Are *Somatisation* Disorders any use to clinicians or patients?

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Charlotte Feinmann
Outline

* Context and Definitions
* Changing Classification
* Changing Medical Attitudes
* Understanding Psychological Mechanisms
* Collaborative Patient Care
* Integrated Care
* Conclusions
Previously **Briquet’s syndrome** or **Hysteria**

Somatisation is the association of medically unexplained somatic symptoms with psychological distress and health seeking behaviour

**Pejorative term** with enormous costs due to investigational non treatment (Tyrer 2013)

Better understood as **Bodily Distress** or **Health Anxiety** - 4 x times higher in patients attending medical clinics (Tyrer et al 2011)
Changing Classification:
Terminology

- Psychosomatic X
- Functional Syndromes / Persistent Symptoms
- Psychogenic X
- Medically unexplained?
- Somatisation?
Labels such as “psychogenic”

- Change how the individual is viewed and treated
- Implicitly blames patient for the pain
- Provides nothing helpful in the way of managing pain
3 year retrospective outpatients case note review
Less than 16% of patients received an organic diagnosis
Greater the number of symptoms the greater the likelihood of psychological distress Kroenke and Price 1992
Medically Unexplained Symptoms

- <10% have a physically identifiable cause
- 22% of primary care consultations
- 7% of all prescriptions
- 25-70% of acute services outpatient activity
- 8% inpatient activity
- 5% A&E activity
‘Somatic’ Symptoms

* **Functional** and **somatic** syndromes struggle to be classified logically

* **Clinical practice:** impossible to separate patients who suffer from **functional syndromes:**
  * Medical functional somatic syndrome (e.g. fibromyalgia) vs.
  * Mental disorder (e.g. health anxiety and bodily distress disorder).

* Are **somatic syndromes** a result of **medical specialisation**?
  * Fibromyalgia as a diagnosis → rheumatology
  * Irritable bowel syndrome → gastroenterologists
Some patients have more persistent disabling symptoms such as IBS; fibromyalgia; CFS; etc.

However diagnostic labels depend on the symptom and the specialty to which the patient is referred.

Substantial overlap in symptomatology among apparently diverse syndromes.

Poorly coordinated care, chaotic care pathways and iatrogenic harm.

Diagnostic Labels:
Wessley et al Lancet 1999
Overlap in symptoms for different syndromes/clusters of complaints

- IBS → Chronic pelvic pain / fibromyalgia → IBS

Multiple symptoms from different organ systems → epidemiological studies = separate somatic syndromes → family of closely related disorders sharing common:

- Aetiological factors
- Pathophysiological mechanisms
- Psychological characteristics.

Similar treatment strategies = effective for various functional syndromes → unified approach
One of the most expensive categories of health care expenditure in Europe (≈£200 million pa)
Shift some of this expenditure away from numerous investigations for organic disease
Move towards effective integrated treatment of bodily distress symptoms
Bodily Distress Disorders

* **Bodily distress syndrome (BDS)** introduced as an empirically based term
* **BDD** Hallmark= patient suffers from various physical symptoms of bodily distress.
* **BDD** diagnosis defined by **positive criteria** and is not a **diagnosis of exclusion**
* **BDD** preferred over the term proposed by the DSM-5 Somatic Symptom Disorders Work Group – **Complex Somatic Symptom Disorder**
BDDS captures **10 diagnostic categories** of functional somatic syndromes and somatoform disorders.
Dysphoric disorders
10 Anxious depression (new)
11 Depressive disorder
12 Anxiety disorder
13 Distress disorder (replaces F42.2, F43, F48)
14 Post-traumatic stress disorder (PTSD) (new)
15 Panic/agoraphobia (was panic disorder)

Body distress disorders
16 Bodily distress syndrome (new – was unexplained somatic complaints)
17 Health preoccupation (new)
18 Conversion disorder (was dissociative disorder)
DSM V proposes a multidimensional descriptive system for somatic symptoms

- Type of somatic symptom
- Number of symptoms
- Course – acute, chronic, recurrent
- Disease pathology/pathophysiology
- Health beliefs
- Illness behaviour
- Associated psychiatric disorder
- Social factors
Central Sensitisation

* Assessment becomes part of treatment and helps manage patients
* Allows us to acknowledge the patient’s experience of pain without attempting to validate its source
* Allows us to reassure patients that pain does not mean continuous damage or more serious illness
Pain and Catastrophising

* Catastrophizing: “a tendency to magnify or exaggerate the threat value or seriousness of an event”  
  (Sullivan et al Clin J Pain 2001;17:52-64)

* “I feel I can’t stand it anymore; This pain is overwhelming me; There is nothing I can do about the pain”  
  Coping Strategies Questionnaire (Keefe et al 1983)
Fear Avoidance in Chronic Pain

Vlaeyen et al. 2000

- Disuse
- Depression
- Disability

- Injury/Strain
- Avoidance/Hypervigilance
- Fear of pain/movement/re-injury
- Catastrophising

Pain!

Recovery

Confrontation of movement

No Fear
Collaborative Patient Care: Treatment

* Functional somatic symptoms considered together
* One-stop patient pathway
* Opens way for more general strategies and services for their management
* End to idiosyncratic approach by sub specialists in isolation from work elsewhere
* GP awareness raised with e-learning (rather than face-to-face tuition) RCPsych/Physicians e-module
Organisation of services

*SPLITTING OR LUMPING?*

In danger of having **separate clinics** for:
- Chronic fatigue syndrome
- Chest pains
- Fibromyalgia

Need to join up these different clinics and get them **more centrally placed on the agenda** → make them more visible to all specialists
Lots of advice - who coordinates?

- MUS Whole Systems Approach - Final Dec 2010.pdf
- Primhe GP Mental Health Group 2010
- Guidance for Health Professionals on MUS
  [www.mhhe.heacademy.ac.uk](http://www.mhhe.heacademy.ac.uk)/ 2010
- RCPsych Medically Unexplained Symptoms 2012
- DoH IAPT/LTC MUS Commissioning advice [IAPT](https://iapt.nhs.uk) | [LTC/MUS](https://www.iapt.nhs.uk/ltc-mus) > *Medically Unexplained Symptoms* 2009 and 2013
Model of Care

- Stepped care model recommended
- ‘Mild’ presentations → GP management alone
- Low intensity interventions: IAPT
  - Exercise
  - Health Training
  - Social Prescribing
  - Peer Mentorship
- Complex MUS → collaborative care:
  - Primary care
  - Physical specialist
  - Mental Health specialist (CBT, PIT)
Liaison Psychiatry and the Modern NHS Parsonage et al 2012

- Kensington and Chelsea - Primary Care Psychological Service lead by a Consultant Psychiatrist
- Hackney - Primary Care Psychotherapy Consultation Service
- Cambridge - Combined Liaison Psychiatry and IAPT Service
Conclusions

* Stepped care model which will allow identification of patients in primary care
* Standard packages of care in secondary care ensuring integration of the psychological and physical care of these patients
* Clinical Health Psychologists and or Liaison Psychiatrists to provide supervision, consultation and training