Switches and knives

Evidence-based psychodynamic skills for medically unexplained symptoms

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Outline

- What are medically unexplained symptoms?
- Why should psychiatric staff care about them?
- Psychodynamic concepts
- Psychodynamic skills for MUS
- Discussion

What are medically unexplained symptoms?

- *'Persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology'* (Chitnis et al 2011, FMHPC)

- What do we call them?
  - Psychiatric labels
    - Psychosomatic/Functional/Hysteria/Conversion/Somatoform
  - Medical labels
    - Irritable bowel syndrome (IBS), functional dyspepsia
    - Type 1'brittle' asthma
    - Functional neurological disorders eg non-epileptic attack disorder (NEAD)
    - Non-cardiac chest pain, Chronic pelvic pain, TMJ joint pain, Fibromyalgia
    - Chronic fatigue syndrome, ME, Gulf War syndrome
    - Multiple chemical sensitivity

Where are the patients with medically unexplained symptoms?

Primary care

- ~20% of new consultations (Bridges & Goldberg 1985, Knapp et al 2011)

Secondary acute (physical) care

- ~50% of new referrals (Nimnuan et al 2001)
- 20-25% of all frequent attenders at medical clinics have MUS as main reason for persistent health utilization (Fink 1992, Reid et al 2001)
- Frequent attenders with MUS get investigated more than other frequent attenders (Reid et al 2002)

Healthcare costs

- Annual NHS costs in UK ~£2.89bn in 2008/9 = 11% of total NHS expenditure on working age adults (Knapp et al 2011)

What about in mental healthcare?

- Can occur in the absence of psychiatric disorder, but…

- Number of bodily complaints is related in a linear way to the degree of psychological distress
- Psychological distress is a powerful predictor of poor quality of life and outcome in MUS
- ~25% of patients with severe somatisation have a co-morbid anti-social, borderline, histrionic or dependent PD (Bornfield & Gold 2008)

- ??higher prevalence in psychiatric settings
- ??common aetiological origins of PD and somatisation

Evidence base – what happens in medical consultations for MUS?

Patients signal their concerns and need for explanation of MUS

Patients describe social and emotional difficulties

Doctors do not engage with these cues

Doctors do not empathise

Patients elaborate/extend physical symptoms

Doctors suggest physical investigations

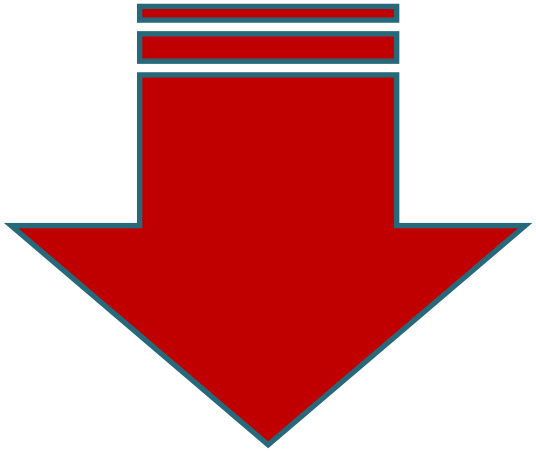
DOCTOR AND PATIENT BOTH DISSATISFIED

Salmon et al (2004) Br J Gen Prac

Ring et al (2005) Soc Sci Med

Salmon et al (2007) Psychosom Med

Lack of empathy for mental distress
Ignoring concerns, psychosocial cues and need for explanation



Patient dissatisfaction
Staff dissatisfaction
Longer consultations
More physical investigations
Absence of appropriate treatment

What is the mental health equivalent?

Lack of empathy for physical distress
Ignoring physical concerns and physical cues

Patient dissatisfaction?
Staff dissatisfaction (quietly)?
Incomplete assessments
Ineffective treatments

Why is it like that?
Blame Cartesian dualism…

BODY

- Acute care services are for organic physical disease. Staff are ‘organicisers’

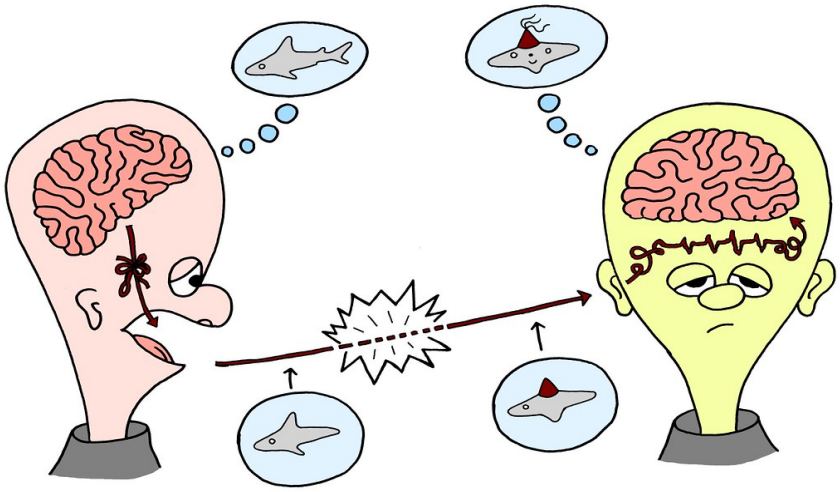
MIND

- Mental health staff are ‘psychologisers’

BODY-MIND

- Patients are somatisers (because we all are)

Talking different languages!



The emotional world is psychosomatic…

- … we all somatise! We emote with our bodies
  - First day at school
  - Exam nerves
  - Panic attack
  - Depression

- We also use many bodily metaphors for feelings
  - She's a pain in the neck, she does my head in
  - I had to just sit there and swallow it, but it turned my stomach
  - I've got bad butterflies
  - I felt crushed when he said that… I was really gutted

A psychodynamic theory of MUS

What enables us to know what causes physical sensations?

Integration of mental and physical functions…

= knowing who I am…

= MY SENSE OF 'SELF'

A psychodynamic theory of MUS

The self is both a mental and physical entity

eg our emotional world is a highly physical one

The self develops through interpersonal relationships

We need other people in order to develop a healthy sense of self

Integration of physical and mental experience is a developmental achievement, dependent on adequate care

eg the ability to experience ***tummy pain (i)as a sign of distress, which (ii)can be coped with*** *depends on relational experiences*

Dissociation of physical and mental experience is a developmental failure, caused by misattunement with caregivers in early childhood or as a result of trauma…

… so developmental failure can result in relating to the physical self as if it is a 'thing' rather than 'me'

A psychodynamic approach to MUS

- Assume that the patient's somatic symptoms are
  - (a) real and distressing felt experiences, and
  - (b) metaphorical body statements about feeling states

The patient's words describe symptoms which are ***simultaneously physical and psychological***

- Assume that from a focus on physical problems can develop a conversation which includes emotional & relational issues

We have to tune ourselves to the patient's wavelength first, by using their language = LISTENING TO THE STORY OF THE SYMPTOMS

Phase 1 - engagement

(i)Address ambivalence

- Introduction *Who you are*
- Indication of referral process *Why you have come to see them*
- Exploratory statement re: patient's view of being referred
  "Maybe this is a bit strange for you…….having a mental health worker come to see you"
- Elicit all of the patient's concerns about referral
- Emphasise the reality of the physical symptoms *(can use biopsychosocial model)*
- Show intention to listen to their story
- Make it clear that they have a choice whether to have assessment/treatment

Phase 1 - engagement

(ii) Listen to the story of the symptoms

- Attitude of expectation and interest

  "I'd like to know more about your pain here" [pointing to your own stomach]

- Be tentative *"I wonder…. Maybe it's a bit like… sort of as if…"*

- Note use of language, try to extend metaphors

Phase 1 - engagement

(ii) Listen to the story of the symptoms

- Attitude of expectation and interest
  "I'd like to know more about your pain here" [pointing to your own stomach]
- Be tentative I wonder…. Maybe it's a bit like… sort of as if…
- Note use of language, try to extend metaphors
- Note non-verbal cues, including gestures
- Stay with 'here-and-now" when it arises *Physical or psychological distress*
- Note links between symptoms and relational issues

Basic MUS skill set

- Empathise with physical distress
- Show interest in physical experiences
  - Ask about physical symptoms not just physical illnesses
  - Pick up on cues about physical symptoms
- Regard symptoms as metaphors

Advice for all clinicians

- MUS is everyone's business
- Start with:
  - Empathy for physical distress (it is a real experience)
  - interest in physical symptoms (ask about them, pick up cues)
- Remember the developmental perspective
- Remember the metaphorical approach
- If the patient feels believed and cared-for they may become open to your thoughts about their symptoms