An introduction to “medically unexplained” persistent physical symptoms

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IMPARTS
Integrating Mental and Physical Health Care: Research Training and Services

IMPARTS is funded by King’s Health Partners Academic Health Science Centre, with the overall aim to improve integration of mental and physical healthcare in general hospital settings.
Different terms for persistent physical symptoms

- **Functional** (e.g. “functional dyspepsia”; affecting physiological or psychological functions but not due to structural / physical / chemical disorder)

- **Medically unexplained symptoms (MUS) / Medically unexplained physical symptoms (MUPS)** (symptoms not explained by the medical model)

- **Idiopathic pain** (e.g. idiopathic chest pain – means unknown cause)
- **Bodily distress disorder** (Fink & Schroder 2010)
- **Somatisation** (usually implies physical symptoms are expression of emotional distress)
Two surveys : Same answer

• Survey of healthy population – preferred term was Persistent Physical Symptoms (PPS) (Hunter et al accepted)

• Survey of CFS patients in specialist clinic in secondary care – preferred term was PPS, then Complex Physical Symptoms (Picariello et al in prep)
## Hospital Specialists

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>Irritable bowel syndrome</td>
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<tr>
<td>Rheumatology</td>
<td>Fibromyalgia</td>
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<tr>
<td>Infectious diseases</td>
<td>Chronic fatigue syndrome</td>
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<tr>
<td>Neurology</td>
<td>Headache / Non-epileptic seizures</td>
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<tr>
<td>Hand surgery</td>
<td>Repetitive sprain injury</td>
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<tr>
<td>Dental</td>
<td>Atypical facial pain</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Non-cardiac chest pain</td>
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<tr>
<td>Gynaecology</td>
<td>Chronic pelvic pain</td>
</tr>
<tr>
<td>Urology</td>
<td>Irritable bladder syndrome</td>
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DSM-IV somatoform disorders

- Criticised for containing mixture of relatively specific categories such as somatisition disorder and hypochondriasis, and vague non-specific categories such as undifferentiated somatoform disorder
Somatoform Disorders

- Body Dysmorphic Disorder
- Conversion Disorder
- Hypochondriasis
- Somatisation Disorder
- Somatoform Pain Disorder
- Undifferentiated Somatoform Disorder
DSM-V – Somatic Symptoms Disorders

- Complex somatic symptom disorder
- Simple somatic symptom disorder
- Health anxiety disorder
- Functional neurological symptom disorder
- Factitious disorder
Somatic symptom disorder (SSD) (Dimsdale & Levenson 2014)

• The diagnosis of SSD is established when three criteria are met:
  – distressing and impairing somatic symptoms are present
  – the symptoms are persistent (i.e., >6 months)
  – associated with abnormal and excessive thoughts, feelings, and behaviors, typically manifested by disproportionate catastrophizing, high levels of anxiety, and illness behavior (Trudie Chalder 2014)
More questions than answers!

• Research has demonstrated that in many medical disorders, psychological factors account for more of the variance in physical symptoms than objective measures of disease severity BUT

• Is it right to group together patients with medically explained and unexplained symptoms?

• How do we operationalize disproportionate thoughts, feelings, and behaviors?

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Clinical and research implications

- When it comes to research we will still make the distinction between those with pathology and those without.
- In practice it is easy to see how treatment protocols can be adapted.
- It is important to include physiological as well as cognitive, behavioural and affective mechanisms in information for patients.

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Symptoms in US primary care

Kroenke & Mangelsdorff, 1989
Prevalence of unexplained symptoms in medical clinics

*Nimnuan et al., 2001*

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Prevalence (95% CI)</th>
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<tbody>
<tr>
<td>Chest</td>
<td>59% (46-72)</td>
</tr>
<tr>
<td>Cardiology</td>
<td>56% (46-67)</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>60% (45-73)</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>58% (47-69)</td>
</tr>
<tr>
<td>Neurology</td>
<td>55% (45-65)</td>
</tr>
<tr>
<td>Dental</td>
<td>49% (37-61)</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>57% (50-68)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56% (52-60)</strong></td>
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</tbody>
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Models

- Cognitive behavioural model (most supporting evidence)
  - Differs from bio-psycho-social model
- Psychodynamic models (little evidence, an exception being treatment efficacy in IBS e.g. Creed et al., 2003)
Predisposing factors

Genetic factors
(CFS: Buchwald et al., 2001; IBS: Saito et al., 2005)

Neuroticism & chronic stress
(CFS; Kato et al., 2008; IBS: Gwee et al., 1996, 1999)

Perfectionism (relating to personality and learning; linked to avoidance of criticism)
(CFS/IBS: Spence & Moss-Morris, 2006; Deary & Chalder 2009)


Paternal rejection or hostility (IBS: Lackner et al., 2004)

Childhood experience of illness in self or parent (Craig et al., 1993; see next slide)
Learning in childhood that symptoms are dangerous or catastrophic (Hotopf et al 1999)
South London Somatisation Study: Childhood Risk Factors for Somatisation in Primary Care.  
*Craig et al 1993*

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<tr>
<th></th>
<th>Psychologisers</th>
<th>Physical illness</th>
<th>Somatisers</th>
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<tbody>
<tr>
<td>Physical illness before 17 years</td>
<td>18%</td>
<td>20%</td>
<td>55% (0.001)</td>
</tr>
<tr>
<td>Parental physical illness before 17 years</td>
<td>9%</td>
<td>23%</td>
<td>41% (0.05)</td>
</tr>
<tr>
<td>Parental lack of care</td>
<td>34%</td>
<td>2% (0.001)</td>
<td>36%</td>
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Precipitating Factors

• Life events
• Infections or other health problems
• Combination of illness and stress
Maintaining factors - examples

Behaviours
- Boom-or-bust (all-or-nothing) behaviour
- Excessive avoidance / precaution taking
- Disturbed sleep routine
- Repeated investigations (NHS, privately or alternative practitioners)
- Repeatedly seeking external ‘cure’
- Medications which can produce side-effects
Perpetuating factors

**Emotional**: Stress, anxiety, frustration, low mood, hopelessness

**Cognitive**
- Unhelpful beliefs about symptoms
- Unhelpful beliefs about general performance, standards, asking for help
- Rumination and worry
- Symptom-focusing and monitoring
Maintaining factors (continued)

Physiological
Hypothalamic-pituitary-adrenal axis disturbance
(low levels of cortisol)

Social
Too much or too little
Unhelpful advice (e.g. rest) or lack of specific advice / explanation

Cultural
Mind / body dualism
Stigma around psychological problems
Efficacy of short term psychotherapy for MUS: A meta analysis (Kleinstauber et al 2011 Clin Psy Rev)

- 27 studies
- Small to moderate between group effect sizes (0.40) for disorder specific outcomes,
- Small effect sizes for depressive symptoms and functional impairment and health care utilisation
- Small to large within group effect sizes (0.80)
• More therapy sessions, younger age, higher % of women were associated with better effect sizes for depression

• Control of concomitant treatments, higher quality assessment, more sessions and MHP involvement were associated with change in cognitions and behaviours

• In patient treatment, non MHP & less sessions related to reduced health care utilisation

Trudie Chalder 2011
THANK YOU FOR LISTENING