Working with medically unexplained symptoms

Dr Simon Heyland  MRCPsych, Birmingham & Solihull Mental Health NHS Foundation Trust
and
Dr Julian Stern FRCPsych, Tavistock and Portman NHS Foundation Trust

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MUS workshop overview

• Introduction
  ◦ Terminology, epidemiology, health care costs
  ◦ Psychodynamic theories

• Case presentation & discussion

• Psychotherapeutic principles for (i)assessment (ii)therapy

• BREAK 10 -15 minutes

• Applications
  ◦ Service models – City & Hackney PCPCS, Birmingham MUS project

• Discussion
Ms A has a working diagnosis of a depression and longstanding complex problems including somatisation, chronic pain and also recent episodes of illnesses including bleeding, paralysis, headaches, pseudoseizures and self-harm. She is 27 yrs old, single, with lots of support from her aunt. …
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, FHMPC)

- **Psychiatric labels**
  - Psychosomatic/Functional/Hysteria/Conversion/Somatoform/bodily distress

- **Medical labels**
  - IBS, functional (non-ulcer) dyspepsia
  - Non-epileptic attack disorder, tension headaches
  - Non-cardiac chest pain, Chronic pelvic pain, TMJ joint pain, Fibromyalgia
  - Chronic fatigue syndrome, ME, Gulf War syndrome
  - Multiple chemical sensitivity
  - Type 1‘brittle’ asthma

- **Colloquial labels**
  - .....

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 estimated £2.89bn in 2008/9, or 11% of total NHS expenditure (Knapp et al 2011)
What impact does MUS have on medical staff?

- Finding MUS stressful (Ringsberg 2006; Dowrick et al 2008)

- GPs devalue their psychological skills in working with MUS (Salmon et al 2007)

- GPs frequently suggest physical interventions even when patients are not demanding them (Ring et al 2005)

- MUS consultation skills are not taught to acute care specialists at any stage of medical education (Salmon 2007a)
‘Sorrow that finds no vent in tears may make other organs weep’

*Sir Henry Maudsley 1835 - 1918*
Psychodynamic theories

- Classical vs contemporary
- Defence vs deficit
- Primary vs secondary symbolism vs non-symbolism
- Conversion vs somatisation
- Affect regulation and desomatisation
Classical theory - Freud

- Theory of sexual trauma (or unacceptable sexual/aggressive fantasies)
  Internal conflict between idea/wish and morals

  *Repression of idea/wish*

  Energy converted into a bodily site innervated by the sensory or voluntary motor nervous system

  Symptoms symbolically express both the forbidden idea/wish and defences against the idea/wish ie conversion

- eg Mrs A has pseudoseizures – precipitated by aggressive feelings, render pt unable to attack anyone else, but enacting a violent scene on the floor and with dazed mental state
Classical theory - Janet

Trauma causes:

- Severe developmental arrest in personality
- Dissociations and conversions
- Atomised/fragmentary sensory impressions are recorded in the body, like literal imprints of bits of the traumatic experience (Meares 2012)
Contemporary theory

Similar symptoms, different underlying mechanisms? (Taylor 2003)

- Conversion – leaps from mind to body, follows psychic laws

- Somatisation – begins in the body, follows somatic laws

- Secondary symbolism
Contemporary theory

Desomatisation

- Emotions start as sensorimotor phenomena, which acquire a psychological component (idea/imagery) to become feelings

- Affect development = process of desomatisation, and verbalization as feelings

- Desomatisation (experience of body as ‘self’) = developmental achievement dependent on adequate care
Contemporary theory

- Deficits in sense of self may include:
  - Alexithymia
  - Failures of self-regulation eg weakness of higher order inhibitory pain mechanisms (Meares 2012)
  - Failure of identification of bodily experience as self
  - Affect dysregulation and somatisation - link to personality disorder?
Ms A-referral

- 42 y.o. woman referred by gastroenterologist with almost 40 yrs history of withholding of stool, profound constipation and development of a megacolon
Questions

- Would she have agreed to go to a more “typical” Psychological Therapy dept, or did it “need to be in a medical setting”?

- What about liaison with medical carers? Traditionally this does not happen in a “pure” psychoanalytic therapy. What are the pro’s and con’s? She found it reassuring.

- Does the presence of medical disease require modification to “standard practice”?
Future

- What is possible for her?
- What links can she allow in her mind?
- What links need to be made in the mind of the therapist, even if she cannot hold them?
Therapeutic techniques

- Basic principles applicable for assessments in all healthcare settings
- Working in formal psychotherapies
Basic therapeutic principles applicable in all healthcare settings - ASSESSMENT

- **Referral management**
  - Investigation
  - Reassurance
  - Explanation

- **Engagement**
  - Address ambivalence
  - Story of the symptoms
Phase 0 – referral management (aka Advice to physicians)

Ensure referrer has:

- Completed investigations and discussed:
  1. Results of Ix,
  2. Why no further Ix are indicated
  3. Success with further medical treatment is unlikely

- Reassured patient about absence of organic disease

- Explained symptoms - biopsychosocial model
  - Complex interaction of psychological factors may contribute to maintenance of physical symptoms…
    
    ......and you have specialist colleagues whose help is available
Biopsychosocial model of illness

Physiological change  Psychological/social stress factors
Phase 1 - engagement

(i) Address ambivalence

- Acknowledge referral process
- Validate physical symptoms
- Elicit all concerns about referral
  
  “Maybe this is a bit strange for you……..seeing a psychiatrist”

- Highlight that they have a choice whether to have assessment
Phase 1 - engagement

(ii) Listen to the story of the symptoms

- Curiosity
  “I’d like to know more about your pain here” [point to your own stomach]

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

- Note use of language, esp metaphorical descriptions of symptoms

- 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
Technique in formal psychotherapy

- Debate in psychoanalytic circles-to what extent should “classical” technique be modified for such patients?
- Bronstein:
- Guthrie: non-linear causality; symptom narrative is key to relational disturbance; work with secondary symbolism (both/and approach)
Bronstein, C (2011)

“In Britain, these types of referrals (patients with psychosomatic complaints) are not very common (to analysts). However, some patients with psychosomatic conditions are seen by psychotherapists working in their hospital settings and some do seek analysis.

Question-in passing

- Why are these patients not often seen and written about in British psychoanalytic circles?
- What is it about the body, and the reality of bodily processes, sensations and functions, that means it is ignored, or brushed aside?
BREAK
Why is MUS important?

- Common
- Expensive
- Neglected in medical training
- Stressful for doctors
- Over-investigated
- Few care pathways or services
- Effective treatments not usually available
...but the good news is...

- Effective evidence-based treatment strategies exist.¹³

- Collaboration between mental health and physical health specialists can improve physical symptoms and reduce frequent attendances (Reid et al. 2002)

- UK expert guidance exists (Chitnis et al. 2011, Creed et al. 2011)

- Political interest exists currently
What should we be doing about MUS?

1. Improve clinicians’ and healthcare commissioners’ awareness of treatability

2. Make services less dualistic
   - Collaborative professional relationships
   - Joined-up care pathways
   - Multi-disciplinary team
   - Psychological therapies in acute settings

3. Train clinical staff
   - GPs
   - Hospital specialists
   - Mental Health Professionals

In other words

Changed pathways and behaviour in primary and secondary care are needed, along with improved access to psychological therapy services (Bermingham et al. 2010)
Service development

- Top-down: PCPCS
- Bottom-up: Birmingham MUS project
A new service in Primary Care

- Tavistock PCPCS service (Primary Care Psychotherapy and Consultation Service) in Hackney
- Works in about 40 GP practices
- Offers up to 16 treatment sessions with patients/families—especially those “falling between the gaps”.
- Special interest in patients with LTC’s and MUS (Medically Unexplained Symptoms)
"What we wanted was a service which had very flexible referral criteria - based in surgeries, for GP referral only - and who could both see patients and consult to GPs about patient management"

"We knew the service would have to be comprised of very experienced clinicians - as we also knew that the patients we were “holding” were often highly complex patients."

Dr Rhiannon England
City & Hackney GP
3 particular groups of patients

- Patients with MUS/LTC’s
- Those with psychiatric diagnoses - some not reaching CMHT threshold, some discharged by CMHTs, others won’t engage
- Those with personality pathology/disorder but not reaching PD service thresholds
- (Predominantly HoNOS Clusters 4-8)
Our patients: 1

49% of patients have ‘medically unexplained symptoms’ (MUS)

52% of patients have received two or more previous treatments

51% of patients have features of or a diagnosis of personality disorder

45% of patients are frequent attenders

8% have severe and enduring mental health problems
Distinctive Features

- GP commissioned and embedded in GP surgeries
- Addressing complexity in PC: between IAPT & traditional psychiatry
- Dual focus
  - Capacity & capability-building of primary care system through various interventions aimed at supporting GPs and surgery teams
  - Providing a direct clinical service to patients and their families with brief, focused interventions
- Few exclusion criteria
- Active collaboration with other services: integrated pathway
What we offer

To GPs:

- **Professional consultation** to GP and other primary care staff
- **Case based discussions** with GPs and other practice staff
- **Joint consultations** with GPs and patients
- **Tailored training** to GPs and other practice staff
- **Liaison** with other services and agencies
- **Signposting** to other appropriate services

To patients:

- **Assessment** (1 or more sessions) identifying on-going care plan
- **Extended consultation** (typically offered over 4 - 6 sessions working on a specific issue identified during assessment)
- **Brief psychological treatment**, one-to-one (6-16 week, evidence-based psychological therapies, incl. cognitive behavioural, dynamic interpersonal, and mentalization-based therapies)
- **Group psychological treatment** (Brief, structured psycho-educational, therapeutic groups; physical symptom groups; and mentalization-based therapy groups)
- **Case Management** (Face to Face / Telephone / Service Liaison)
- **Family therapy and couple therapy**
The team

- Multidisciplinary (psychology, psychiatry, nursing and social work)
- Experienced clinicians, skilled in psychodynamic and systemic approaches with an interest in psychological and physical presentations
- In-house medical consultant facilitating an integrated care approach: combining the perspectives from GPs, psychiatry & psychological modalities to patient care.
We haven’t stood still

- BME Horticultural Community Project for Turkish community
- Contribution to deliver Rapid Assessment, Interface and Discharge (RAID) to A&E
- Care Planning Service
- Recently commissioned -similar service in London Borough of Camden
Evaluation is Crucial
Capita (2011) & CMH (2014)
Capita report (2011)

- GPs found the “level of skill, professionalism and responsiveness of the service as being significantly superior”

- “… genuine sense of pride in this service and many felt that [other] GPs … were very envious of the service they had”
Dr Geraldine Strathdee, National Clinical Director for Mental Health, NHS England:

- The ground-breaking PCPCS…offers help for a range of needs, close to home, rather than in remote clinics.
- This kind of innovation should be the hallmark of a twenty-first century NHS.
- The Centre for Mental Health has shown that the PCPCS does not just get good clinical results but that it represents a good use of scarce public money.
IAPT benchmarked measures:
- c. 75% of all patients show improvements in their mental health, wellbeing and functioning
- c. 55% are shown as having “recovered”.

Favourable with outcomes achieved by IAPT services, even though typically treating more severe and complex cases.
Cost Savings

- The treatment by the PCPCS reduced the costs of NHS service use by £463 per patient in the 22 months following the start of treatment.
- Savings in primary care accounted for 34% of this total (mainly fewer GP consultations*) and savings in secondary care for 66% (fewer A&E and outpatient attendances and inpatient stays).
“Good Value for Money”

- The subsequent savings from reduced health service use are equivalent to about a third of this cost: a significant offset.

- Based on the cost-effectiveness framework used by NICE, PCPCS QALY (quality-adjusted life-year) of around £10,900 … below the NICE threshold range of £20,000 - £30,000.
“It feels genuinely collaborative, the most rewarding relationship in 25yrs of practice”.

“I really got a lot of benefit from the joint consultation.”

“Excellent clinicians and very straight forward; I wish the waiting list could always be shorter. I think this is because there are problems with the quality of the alternate service - primary care psychology IAPT.”

“It is very helpful to speak to therapist personally to see whether a referral is appropriate. It is usually easy to get hold of the therapist.”
Propagating the model

- Awards (RCPsych 2013, shortlisted BMJ Mental Healthteam 2015)
- E-learning modules
- Publications
- Presentations
Conclusions

- Prescient
- Patient focussed
- Popular with GP’s
- Adds significantly to the pathway
- Capacity and capability
- Value for money
Birmingham MUS pilot project

- Liaison psychiatrist & medical psychotherapist
- Awareness of evidence-based psychodynamic model for MUS
- Identified need in acute hospital & interested physicians
- SHA funding for ‘workforce development’
- Senior management support
- Link to local GPs with interest in MUS
Birmingham MUS pilot project

- Literature review – what’s the evidence?
- Talk to experts on MUS and medical education
- Shadowing each other in clinic
- Recruitment and secondments
Birmingham MUS pilot project

A small-scale whole-system redesign

GP practice + Gastroenterology service + BSMHFT

- Raising awareness
- Joint medical training course
- New care pathway to multidisciplinary ‘Symptom Management Group’
- Triage & assessment by MUS specialists
- Advice & signposting
- Provision of psychological therapies in acute settings and primary care: PIT, CBT
Doctors (training)

- Limited evidence for existing training approaches (e.g., reattribution)

- Evidence of microskill deficits in GP consultations for MUS

- Microskills training based on psychodynamic approach?
Joint medical training course

One-day intensive for GPs and gastroenterologists

- Introduction to MUS
  - Concepts, epidemiology, costs

- Consultation skills
  - Anti-therapeutic (role-play)
  - Therapeutic (role-play)

- Management of MUS
Distribution (ie change care pathways)

- Direct referrals from GPs and gastroenterologists
- MUS specialists based in hospital and GP surgery
- Monthly multi-disciplinary meeting
- Consultation
- Advice
- Signposting
Distribution (ie change care pathways)

**MUS pilot project**

- **Neurology**
- **Neuropsychiatry**
- **Psychotherapy & clinical psychology**
- **CMHTs**
- **Eating disorders**

**Embedded clinical psychologist/liaison nurse therapists → network of MUS expertise**

**Seamless direct access to specialist mental health services**

**Gastroenterology**

**Cardiology**

**Pain**

**COMPLEX MEDICAL SYMPTOM MANAGEMENT CLINICS**

- GPs with special interest in MUS
- Acute hospital specialists
- Liaison psychiatrists
- Medical psychotherapists
- OT, physio, IAPT, hospital MUS therapists

- Training in diagnostics & communication skills
- Consultation-liaison
- Assessment and supervision
- Psychological therapies (CBT, PIT, family therapy)
- Rehab & community support resources

**IAPT**

**GENERAL PRACTICE**
Outcomes

• Referrers
  ◦ Training increased confidence and competence in managing MUS
  ◦ Improvements in communication and working relationships between primary and secondary care
  ◦ Valued having a specialist team to refer to

• Patients
  ◦ Positive experiences of care (clear, accessible, empathic)
  ◦ Reduced symptom severity
  ◦ Improved well-being

• Health economic outcomes
  ◦ Primary care activity and costs – no sig diff
  ◦ Secondary care activity – no sig diff
  ◦ Secondary care costs reduced by £852 per patient per year ($p<0.0001$)
  ◦ If 500 patients per year reduce healthcare costs by £426,000
Discussion