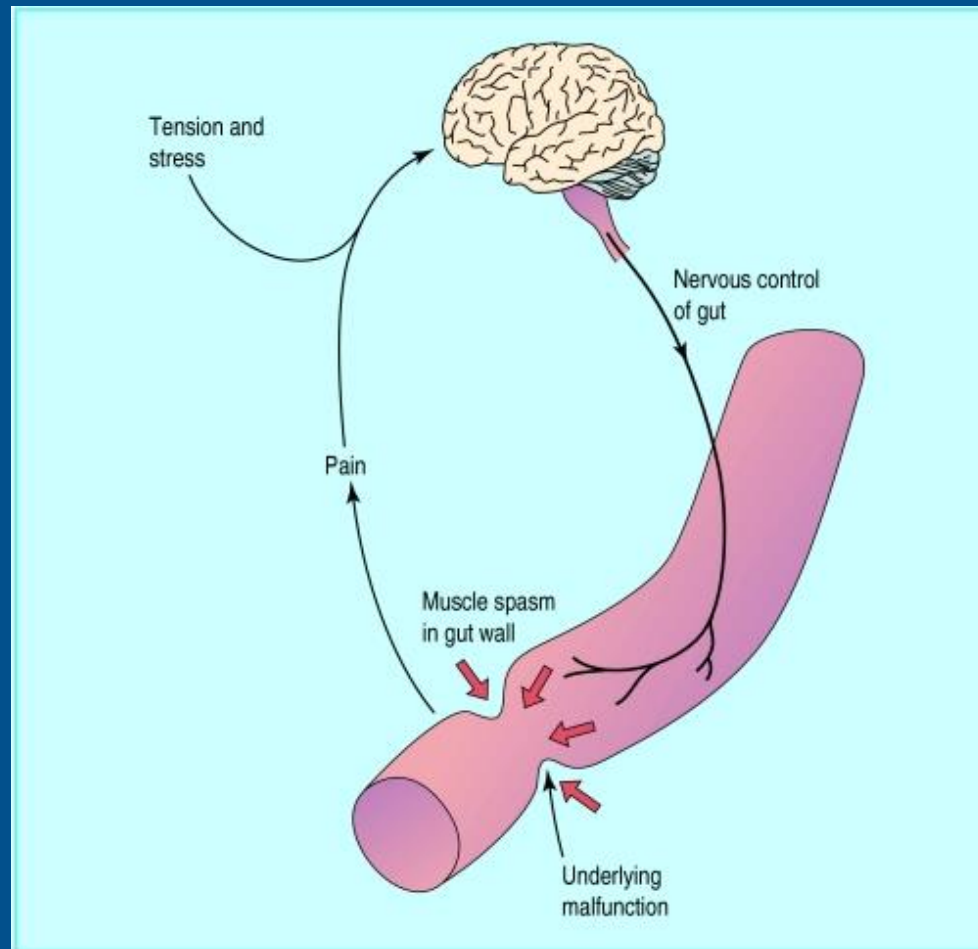
What helps

- Listen – acknowledge and validate the reality of the problem for the patient
- A credible alternative explanation
- Treat the treatable (screen for depression)
- DON'T treat what doesn't need to be treated
- When risks are low, NOT investigating may be better for the patient
- Be clear about referrer and patient expectations
- Close liaison with other professionals involved



A credible alternative explanation

How physiological and psychological factors combine to produce abdominal pain (Guthrie & Thompson, BMJ 2002)





What to say

“...so, you seem to be experiencing a, b & c symptoms and they are affecting x, y & z.

It is reassuring that [describe the normal function]; but I can see these symptoms are affecting you [describe how – 5 modalities]. We may need to try a different approach to [medication, surgery etc].

We know that stress can aggravate headaches, chest/abdo/other pain so a psychological assessment might help us both to understand the symptoms better and consider whether any treatment may be helpful...”



CBT approach (Stone et al 2005)

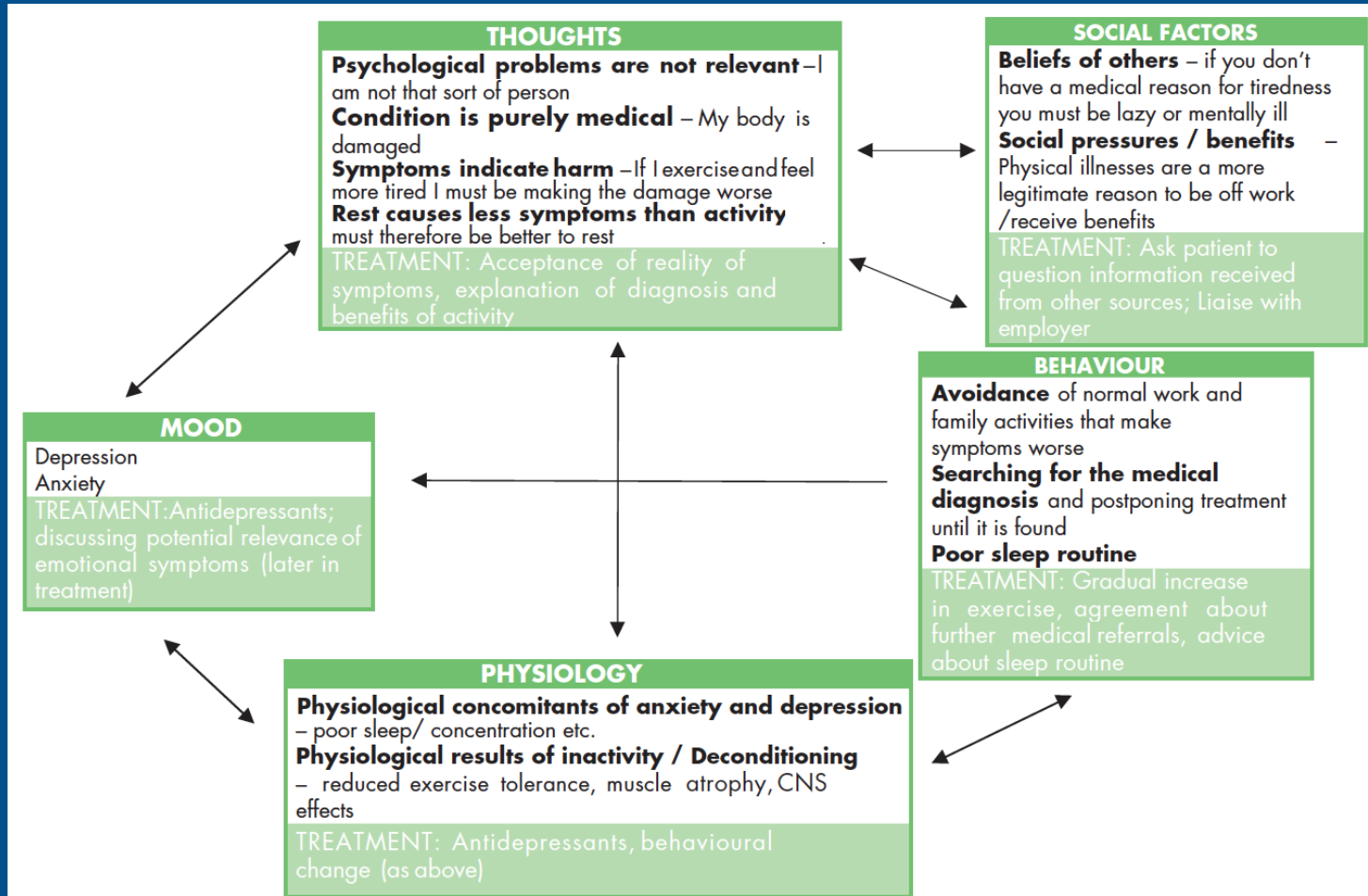


Figure 4 A model of perpetuating factors in functional symptoms (in this example, fatigue) illustrating some targets for treatment with cognitive behavioural therapy and antidepressants.



Outcomes

- 4%-10% go onto have an organic explanation for their presentation
- 75% remain unexplained at 12 months
- 30% (10% – 80%) have an associated psychiatric disorder (depression, anxiety)
- 25% persist for over 12 months in primary care

Source: **Guidance for health professionals on medically unexplained symptoms (MUS) RCGP 2011**

http://www.rcpsych.ac.uk/pdf/CHECKED%20MUS%20Guidance_A4_4pp_6.pdf



Hazards

- Iatrogenic harm
- Misdiagnosis
- ~ 5% may subsequently be found to have an organic explanation for their symptoms (Systematic review of misdiagnosis of conversion symptoms and “hysteria”. Jon Stone, Roger Smyth, Alan Carson, Steff Lewis, Robin Prescott, Charles Warlow, Michael Sharpe. BMJ 2005).



When functional symptoms are misdiagnosed as organic

- Needs to be handled with similar sensitivity and empathic approach
- May be an experience like bereavement
- Worse with greater chronicity and consequences
- May need to acknowledge iatrogenic harm



Who to refer and where to?

- Not all cases need a psychiatrist
 - Complex or severe cases
 - Mixed organic and functional pathology where one is impacting on the other
 - Removal of longstanding diagnostic labels
- CMHT/liaison psychiatry service
- Health psychology or local IAPT program
- GPs can manage depression and anxiety and refer to secondary care mental health as needed.



References and resources 1

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- www.neurosymptoms.org
- <http://www.iapt.nhs.uk/silo/files/medically-unexplained-symptoms-postive-practice-guide-2014.pdf>
- <http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/medicallyunexplainedsymptoms.aspx>
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- Commissioning support for London <http://www.londonhp.nhs.uk/publications/medically-unexplained-symptoms/>



References and resources 2

- NHG GUIDELINE ON MEDICALLY UNEXPLAINED SYMPTOMS (MUS) Hartman et al, 2013 https://www.nhg.org/sites/default/files/content/nhg_org/uploads/standaard/download/final_m102_solk_guideline_sk_mei13_0.pdf
- Clinical guidance (RCGP/RCPsych) <http://www.rcpsych.ac.uk/healthadvice/improvingphysicalandmh/medicallyunexplainedsymptoms/clinicalguidance.aspx>
- MUS Long term conditions toolkit (Online training module and materials) http://www.nes.scot.nhs.uk/media/2546310/mus_f2_1evaluation_link.pdf

ICD-10 (WHO, 1990 and annual updates)	DSM-IV-TR (APA 2000)	DSM 5 (APA 2013)
Multiple somatization disorder	Somatization disorder	Somatic symptoms and related disorders (SSD)
Dissociative (conversion) disorders	Conversion disorder	
Hypochondriasis	Hypochondriasis	
Pain syndromes without specific organic cause	Pain disorder	
Undifferentiated somatoform disorder	Undifferentiated somatoform disorder	
Other psychogenic disorders of sensation, function and behaviour	Somatoform disorder not otherwise specified	
Factitious disorder	Factitious disorder	
Malingering	Malingering Malingering is not a mental disorder	

Diagnostic classification



Key differences

	Generation of symptoms	Motivation
Somatoform disorders	Unconscious	Unconscious
Conversion disorders	Unconscious	Unconscious
Factitious disorders	Conscious	(Un)conscious – to enter sick role, but why?
Malingering	Conscious	Conscious – benefit of some type

Somatoform vs conversion: conversion requires ‘an alteration or loss of physical functioning’ rather than subjective experience of symptoms alone.



Somatization disorder (DSM-IV)

“a history of many physical complaints or a belief that one is sickly, beginning before the age of 30, and persisting for several years”
(APA, 1992)



Conversion disorder (DSM-IV)

- one or more symptoms affecting voluntary motor or sensory function
- resemblance to neurological or medical disease
- involvement of psychological factors
- unintentional, unfeigned symptoms.

(APA, 1992)



Hypochondriasis (DSM-IV)

- A. The preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
- B. The preoccupation persists despite appropriate medical evaluation and reassurance.
- C. The belief is not of delusional intensity and is not restricted to a circumscribed concern about appearance.
- D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The duration of the disturbance is at least 6 months.
- F. The preoccupation is not better accounted for by other psychiatric conditions.



Factitious disorder (DSM-IV)

- Intentional production or feigning of physical or psychological signs or symptoms.
- The motivation for the behavior is to assume the sick role.
- External incentives for the behavior are absent.
- Imposed on self (Munchausen's)
- Imposed on others (Munchausen's by proxy)

Special Articles

MUNCHAUSEN'S SYNDROME

RICHARD ASHER
M.D. Lond., M.R.C.P.

HERE is described a common syndrome which most doctors have seen, but about which little has been written. Like the famous Baron von Munchausen, the persons affected have always travelled widely; and their stories, like those attributed to him,¹ are both dramatic and untruthful. Accordingly the syndrome is respectfully dedicated to the baron, and named after him.

The patient showing the syndrome is admitted to hospital with apparent acute illness supported by a plausible and dramatic history. Usually his story is largely made up of falsehoods; he is found to have attended, and deceived, an astounding number of other hospitals; and he nearly always discharges himself against advice, after quarrelling violently with both doctors and nurses. A large number of abdominal scars is particularly characteristic of this condition.

That is a general outline; and few doctors can boast that they have never been hoodwinked by the condition. Often the diagnosis is made by a passing doctor or sister, who, recognising the patient and his performance, exclaims: "I know that man. We had him in St. Quinidine's two years ago and thought he had a perforated ulcer. He's the man who always collapses on buses and tells a story about being an ex-submarine commander who was tortured by the Gestapo." Equally often, the trickster is first revealed in the hospital dining-room, when, with a burst of laughter, one of the older residents exclaims: "Good heavens, you haven't got Luella Priskins in again, surely? Why she's been in here three times before and in Barta, Mary's, and Guy's as well. She sometimes comes in with a different name, but always says she's coughed up pints of blood and tells a story about being an ex-opera-singer and helping in the French resistance movement."

these patients are often quite ill, although their illness is shrouded by duplicity and distortion. When the whole truth is known, past history sometimes reveals drug-addiction, mental-hospital treatment, or prison sentences, but these factors are not constant, and the past may consist solely in innumerable admissions to hospitals and evidence of pathological lying. Often a real organic lesion from the past has left some genuine physical signs which the patient uses (to quote Pooh Bah) "to give artistic verisimilitude to an otherwise bald and unconvincing narrative."

SOME CHARACTERISTIC FEATURES

Most cases resemble organic emergencies. Well-known varieties are:

1. The acute abdominal type (laparotomophilia migrans), which is the most common. Some of these patients have been operated on so often that the development of genuine intestinal obstruction from adhesions may confuse the picture.
2. The hæmorrhagic type, who specialise in bleeding from lungs or stomach, or other blood-loss. They are colloquially known as "hæmoptysis merchants" and "hæmatemesis merchants."
3. The neurological type, presenting with paroxysmal headache, loss of consciousness, or peculiar fits.

The most remarkable feature of the syndrome is the apparent senselessness of it. Unlike the malingerer, who may gain a definite end, these patients often seem to gain nothing except the discomfort of unnecessary investigations or operations. Their initial tolerance to the more brutish hospital measures is remarkable, yet they commonly discharge themselves after a few days with operation wounds scarcely healed, or intravenous drips still running.

Another feature is their intense desire to deceive everybody as much as possible. Many of their falsehoods seem to have little point. They lie for the sake of lying. They give false addresses, false names, and false occupations merely from a love of falsehood. Their effrontery is sometimes formidable, and they may appear many times at the same hospital, hoping to meet a new doctor upon whom to practise their deception.



Malingering (DSM-IV)

- NOT a mental disorder
- “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.” (APA, 2000)



Somatic Symptom Disorder (DSM 5)

A. Somatic Symptoms: One or more somatic symptoms that are distressing and/or result in significant disruption in daily life.

B. One or more of: Excessive thoughts, feelings, and/or behaviours related to these somatic symptoms or associated health concerns:

- 1) Disproportionate and persistent thoughts about the seriousness of one's symptoms
- 2) Persistently high level of anxiety about health or symptoms
- 3) Excessive time and energy devoted to these symptoms or health concern

C. Chronicity: Although any one symptom may not be continuously present, the state of being symptomatic is persistent and lasts > 6 months.



Severity

- Somatic Symptom Disorder is a disorder characterized by persistency, symptom burden, and excessive or maladaptive response to somatic symptoms. There is a considerable range of severity. Typically, the disorder is more severe when multiple somatic symptoms are present. In addition to fulfilling criteria A and C, the following metrics may be used to rate severity:

Mild:	Only 1 of the B criteria fulfilled
Moderate:	2 or more B criteria fulfilled
Severe:	2 or more B criteria fulfilled plus multiple somatic symptoms

Aetiology (Stone et al,2005)	Biological	Psychological	Social
Predisposing	<ul style="list-style-type: none"> Genetic factors affecting personality Biological vulnerabilities in nervous system? Disease 	<ul style="list-style-type: none"> Poor attachment to parents and others Personality/coping style 	<ul style="list-style-type: none"> Childhood neglect/abuse Poor family functioning
Precipitating	<ul style="list-style-type: none"> Abnormal physiological event or state (e.g. hyperventilation, sleep deprivation, sleep paralysis) Physical injury/pain 	<ul style="list-style-type: none"> Perception of life events as negative, unexpected Depression/anxiety Acute dissociative episode, panic attack 	<ul style="list-style-type: none"> Symptom modelling (via media or personal contact) Life events and difficulties
Perpetuating	<ul style="list-style-type: none"> Plasticity in CNS motor and sensory (including pain) pathways Deconditioning (e.g. lack of physical fitness in chronic fatigue, deconditioning of vestibular responsiveness in patients with dizziness who hold their head still) Neuroendocrine and immunological abnormalities similar to those seen in depression and anxiety 	<ul style="list-style-type: none"> Perception of symptoms as being outwith personal control/due to disease Anxiety/catastrophisation about cause of symptoms Not being believed Avoidance of symptom provocation (e.g. exercise in fatigue) 	<ul style="list-style-type: none"> Fear/avoidance of work or family responsibilities The presence of a welfare system Social benefits of being ill Availability of legal compensation Stigma of “mental illness” in society and from medical profession