COMMUNICATION ABOUT FUNCTIONAL COMPLAINTS

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Medical Communication lecture

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Case example 1.

- 42 yo woman referred by neurologist
- Globus and pain in the throat, started after gastroscopy. Examinations (ENT, neurology, imaging) show no damage.
- History taking reveals that the gastroscopy was made for unexplained stomach ache. Dg: reflux.
- The patient also reports severe and frequent migrain headaches since her adolescence.
- In her early thirties several of her otherwise healthy teeth extracted because of unexplained, burdening jaw pain.

Case example 2.

- 51 yo male patient referred by cardiologist for arrythmias
- Although arrythmias were confirmed by Holter monitoring, they are considered benign, harmless.
- All other imaging and functional heart tests were normal.
- The patient is very worried, stopped most of his activities except for his white collar work. Doing his work takes great effort, he feels every day like „just surviving".
- As medication did not help, catheter ablation is considered (tx for different types of tachycardia that result in a fast (palpitations) and at times irregular heart rate) – but cardiologist suspects psychological causes.

Case example 3.

- 22 yo student seen by a gastroenterologist for 1,5 years. A family friend mentioned she might have IBS (irritable bowel syndrome) – she found our Clinic on the internet.
- Her symptoms started as persistent stomach ache, heart burn. Gastroscopy revealed mild reflux. Reflux medications helped temporarily.
- During a travel 1 year ago she had a diarrhea; since this she often had urging loose stool. She regularly used antidiarrheal medicines and avoided eating before leaving the house. She also avoided all places / situations where toilet was impossible or difficult to reach (eg. university auditorium). Worried to fail her studies.

What is common in my 3 cases?

- The patients are presenting with clearly somatic complaints
- Examinations found no or minimal physical symptoms
- Medication did not dissolve the symptoms
- The symptoms persisted over years
- Multiple symptoms, variable intensity
- Worry of the symptoms, avoidant behavior
- The patients were sceptic about the „psychological" origin of their symptoms
- **Their physician (or relative) could convince them to see a „psychologist" just to „give a try".**

Learning objectives

- Identify patients with „somatic symptom or related disorder" (somatization)
- Recognize the communicational signs of somatization
- Understand the process of somatization in order to be able to explain it to your patient
- Be aware of the avoidable communication strategies
- Learn the effective communication strategies

Somatic or psychological?

- „René Descartes (1596–1650) formulated the philosophical principle of separation of brain and mind. This has led to continuing dualism—separation of body and mind—in Western medicine and difficulty in accepting the interaction of physical and psychological factors in aetiology" (Mayou R., Farmer A. BMJ, 2002.)

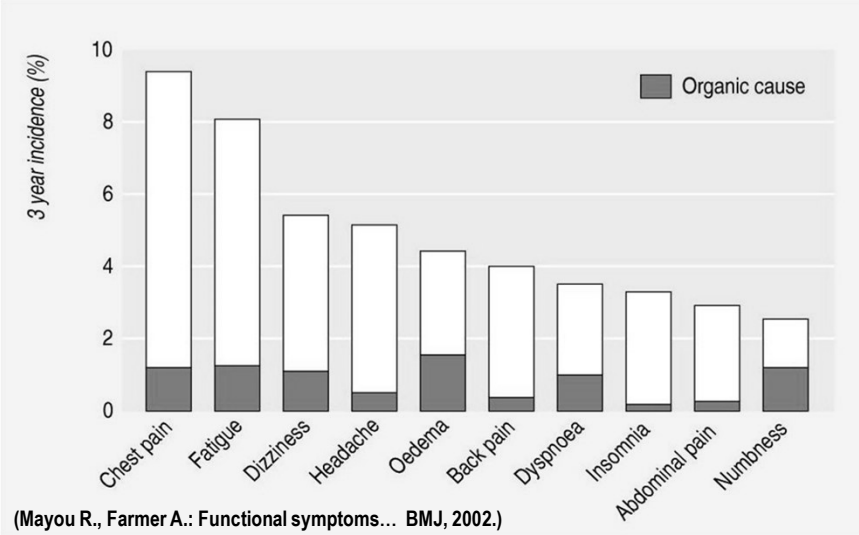
- MUS (medically unexplained symptoms) : 5-10% of GP patients
- Take up 20-25% of GP consultations.
- Similar results in various settings: approx. 20% of the „frequent attenders" have no 'relevant organic disease"
- Investigations for somatising patients were twice as costly (Reid et al. BJP 2002)

Functional complaints in different areas of medical specialisation

Cardiology	Atypical chest pain Functional palpitations
Gastroenterology	Irritable bowel syndrome Non-ulcerous dyspepsia
Pulmonology	Hyperventilation syndrome
Neurology	Tension headaches
Dentistry	Atypical facial pain
Ear, nose and throat	Globus syndrome Tinnitus
Infectious diseases	Chronic fatigue syndrome
Gynaecology	Premenstrual syndrome Chronic lower abdominal pain
Rheumatology	Fibromyalgia

(after Wessely et al. 1999)

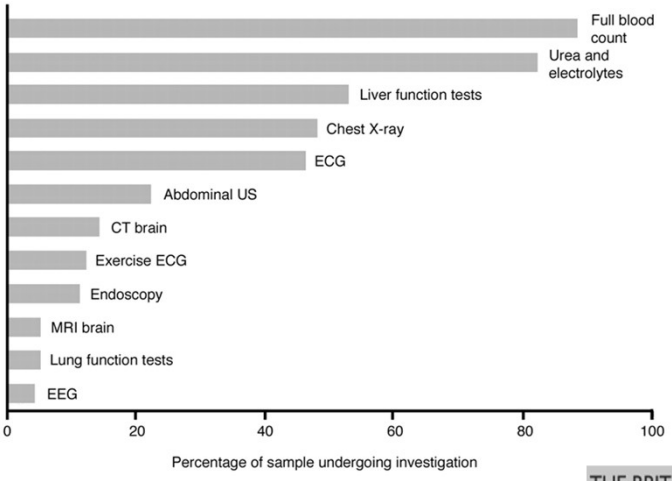
3 year incidence of 10 common presenting symptoms and % of symptoms with a suspected organic cause in US primary care



(Mayou R., Farmer A.: Functional symptoms… BMJ, 2002.)

Frequency of selected medical investigations in frequent attender sample

(CT, computed tomography; ECG, electrocardiogram; EEG, electroencephalogram; MRI, magnetic resonance imaging; US, ultrasound).



STEVEN REID et al. BJP 2002;180:248-253

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Psychiatric diagnosis (DSM-V)
Somatic Symptom and Related Disorders (SSD)

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

- 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 concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013:311.

Psychiatric diagnosis (DSM-V)
Somatic Symptom and Related Disorders (SSD)

Specify if:

A. With predominant pain (previously pain disorderSpecify if:

B. Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

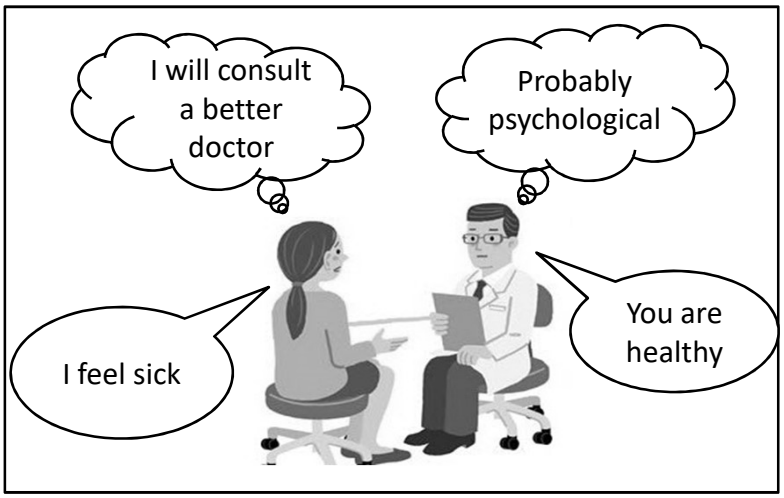
- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013:311.

Subsets of Somatic Symptom Disorder

Subset	Description
Conversion disorder	One or more symptoms of altered **voluntary motor or sensory** function inconsistent with a known condition
Factitious disorder	**Falsification** of physical or psychological symptoms, or induced injury or disease; can be with regard to self or imposed on others, although not for personal gain (as with malingering)
Illness anxiety disorder	Preoccupation with getting or having a serious medical disorder; the two types include care-seeking and care-avoidant; previously included in **hypochondriasis**
Psychological factors affecting other medical conditions	**A medical condition must exist** and psychological factors must negatively affect the condition
Other specified somatic symptom and related disorders	Symptoms consistent with somatic symptom disorder are present, but **do not meet full criteria for any** of the above disorders
Unspecified somatic symptom and related disorders	Symptoms consistent with somatic symptom disorder are present, but do not meet criteria for any of the above disorders; should be used only **when there is insufficient information** to make a more specific diagnosis

MISUNDERSTANDING: NO ABNORMALITIES ≠ HEALTHY

and ABNORMALITIES ≠ DISEASE



How somatisation develops?

- Predisposing factors
- Triggering factors
- Maintaining factors

Predisposing factors

- Family history of anxiety, depression or somatisation
- Personality traits (anxiety, alexythymia, catastrophizing, difficulty to deal with conflicts)
- Family history of physical disease
- Increased attention paid to somatic symptoms in childhood

Triggering factors

- Life stressors, psychosocial problems (relationships, work)
- Accumulation of microstressors
- Own or significant other's physical disease

Maintaining factors

- Increased self-attention – vitious circle
- Somatosensory amplification
- Reduced activity
- Disease benefits
- Medical over examination

Diagnosis of somatization

- Negative test results
- Patients brings a list of long standing symptoms
- Patient arrives with a pile of medical reports
- Short periods of sick leave in the anamnesis
- Diverse, “disconnected” complaints
- Contradiction: good physical condition from medical viewpoint, while patient talks of serious symptoms
- Attribution of great significance to test results showing minor irregularities
- The patient is dissatisfied and thinks that the real cause of the symptoms has not been found
- Negative attitudes to doctors and health services, demanding behavior
- Fluctuating or extreme emotional reactions, anx, depr

SSD12 **answers: Never /rarely/sometimes/often/very often**

1. I think that my physical symptoms are signs of a serious illness (I).
2. I am very worried about my health (II).
3. My health concerns hinder me in everyday life (III).
4. I am convinced that my symptoms are serious (I).
5. My symptoms scare me (II).
6. My physical complaints occupy me for most of the day (III).
7. Others tell me that my physical problems are not serious (I).
8. I'm worried that my physical complaints will never stop (II).
9. My worries about my health take my energy (III).
10. I think that doctors do not take my physical complaints seriously (I).
11. I am worried that my physical symptoms will continue into the future (II).
12. Due to my physical complaints, I have poor concentration on other things (III).

(I) = cognitive aspects ; (II) = affective aspects; (III) = behavioral aspects

Symptom diary

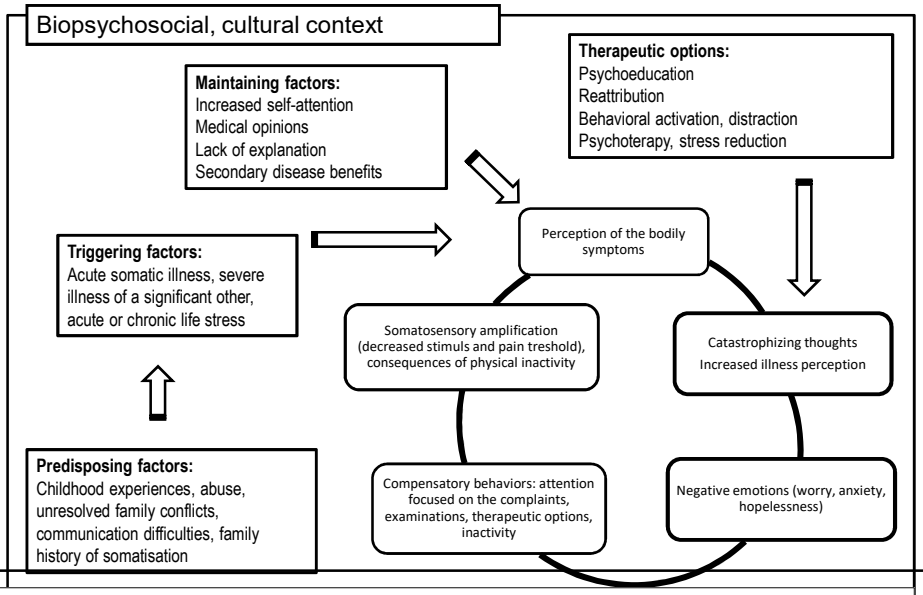
Date and time	symptom 1 its acuteness 1-10	symptom 2 its acuteness 1-10	What have I done to overcome symptoms?	What were my plans for that day? Any stress situations?	Overall stress level this day (1-10)	Time spent on being occupied with the symptoms?	Other thougts, comments
29 Sept 2015. Monday 8.00 AM	*dizziness 7*	*Palpitations 8*	*layed back to my bed called ill arrhytmia medication*	*Going to work (meeting my boss) visiting my mother after work have dinner with my partner*	*10 in the morning 6 in the afternoon*	*the whole day*	*There was a change in the weather, I am sensitive to that*

Focusing on symptoms, behavior, thinking, feelings, situations, relationships

How to deal with somatizing patients?
1. Errors to avoid

- Prejudices: "playing up" or "work-shy", crux medicorum (the doctor's cross).
- Denial of the reality of the symptoms "you don't have any problem." „ You are just imagining"
- Collusion : accept patient's hypothesis despite your opinion and prescribe tests and medications
- Pseudo-diagnoses: the doctor offers a diagnoses to recomfort the patient „you have mitral prolapse"
- Ordering further tests
- Sending the patient immediately to a psychologist and psychiatrist

The Vitious Circle of Somatization



Stauder A, Eörsi D, Pilling J: Orvosi Hetilap 2016: 157(17), 664-668

How to deal with somatizing patients?

Recommended methods

- <u>SSD cannot be remedied without the active and conscious involvement of the patient</u> ⟺ D-P relationship!

<u>1) Acceptance and reassurance</u>

- detailed history of the symptoms
- review examination results
- ask about previous consultations
- explore potential prejudices
- make clear the symptoms are real, and also common
- ask about the patient's hypothesis
- give feed-back what is correct

Goldberg, Gask, O'Dowd 1989

How to deal with somatizing patients?
Recommended methods

2) Broadening the agenda - reframing:

Assess psychosocial factors, context of the symptoms.

- What aggravates or relieves the symptoms?
- Family and workplace circumstances, current life situation
- How symptoms affect work, family life, everyday affairs?
- How much the symptoms depress or unsettle the patient?
- When symptoms first appeared? Any key events, changes?
- Emphasize that with such complaints often no bodily lesion can be found to be causing them. Say clearly that similar complaints are often associated with life difficulties
- Observe the patient reactions (acceptance or denial?)

Goldberg, Gask, O'Dowd 1989

How to deal with somatizing patients?
Recommended methods

3) **Connection (or reattribution):**

Explain to the patient how psychosocial difficulties are associated with bodily symptoms (psychoeducation).

- Complaint can have mental AND physical origin, interact.
- Illustrate with common examples (frightened, or in love – faster heart bit, exam-diarrhea, watch ticking in silence…)
- Place the complaints in the psychosocial context
- Words like “stress, tension, difficulty, burden,” are better accepted than “nervous, mental, psychological”
- In case of organic diseases emphasize how life difficulties may interact with their management, may worsen outcome

Goldberg, Gask, O'Dowd 1989

How to deal with somatizing patients?
Recommended methods

4) **Establish cooperation:**

<u>Involve the patients and encourage them to cope with the situation and become active.</u>

Draw up plan, together with pt, complex, several sessions.

Address life difficulties: problem solving, acceptance, social supports, prioritizing.

Stress management – relaxation, meditation (in group)

Cognitive restructuring of negative catastrophizing thoughts

Break the vitious circle of self attention, use symptom diary

Treat depression or anxiety (50% comorbidity).

Increase activity despite symptoms. Physical exercise.

Discuss regular consultations. Coordinate „rehabilitation".

„Give a try" to psychiatric consultation or psychotherapy.

Goldberg, Gask, O'Dowd 1989

Reattribution training effects

David Goldberg, Linda Gask, and Terry O'Dowd. "The treatment of somatization: teaching techniques of reattribution." J Psychosom Res (1989)

Improvement of doctors attitudes and skills

Increased confidence, better D-P relationship

Better physical functioning of the patients

Little improvement in the symptoms

Better results when shorter history of somatization

Better outcomes with combined psychopharmacotherapy

Effective psychotherapy methods

- Cognitive Behavior Therapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Psychodinamic therapies
- Symbol therapies
- Interpersonal Psychotherapy (IPT)
- Relaxation
- Hypnosis

Patient preferences?
Availabilty?

Initial case examples: psychotherapy focuses

- Exploring history of the symptoms, **onset**?
- Predisposing factors (developmental and family hx)
- Triggering factors – symptom diary
- Maintaining factors – compensatory behaviors

Findings: Typically negative thoughts (cognitive distortions) , relationship problems, lack of assertion, avoidant behavior

Therapy: Relaxation, cognitive restructuring, interpersonal skills training, behavioral activation

„Lets make an experiment" „What can you try to change even if your symptoms would not improve?"