RCPsych Eastern Division Spring Conference

All in the mind?: assessing and managing medically unexplained symptoms

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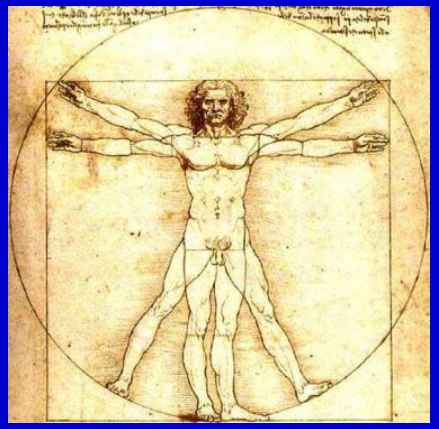
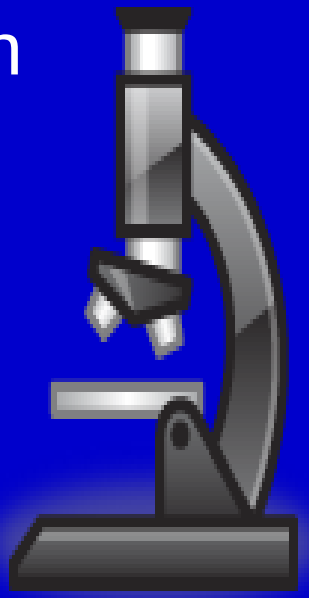
Mind-body divide



- In our thinking & language
- In our health services
- Where does it come from?

Mind-body divide

- Light microscopy - observable pathology
- Symptoms due to something we can see
- With positive findings on examination or investigation
- Problems when physical symptoms remain “medically unexplained”
- Are they “all in the mind”?



What patients hear (& what some health professionals think!)

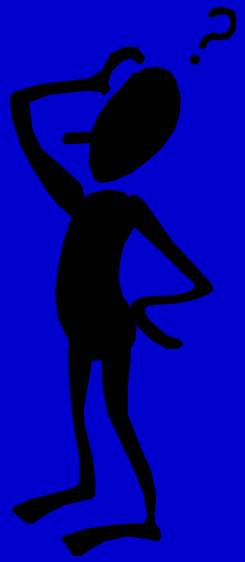
- "Your investigations are normal"
  - "Your problem isn't real"
  - "You're putting it on"
  - "You're mad"
  - "It's all in your mind"
- Which leaves a disgruntled patient, who still has their symptoms

Questions

- How do we diagnose and classify these problems?
- How common are they?
- Why do they happen?
- What can we do about them?
- Are they “all in the mind”?

Making a diagnosis

- Diagnostic systems are confusing
- Wide range to choose from
- Specialties speak different languages



Making a diagnosis

By aetiology

Examples

- Dissociative disorder (hysteria)
- Somatisation disorder
- Hypochondriasis (health anxiety)

By syndrome

Examples

- Irritable bowel syndrome
- Chronic fatigue syndrome
- Atypical chest pain
- Fibromyalgia
- Tension headache
- Multiple chemical sensitivity
- Chronic pelvic pain

So what should we call them?

- Symptoms not adequately explained by physical pathology

- Umbrella terms
  - Functional disorders
  - Medically unexplained (physical) symptoms

How common are MUS?

- Primary care: 20%
- Outpatient clinics: 25-50%
- Medical inpatients: 1-2%
- Liaison psychiatry: common referral

How much do MUS cost?

- MUS cost NHS in England over £3 billion p.a.
- Costs include
  - high levels of investigation
  - unnecessary and costly referrals
- Minority have a disproportionate cost
  - Complex and chronic cases
  - More likely to be referred to secondary care
  - Higher rates of investigation
  - Repeated primary care & ED presentations

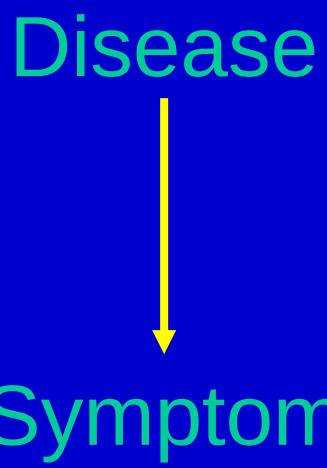
Symptoms which commonly remain medically unexplained

- Muscle and joint pain
- Low back pain
- Tension headaches
- Fatigue
- Chest pain
- Palpitations
- Irritable bowel
- Why are so many symptoms not adequately explained by physical pathology?

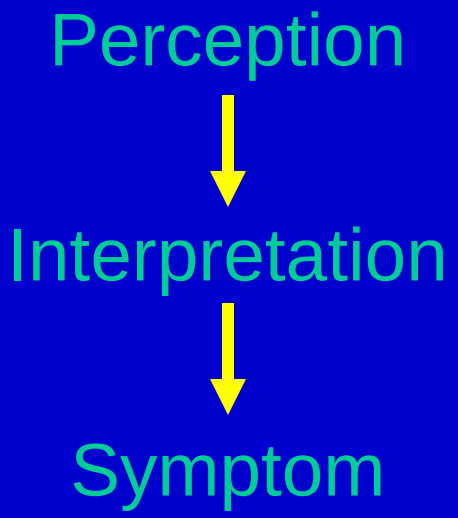
Back to basics: what is a symptom?

- “A phenomenon... arising from and accompanying a disease.”

Oxford English Dictionary



What is a symptom?



- Many symptoms are due to the perception of organic disease
- But many remain medically unexplained
- What factors are associated with MUS?

What factors are associated with MUS?: Predisposing factors

- Genetics
  - CFS, IBS
- Experiences of illness
  - Childhood
  - Family
- Childhood abuse & neglect
- Illness beliefs

What factors are associated with MUS?: Precipitating factors

- Life events
- Stress
- Infection & injury

What factors are associated with MUS?:
Perpetuating factors

- Anxiety & depression
- Reaction of others
- Iatrogenic

Aetiology of MUS

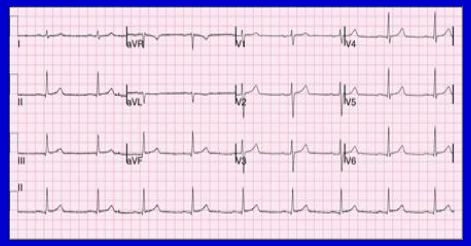
Perception

↓

Interpretation

↓

Symptom



Management

Stepped care:

- 1) Basic management
- 2) Specialist management
- 3) “Damage limitation”

Basic management

History

- What are the patient's concerns and beliefs?
- "What do you think is wrong?"
- Are there any background problems?
- Screen for drug & alcohol misuse (don't forget caffeine)
- Screen for anxiety and depression

Examination & investigation

- “How much should I investigate?”
- As much as is appropriate
- Over-investigation can reinforce the patient’s conviction that there must be something physical wrong

Examination & investigation

- Prepare patients for results
- If they are negative, what might this mean?

Reassurance

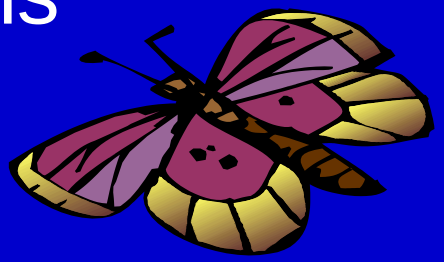
- Most patients are reassured
- Bland reassurance is unhelpful
- Address the patient's fears and beliefs
- Correct any misconceptions
- This goes hand in hand with...

Explanation

- Give a positive explanation
- Put the mind and body back together
- Explain how physical, psychological and social factors interact
- “Reattribution”

Explanation

- Bodily symptoms of emotions
  - blushing
  - butterflies in the stomach



- Vicious circle of pain & depression
- Hardware vs. software
- Fight or flight response
- RCPsych leaflet: MUS

Specialist management

Specialist management

- Chronic problems
  - often several volumes of notes
- Number of specialities
- Reasons for the problem are unclear
- Patient finds alternative explanations difficult to accept

Assessment

Aims

- Build a relationship
- Broaden the agenda
- Education
- Treatment plan

- May be a long meeting!

Antidepressants

- Anxiety and depression have physical symptoms
- Patients often have both physical illness and depression
- Analgesic effect
- Helpful even in the absence of depressive illness
- Evidence: IBS, chronic fatigue syndrome, chronic pain

Psychotherapy

- Most evidence for CBT
  - e.g. somatisation, CFS, IBS, non-cardiac chest pain, chronic pain
- What about psychodynamic therapy?
  - Looks at contributory factors in earlier life and current relationships
  - Often more helpful in understanding than treatment

Psychodynamic perspective

- Childhood emotional deprivation
  - Lack appropriate adult emotional responses
  - Symptoms a way of expressing emotions...
  - ...or a defence against difficult feelings
- Metaphorical symptoms
- Carer / invalid relationship
- What would life be like without symptoms?

Cost savings

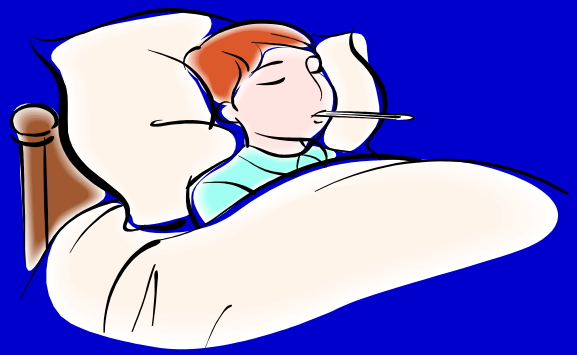
- Single psychiatric consultation
- 40% reduction in cost of investigations

Barsky et al (1986)

“Damage limitation”

“Damage limitation”

- Psychological understanding may not lead to an improvement in symptoms
- Recognise poor prognosis
- Reduce expectations of “cure”



“Damage limitation”

- Facilitate communication
- Limit unnecessary investigations and appointments
- Contain consulting behaviour with regular appointments

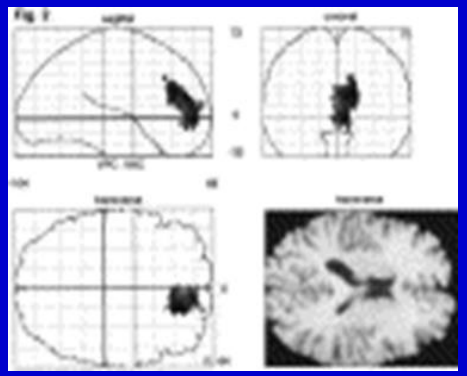
Misdiagnosis?

- Slater (1965)
  - Diagnosis of ‘hysteria’
  - Over half developed neurological or psychiatric disorders on 10-year follow-up
- Later studies e.g. Crimlisk (1998)
  - Failed to show this level of diagnostic instability
  - But noted high levels of psychiatric comorbidity
  - Better prognosis with shorter duration of symptoms and co-morbid mood disorder

The future: diagnosis

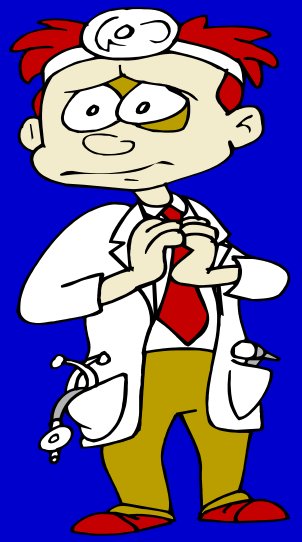
- DSM-5 (2014), ‘somatic symptom disorder’
- ICD 11 (2018), ‘bodily distress disorder’
  - distressing symptom(s), disproportionate to physical pathology; excessive attention, not alleviated by clinical contact and reassurance
- No ‘medically unexplained’ criterion
- Dissociative disorders & hypochondriasis coded separately

The future: aetiology



- PET studies of regional blood flow in unilateral dissociative paralysis
- Low blood flow in thalamus & basal ganglia, which resolved with recovery
- Hypothesis
  - Unconscious inhibition of willed movement
  - Neurobiology of dissociation

The future: MUS services



- Recognition by policy makers
  - common & expensive problem
- Reinforce basic skills of all health professionals
- Specific integrated physical and mental health services

Conclusions

Medically unexplained symptoms:

- Common
- Costly
- Treatable
- Cost savings

Medically unexplained symptoms - are they *all in the mind?*

- Not “unexplained”
- Explaining them depends on consideration of physical, psychological & social factors
- And recognising that we are not separate minds & bodies

Further reading

- RCPsych leaflet: Medically Unexplained Symptoms
  - www.rcpsych.ac.uk
  - Includes further information & suggested references
- Joint Commissioning Panel for Mental Health: Guidance for commissioners of services for people with medically unexplained symptoms
  - www.jcpmh.info