

Medically Unexplained Symptoms

RACP Congress, Auckland 7 May, 2019

Who we are:

Chris Kenedi, MD, MPH, FACP, FRACP
General Medicine Physician and Liaison Psychiatrist
Auckland Hospital
Duke University Medical Center

Kristy Bolter, PhD
Consultant Clinical Psychologist & Service Clinical Director
Reablement Services, Auckland Hospital

Megan McEwen MSc (hons), PGDipSci (dist), BSc
Exercise Physiologist

Case

- 63 y/o female dx with CVID and a few other issues

The other issues:

1. **Common Variable Immune Deficiency**
2. **Bronchiectasis (secondary to #1)**
3. **Chronic Rhinosinusitis (secondary to #1)**
4. **Chronic candidiasis (secondary to #1 and prophylactic antibiotics)**
5. **Chronic otorrhoea (secondary to #3)**
6. **Glaucoma**
7. **Falls (drop attacks)**
8. **Shoulder injury (bilateral surgical operations)**
9. **Adverse reactions to drugs (antibiotics, Naproxen, Diclofenac, ? Tramadol, ? Vioxx, ? Frusemide, Ciprofloxacin)**
10. **Bilateral Carpal Tunnel Syndrome (both sides released)**
11. **Chondroma of the left middle finger (excised)**
12. **Previous adverse reactions to reactions to Intragam P**
13. **Cholelithiasis (laparoscopic cholecystectomy)**
14. **Hypertension- Blood pressure 200/80**
15. **? Cor pulmonale**
16. **Joint symptoms (for evaluation)**
17. **Right sided wrist surgery**
18. **Chest pain (chest wall pain June 2010)- related to portacath removal**
19. **Irritable bowel syndrome and diverticulitis**
20. **Depression, treatment resistant**
21. **Systemic reaction to hymenoptera sting**
22. **Poor venous access**
23. **Fibromyalgia**
24. **Probable nut allergy (26/12)**
25. **Elevated lipids 27.6.12**
26. **Bilateral Shoulder impingement**

Unusual symptom pattern

- Fibromyalgia
- ? Cor pulmonale
- Adverse reactions to drugs (antibiotics, Naproxen, Diclofenac, ? Tramadol, ? Vioxx, ? Frusemide, Ciprofloxacin, multiple antidepressants, Instringram P
- Treatment resistant depression
- Anxiety NOS
- Chest pain (chest wall pain June 2010) - followed by TARPS
- Irritable bowel syndrome and diverticulitis
- Falls (drop attacks)
- Joint symptoms (for evaluation)

Recent Services involved

- Immunology
- Neurology
- Psychiatry
- ENT
- Rheumatology
- General Surgery
- Respiratory
- Orthopedics
- Ophthalmology

- (Previously:, Anesthesia, Pain, GI, GI Surgery, General Medicine, Endocrine)

What are functional disorders?

Conditions where the person has physical symptoms that cause **excessive worry** and/or **discomfort** and lead to health care contact but for which no adequate organ pathology can be found



Prevalence of functional disorders

	Primary care (1) %	Hospitals (2) %	Neurology (3) %
Functional disorders	22-36	18-20	34

Creed et al. J Psychosom Res, 2004

1) Fink et al. Psychosomatics, 1999

Fink et al. American J Psychiatry, 2004

Gureje et al. American J Psychiatry, 1997

Kirmayer et al. J Nerv.Ment.Dis, 1991

Barsky et al. Arch.Gen.Psychiatry, 1990

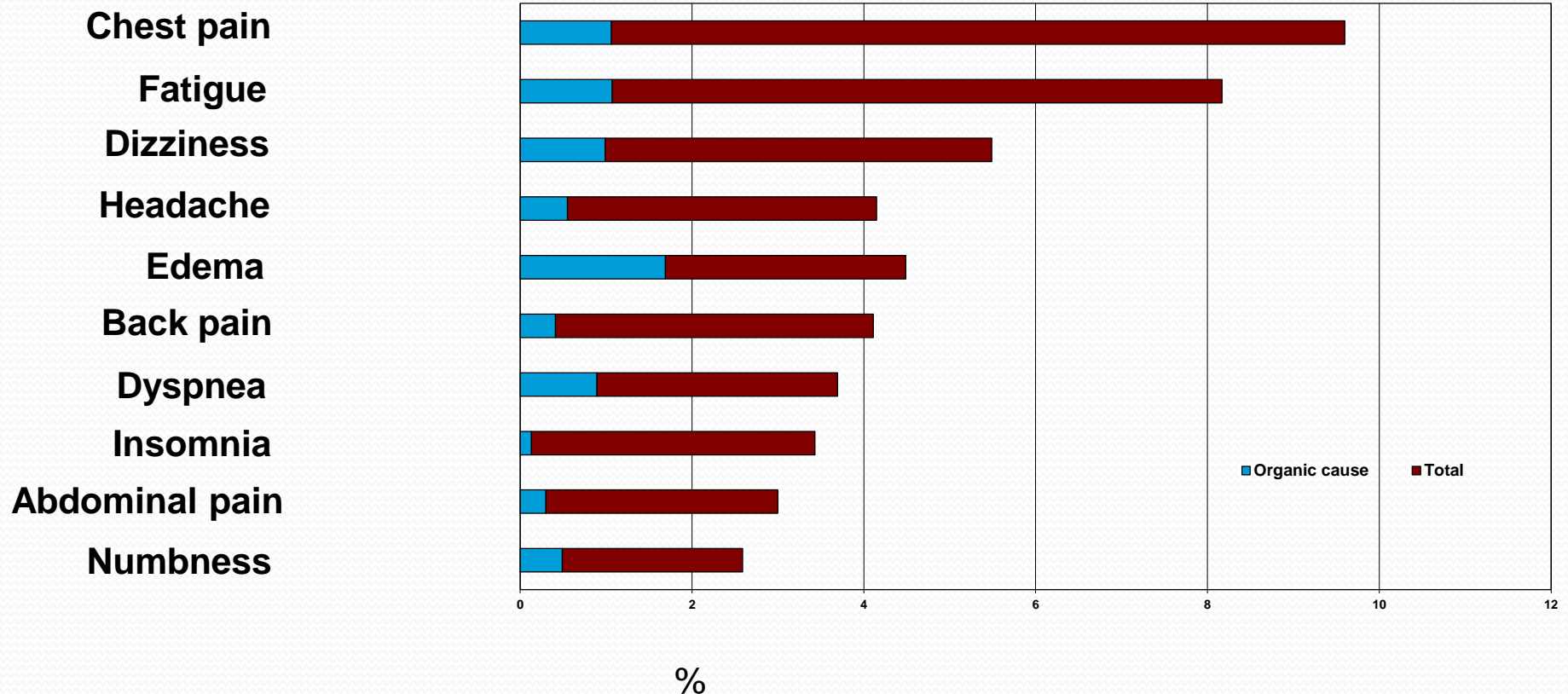
De Waal MW et al. Br J Psychiatry 2004

Toft T et al. Psychol Med, 2005

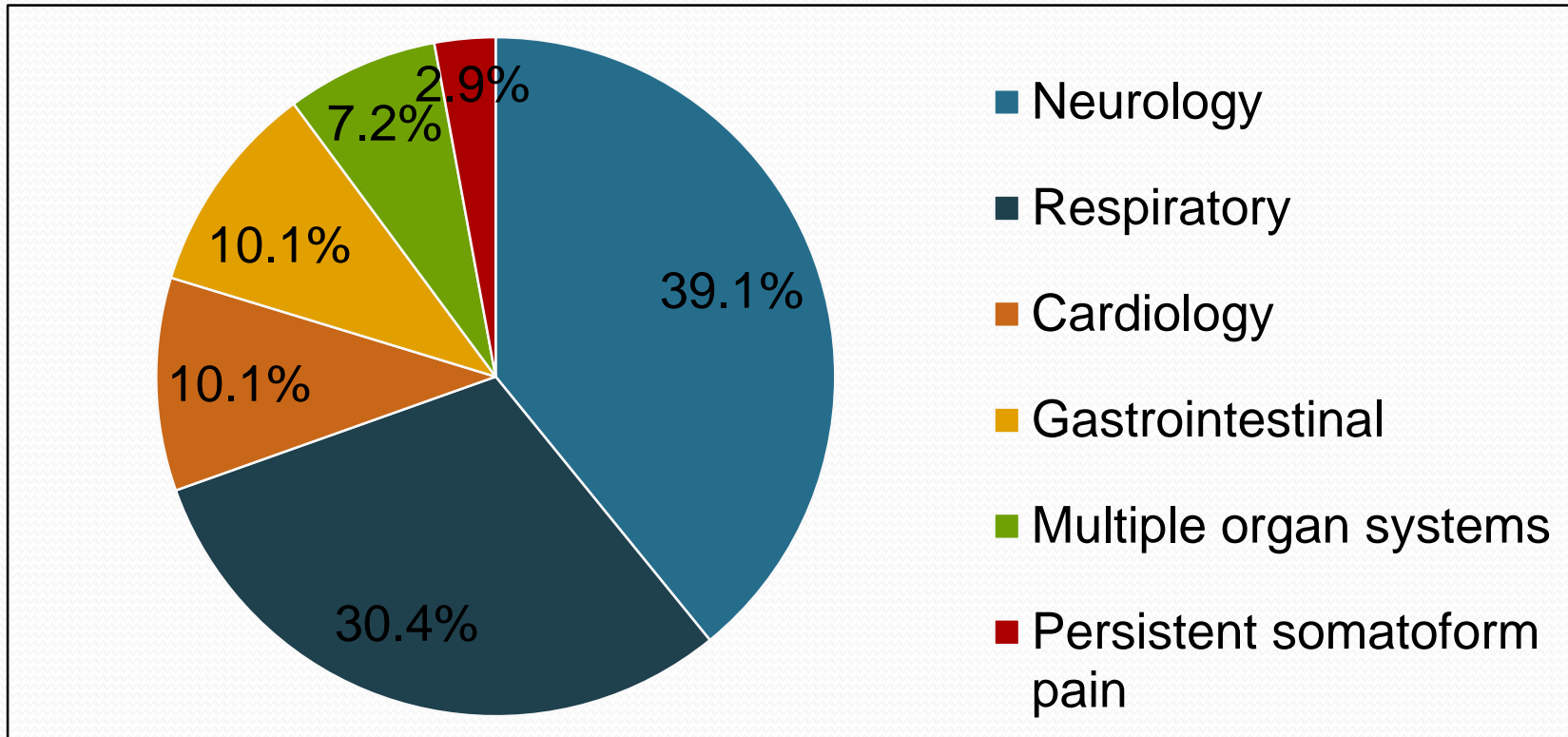
2) Fink et al. J Psychosom Res, 2004

3) Fink et al. Psychosomatics, 2005

Symptom Based: Incidence of 10 common symptoms in 1000 consecutive general practice outpatients



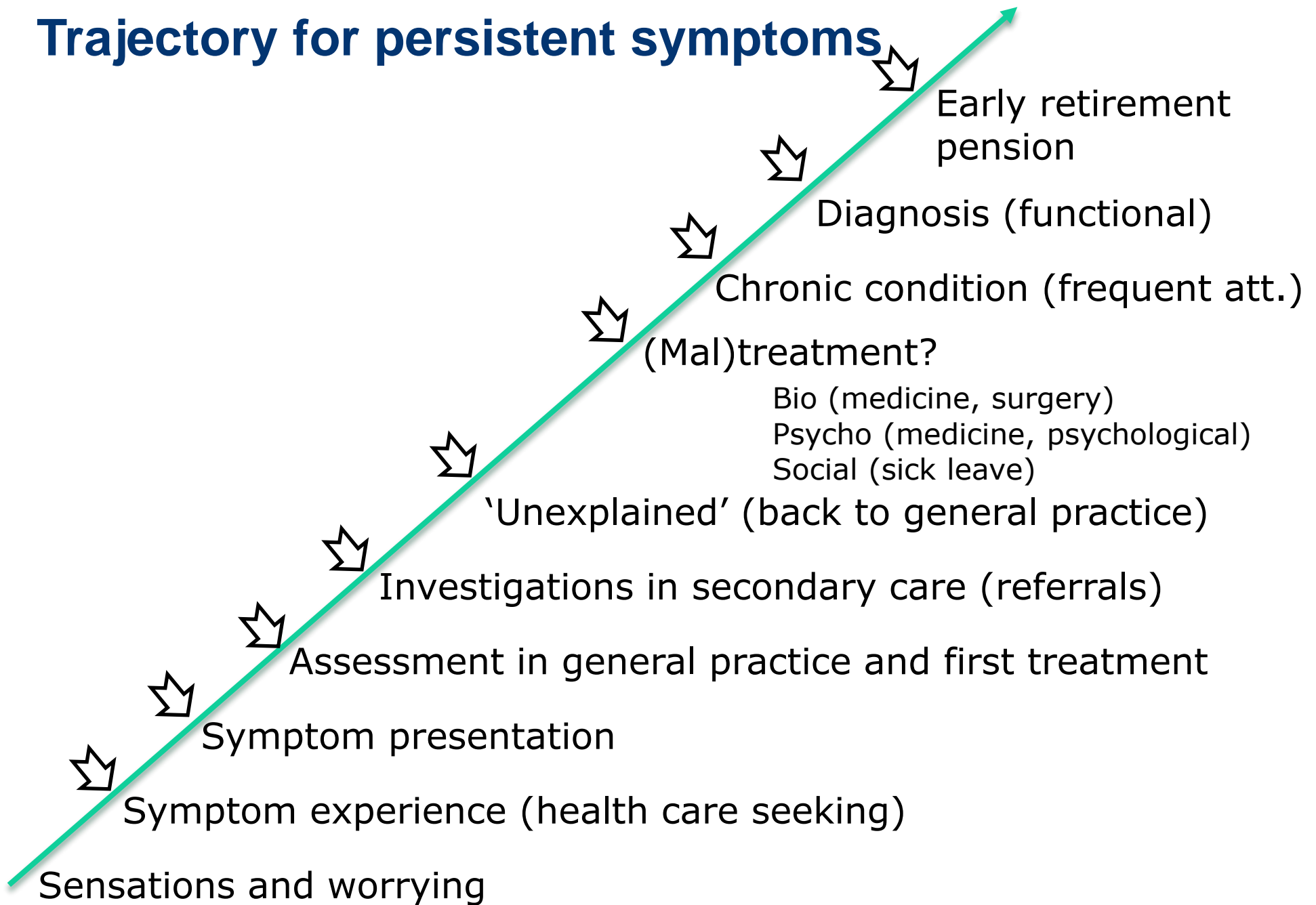
WDHB Data: Type of organ system affected



Thanks to Fred Sundram and Kimberly Lee at WDHB

Symptom	Functional disorder	Physical disease
Localization	Vague, diffuse, fluctuating	Well defined, constant
Intensity	vague, unclear	Well defined changes and fluctuations
Periodicity	Diffuse, hard to delimit	Typical well defined periods with worsening or improvement
Alleviating and/or worsening factors	Vague, diffuse, hard to define	Well defined, few
Number	Many	Few, well defined
Type	Unspecifc	Specific
Character	Uncharacteristic	Characteristic
Main symptoms	Vague, hard to define	Can be identified and discerned from comorbid symptoms or disorders

Trajectory for persistent symptoms



History elements central for treatment planning



Elements	Comment
Systematic symptom screening	Elicit concurrent or previous physical symptoms
Day-to-day function	Build a picture of what the patient can and cannot do
Onset	Use the biopsychosocial framework to look for predisposing factors and triggers that may help you explain back a mechanism to the patient and close relatives
Family illness beliefs and illness behaviours	What the patient/relatives thinks may be wrong?, Look for a possible vicious circle of maladaptive beliefs and behaviours
Prior experience with the health care system	Enquire about the outcome of visits with other doctors. Allow the patient/relatives to vent frustration – without comment.

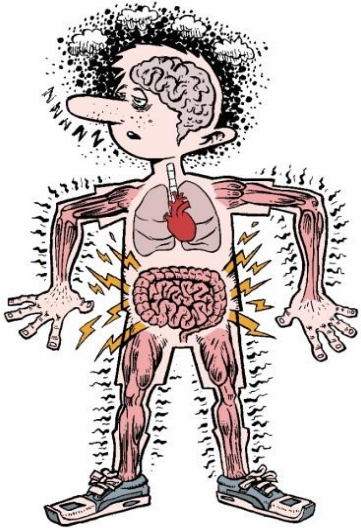
Biopsychosocial framework

Vulnerability

Functional disorders in the family
Anxious, perfectionistic personality traits
Longstanding stress

Triggers

Infection or physical injury
Emotional trauma
Misinterpretation of normal medical results



Maintaining factors

Maladaptive illness beliefs and behaviours
Unnecessary medical examinations
Ineffective treatment
CNS sensitisation and dysregulation in stress system

Symptom onset

Chronic bodily distress/ Somatization

Protective factors

Good intellectual and social resources
Favourable socio-economic background
Supportive network
Engaged clinicians

**The body becomes 'noisy'
and hypersensitive**

Case formulation: JOHNNY

Vulnerability

Former elite sportsman
Pushes himself
Ignores bodily symptoms

Trigger

Develops allergy to peanuts – spreads to other allergies

Maintaining factors

Keeps managerial position, but inactive at home
Social isolation
Boom-and-bust
Lack of diagnosis and accept

Case formulation: KARINA

Vulnerability

Psychologically abusive father
Takes on a lot of responsibility as a child
Very active social life / lack of rest

Trigger

Develops infection-like symptoms – pan-sinusitis – every 6-8th week

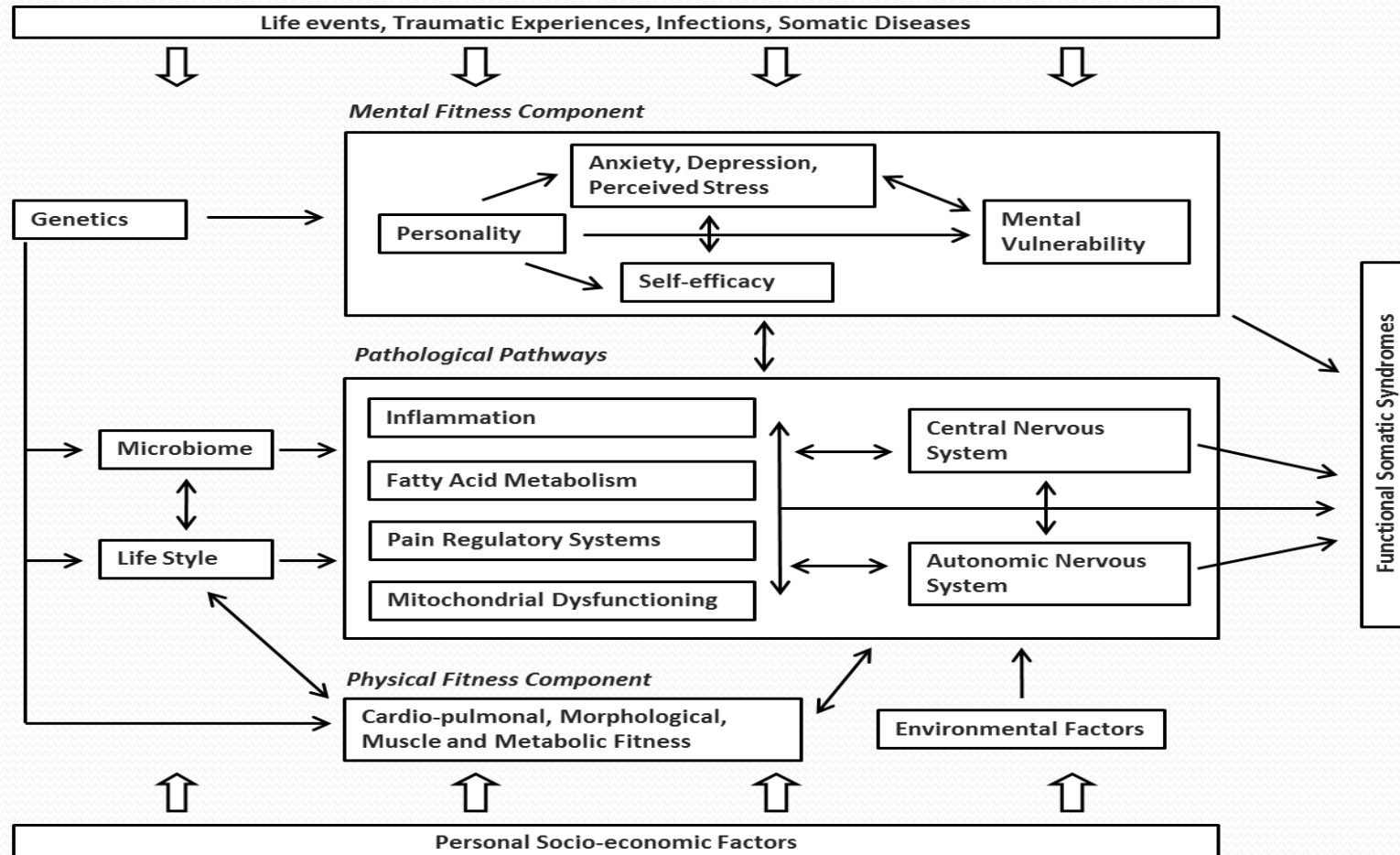
Maintaining factors

Boom-and-bust
High self-criticism
Avoidance of negative emotions
Many neurological examinations and no diagnosis

Functional somatic syndromes by specialty

Gastroenterology	Irritable bowel syndrome (IBS), non-ulcer dyspepsia
Gynaecology	Pelvic arthropathy, premenstrual syndrome, chronic pelvic pain
Rheumatology	Fibromyalgia, lower back pain
Cardiology	Atypical or non-cardiac chest pain, syndrome-X
Respiratory medicine	Hyperventilation syndrome
Infectious diseases	Chronic fatigue syndrome (CFS, ME)
Neurology	headache, pseudo-epileptic seizure
Dentistry	Temporomandibular joint dysfunction, atypical facial pain
Ear, nose and throat	Globus syndrome
Allergy	Multiple chemical sensitivity (MCS)
?	Electricity hypersensitivity
?	Infrasound hypersensitivity
Orthopaedics	WAD – whiplash ass. disorder
Anaesthesiology	Chronic pain syndrome
Psychiatry	Somatoform disorders, Neurasthenia, Dissociative (conversion)

Causal web – tentative model



Pathophysiological connection

- Volumetric alterations in amygdala, hippocampal, as well as in the Anterior Cingulate Cortex
- Limbic scars: long-term consequences of childhood maltreatment revealed by functional and structural magnetic resonance imaging. *Dannlowski U, et al. 2015*
- Early exposure to traumatic stressors impairs emotional brain circuitry. *Korgaonkar MS et al. 2013*
- Sensitive periods of amygdala development: the role of maltreatment in preadolescence. *Pechtel P, et al. 2014*

Somatic Symptoms and Trauma

- Janet 1893 – Traumatic associated dissociative states associated with somatoform responses
- Bradford et al. (2012) Trauma experiences and Irritable Bowel Syndrome (IBS)
- Springer, Sheridan, Kuo, & Carnes, (2007) Childhood abuse associated with fibromyalgia, chronic (non-CA) pain, Chronic Fatigue
- Stein et al. (2004) Sexual Abuse associated with increase somatization, illness anxiety and healthcare utilization
- Soykan et al (2000) 2/3 of women with idiopathic gastroparesis report prior physical or sexual abuse

DA

- 38 y/o female
- Shelf fell on head in 2016 – No LOC

DA – Subjective symptoms – 2 years

- Pain – diffuse
- Fatigue
- Calculation/concentration difficulties
- Bilateral arm weakness
- IBS sx

DA Psych ROS

- Chronic Depression
- Cluster B traits

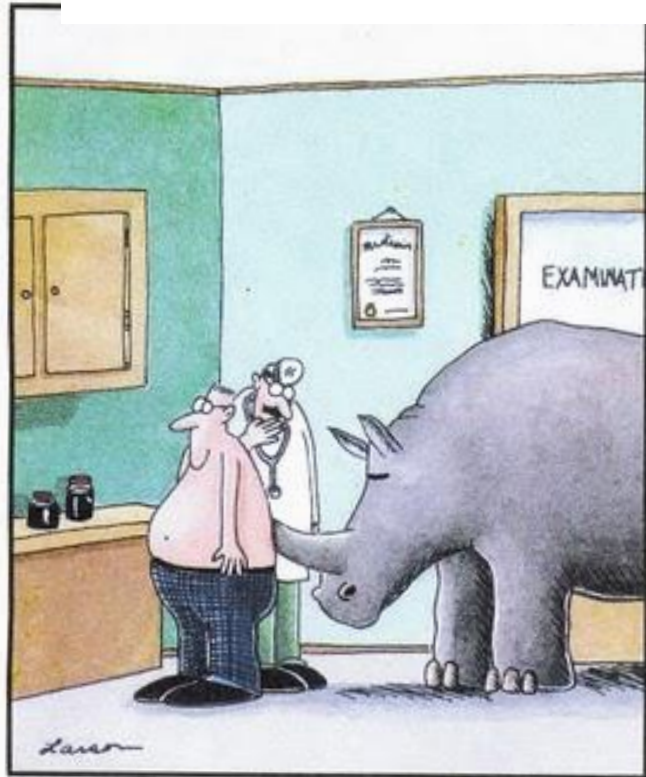
DA History

- Previous sensitive claim from age 11

DA Email

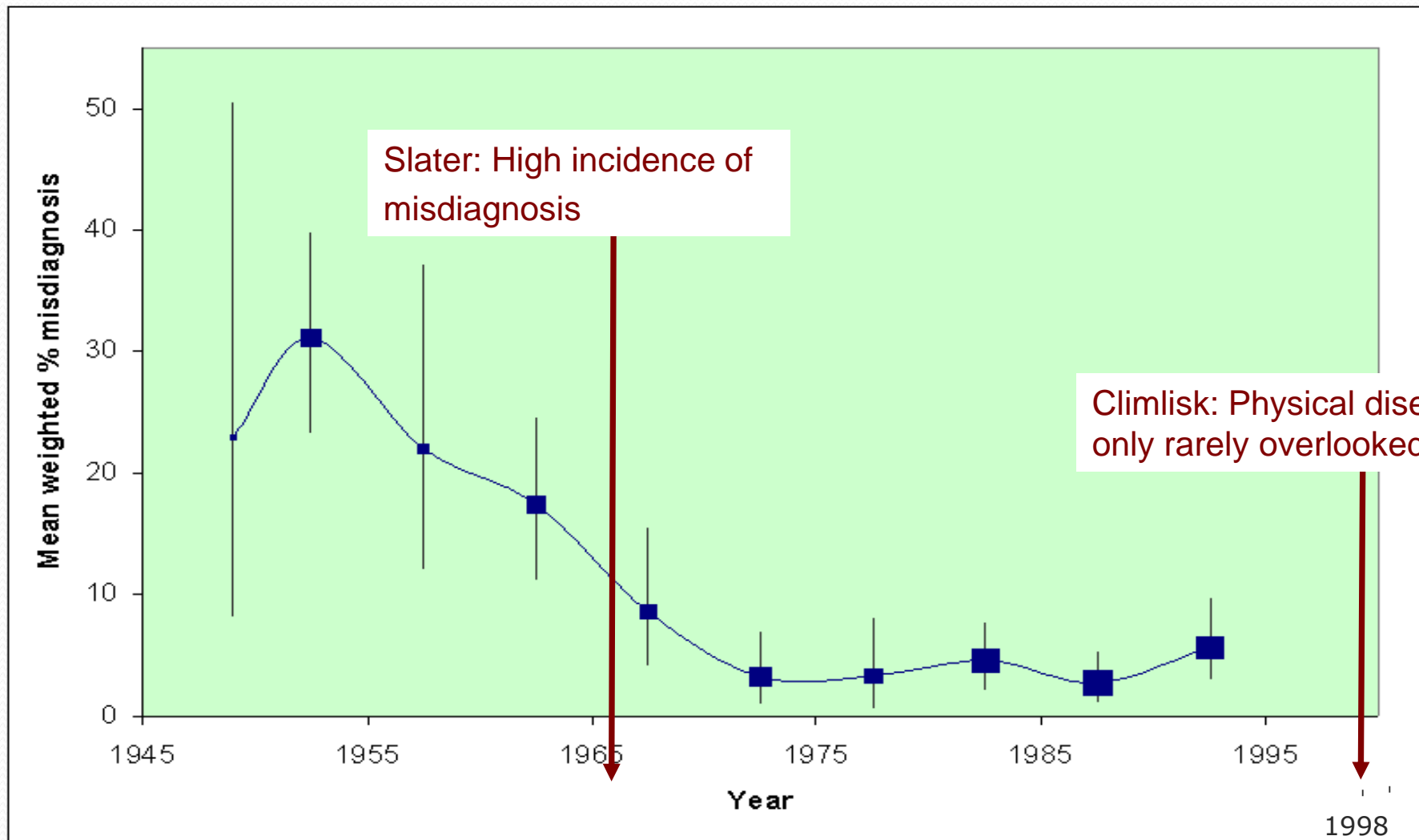
- You were correct in thinking there was more to my story than what I told you, I am ashamed and embarrassed by my past. I had an eating disorder and drug and alcohol problems, all for around 5 years. I had huge family issues in relation to the sensitive file, starting after the abuse, which was worse than I explained as a teenager. I moved countries to distance myself from my family. I didn't trust my parents or myself for over 20 years. I have done therapy as I want to live a healthy life but after seeing you I realise I do need more help. I have trouble opening up to people which hinders my progress

Do we risk overlooking serious physical disease when diagnosing complex symptom disorders?



“Wait a minute here, Mister Anderson... Maybe it isn't kidney stone after all ...”

Misdiagnosis in symptom disorders





Do we have any evidence-based treatments?

Table 1. Evidence for antidepressants, aerobic exercise and psychological interventions in different subtypes of bodily distress

Symptom profile Type of treatment	GENERAL SYMPTOMS	MUSCULO- SKELETAL SYMPTOMS	GASTRO- INTESTINAL SYMPTOMS	CARDIO- PULMONARY SYMPTOMS	MULTIPLE SOMATIC SYMPTOMS
	Chronic fatigue syndrome	Fibromyalgia	Irritable bowel syndrome	Non-cardiac chest pain	Somatization disorders
Antidepressants	+	+++	+++	?	++
Exercise	+++	+++	?	?	+
Psychological treatment (mainly CBT)	+++	+++	+++	++	+++

Evidence ratings are based on meta-analyses or high-quality randomised controlled trials.

+++ strong evidence

++ moderate evidence

+ weak evidence

? no evidence, or lack of studies

Schröder & Fink; Clinic North America 2011

Whiting et al: JAMA, 2001

White et al: Lancet, 2011

Kroenke et al: Gen Hosp Psych, 2009

Price et al: Cochrane Database, 2009

Glombiewski: Pain, 2010

What can you do - Communicate:

- People want to be taken seriously, show you believe them.
- Doctors can make a difference to the patient's well-being even when their symptoms are unexplained.
- Sometimes the only “therapy” needed may be the strength of your doctor-patient relationship – continuity of care and the long-term relationship helps.
- Be explicit about your thoughts, your uncertainties and your expectations of referrals to specialist care

What you can do: Diagnose

- The diagnosis is therapeutic and prevents iatrogenic harm
- Doesn't preclude future care
 - Escalate based on objective clinical findings

What you can do: Treat

- Management Plan
- Liaison with GP/Other services
- Refer to (appropriate) psychology
- Refer for Exercise Physiology
- Consider Liaison Psychiatry input
- Treat the whole person

Treatment

Helpful:

- Psychological therapy
- Physical training
 - graded exercise
- Medicine for comorbid disorders
 - SSRI for anxiety/depression



Not helpful:

- More investigations
- Operation, massage
- Medicine affecting joints and muscles



Megan McEwen

MSc (hons), PGDipSci (dist), BSc

- Business owner of meganmcewen Ltd.
Functional Disorder Specialist
Clinical Exercise Physiologist / Researcher / PG Masters Supervisor
- 12yrs working with medically unexplained symptoms
- Previous student supervisory and lecturing roles at UoA as well as clinic management.
Previous researching and lecturing roles at Fisher and Paykel Healthcare.



Who we're really working with is...

Patients who are:

- Scared / angry / frustrated
- Feel misunderstood
- Uncertain about future and health
- Resistant to change or to try anything new
- Going around in circles ("I've tried everything and nothing works")
- Fear-avoidant with poorly managed illness beliefs
- Non-believers (despite them saying they are believers)
- Well-read - but are often also "cherry-pickers"

What I do – The Process

- Assessment / Reporting (1.5 – 2.5 hrs)
 - Assessment location to suit patient
 - Includes self-report measures, interview and physical measures
 - Full medical report with overview, results and recommendations
- Prescription / Supervision (1-1.5 hrs weekly)
 - Based-on assessment findings, experience and research
 - Weekly supervision (tapered as appropriate) – at home, gym, café or clinic rooms
- Education Programme (each session)
 - Introduction to exercise and its principles + condition-specific information
 - Weekly activities provided and time to review with me each week to troubleshoot



Is Exercising Safe for these Populations?



American College of Sports Medicine. (2006 onwards). *ACSM's guidelines for exercise testing and prescription*. USA: Author.
Clark, LV., et al. (2017). Guided graded exercise self-help plus specialist medical care versus specialist medical care alone for CFS. *The Lancet*; 390:363-73
Fulcher, KY., & White, PD. (2000). Strength and physiological response to exercise in patients with CFS. *J Neurol Neurosurg Psychiatry*, 69:302-307
Bailey et al., (2010). Tired of being tired: Exercise as a treatment for CFS. *ACSM's Health and Fitness Journal*; 15(1): 20-25
Wallman, KE., et al. (2004). Randomised controlled trial of graded exercise in chronic fatigue syndrome. *MJA*: 180:444-448

Exercise Recommendations for Health Benefits

TOTAL HOURS = 11.5hours/wk



The Importance of Exercise

The benefits of exercise for functional disorders (an in-exhaustive list):

- Helps protect individuals from the harmful effects of stress
- Prevents and reduces depression, anxiety, anger and irritability
- Reduces fatigue and increases energy
- Reduces pain and disability perceptions
- Helps maintain a positive outlook, improves perceptions of personal problems and gives perspective
- Improves confidence, self-esteem and motivation
- Improves perceptions of enjoyment and happiness
- Improves cognitive functions such as short-term memory, selective attention, reaction time and learning speed
- Helps to improve quality of sleep
- Helps with daily structure and appropriate pacing strategies
- Conditions the respiratory system (useful with anxiety)
- Reduces muscular tension



What Other Clinicians Often Say

- "Oh it's just exercise - those trainers only know about muscles and what exercises work them"
- "My patient is in pain/has fatigue. You shouldn't be exercising someone with these symptoms"
- "This is far too much exercise" OR "This is far too little exercise"

When to Prescribe Exercise

As soon as you:

- Find out someone has a functional disorder
- Identify mismanaged symptoms
- Notice things are spiralling down and/or they are out of options
- Notice boom/bust patterns
- Notice avoidance behaviours or growing illness belief



If You Are Prescribing Exercise

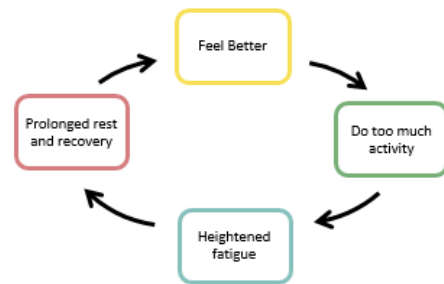
- Do less activity, more frequently
- Aerobic exercise is best for most conditions but sometimes much less manageable
- Get them exercising without them thinking about it



Exercise and CFS

Starting exercise is a scary concept for those who have been diagnosed with CFS. It's likely they will have been encouraged by their GP to start exercising however have struggled to sustain an increased level of activity due to their need for prolonged periods of rest afterwards. This is known as boom-bust. It is important that these habits are discouraged right from the beginning.

Typical activity cycle seen in patients with CFS:



To break the common boom-bust cycle, it is important that you establish a sustainable level of activity early on – balanced evenly between exercises, work, hobbies and family/friends. To do this, prescribe an exercise programme which is small and easily achievable – note, it is likely it'll be much less than what the patient expects, or is used to.

It is also important to encourage rest, before the patient needs it. Sitting down with your patient to determine ways in which they can break up bigger tasks (such as the supermarket shop) is also a very valuable activity. As the patients' confidence and trust in you builds, it is imperative that you push these activity boundaries every few weeks in order to improve their physical capacity.

FAQs

Can the patients' symptoms increase?

Yes. However, as with anybody starting an exercise programme, their body will adapt to this change. It is important to first set a stable baseline before progressing. Progressions may need to be small in volume and altered to occur over an extended period if needed.

What do I do if the patients' symptoms increase?

As this is a normal response, suggest they continue with their exercise for a few weeks to allow their body time to adapt. If the task doesn't become easier then reduce the intensity first (and then the duration if the fatigue continues). Do not attempt to change the frequency.

Do I encourage the patient to exercise even when they are fatigued?

If their fatigue is no more than usual, then yes, definitely. If their fatigue is much, much worse than usual (i.e. unable to get out of bed), you should revisit the exercise plan and implement the above suggestions.

What do I do if the patient is not following their exercise plan?

Something needs to change.

- [Ask them](#) about the programme; what is stopping them (e.g. time, cost, symptoms, fear)? Work with them to identify whether there's a simple work-around or whether a more significant change needs to be made. The exercise needs to work for them.
- Reinforce that their increased symptoms are a normal outcome for any increased or changed exercise and that stopping will not help the fatigue to go away.
- Talk to their psychologist about potential fear-avoidance beliefs or to have them help you encourage the importance of exercise, if you think this is necessary.

Resources

For further information on exercise prescription in patients with CFS and trouble-shooting, please visit: meganmcewen.co.nz or The Pace Trial GET manual

Chronic Fatigue Syndrome and Graded Exercise Therapy

Prescriber Handout



What is Graded Exercise Therapy (GET)?

GET is the use of regular physical exercise to aid the recovery from CFS. Working with the patient you will create a sensibly prescribed, individualised, graded exercise programme.

Pros of GET for your patients:

- Improved perceptions of mood, fatigue and pain
- Reduced anxiety and depression
- Improved resilience to stress and stressful situations
- Improved quality of sleep
- Tool for challenging beliefs on physical limitations
- Improved cardiovascular fitness
- Improved strength, endurance and flexibility
- Improved perceptions of quality of life

The exercise method chosen should be an activity your patient has a personal interest in whether that be walking, cycling, weight lifting etc.



Pitfalls to be aware of

- Programme needs to be appropriately tailored to individual → otherwise risk of poor compliance
- Participants can experience an increase in symptoms on starting activity, however if programme is appropriately prescribed this is easily addressed

Who runs GET programs?

A Physiotherapist or clinical exercise physiologist who has qualifications in working with medical patients. If you do not have speciality training in working with patients with CFS it is important that you have one of these specialised professionals overseeing your exercise prescriptions.

Exercise Programme Structure

Total program length: 24 weeks + Booster session at 36 weeks

Phase 1: Assessment, engagement and treatment planning (sessions 1-3)

Focus: establishing consistent baseline of activity Start gentle stretching programme of major muscle groups.

- Review medical history, current medications, treatments, exercise history, patient expectations of a rehabilitation plan.
- Establish rapport and assess current motivation. Investigate potential goals.
- Determine baseline physical activity. Look for evidence of boom-bust patterns.
- Educate them on the benefits of exercise and the pitfalls to avoid.
- Exercise modality chosen based on patient preference.
- Weekly supervision.

Phase 2: Active treatment (sessions 4-12) – Focus: exercise!

- Step-wise progression of exercises.
- First increase duration. Then intensity i.e. build to walking 30 min 4 x per week before trying to increase speed.
- Fortnightly supervision. Monitor and adjust as needed.

Phase 3: Preparation for discharge (sessions 13-14)

- Encourage variety and independence in patients programme. Plan ongoing exercise.

Phase 4: Booster session (session 15)

- Discuss experiences, maintenance of changes, future goal setting and planning.
- Discharge.

Programme Summary

Session Number	Week No	Time (mins)	Summary	Homework
1	1	90	- Subjective assessment - Engagement in GET model - Education - Start to investigate exercise goals	Activity diary + exercise questionnaire + goal setting
2	2	50	- Goal setting - Education - Review physical activity diary - Negotiate baseline activity - Demonstrate stretches	Baseline physical activity + stretches
3	3	50	- Mutually agreed and prioritised goals - Exercise baseline negotiation	Start exercise baseline + activity baseline + stretches
4	4	50	GET - Active treatment - Demonstrate heart rate monitors - Sleep advice for exercise - HR/Borg comparisons - Reviewing exercise record - Planning next session of exercise - Written setback plan - Assessing motivation - Reviewing goals - Preventing/managing setbacks - Muscle relaxation - Maintaining changes - Adding strengthening exercises	Exercise
5	6	50		
6	8	50		
7	10	50		
8	12	50		
9	14	50		
10	16	50		
11	18	50		
12	20	50		
13	22	50		
14	24	50	- Tail off HRM - Encouraging variety / independence - Plan ongoing exercise	
15	36	50	Treatment booster session: - Maintenance of changes - Future goal setting and planning - Discharge	Ongoing exercise + goal setting

KEY:	
■	Phase 1: Assessment, engagement and treatment planning
■	Phase 2: Active treatment
■	Phase 3: Ending treatment and preparing for future
■	Treatment booster session

What to Expect When Starting Exercise?

- Temporary increases in symptoms
- Exercise is confrontational
- Barriers / excuses / obstacles / lack of acceptance → avoidance
- Boom and bust patterns
- Expect to communicate with other clinicians

When to Refer?

- As soon as the patient tells you they are not exercising, despite your best efforts
- If they don't believe in exercise, still refer
- If you don't have capacity to give them the attention they will need
- If they refuse to medicate, get them exercising



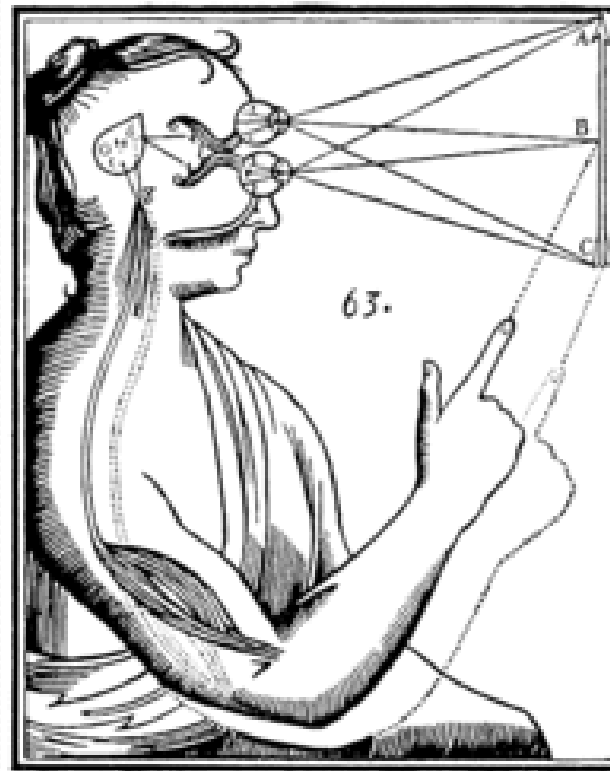
Take-Home Messages

- Exercising is safe when you have a functional disorder
- Exercising is effective, if done properly
- Exercising offers more than just “physical” improvements
- Listen carefully to what they tell you
- Your choice in clinician is paramount
- TEAMWORK IS ESSENTIAL
- It's about the human, not just the body it's in



MUS for RACP

Kristy Bolter, PhD
Consultant Clinical Psychologist
Service Clinical Director, Reablement Services, Auckland
City Hospital
7th May 2019



The idea of mind-body holism as opposed to dualism
The biopsychosocial model...

Previous psychological explanatory models of Functional Disorders

“Conversion”

- Briquet – earlier abuse events increased the risk of conversion
- Freud – unacceptable drives were repressed from conscious awareness – resulting psychic energy converted to physical symptoms
- Contemporary psychodynamic theories – physical symptoms either suppress an emotion or serve to resolve dilemmas

Contemporary views on the role of aversive events – they increase the risk of functional symptoms but do not fully account for their development

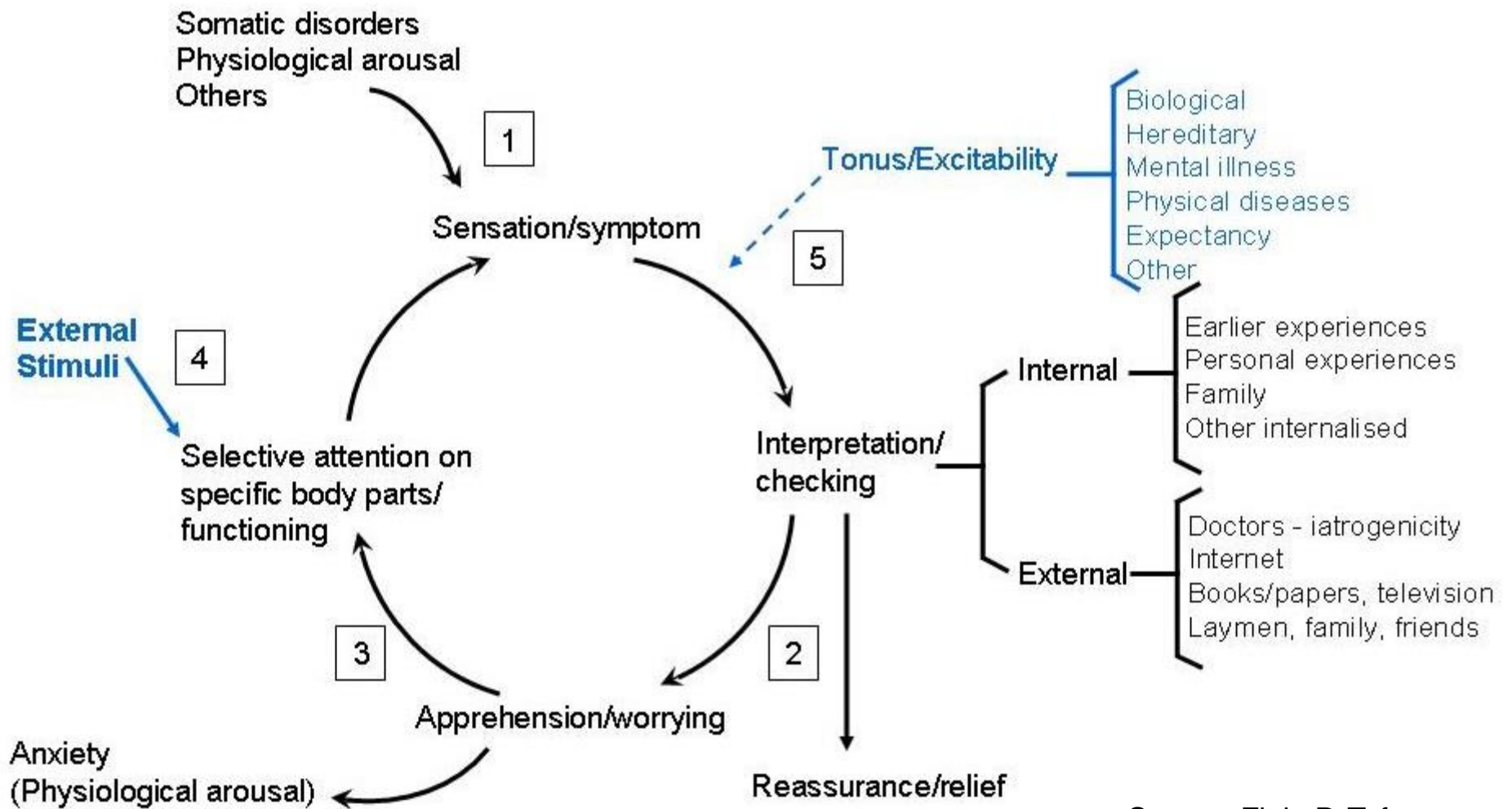
Models emphasising the role of Attentional Dysregulation

- Information flow based on the integration between bottom-up sensory information and top-down predictions about the nature of the expected sensory information
- Differential weighting of the two streams of information leads to abnormal predictions

The Integrated Cognitive Model

- Factors such as inherent responses to emotions, ideas about illness, and illness models contribute to the formation of a symptom scaffold which may be activated by arousal or internal/external stimuli perceived as threatening

Illness perceptions and illness behaviour appear to be important



Source: Fink, P, Toft, T., Rosendale, M., Psychosomatics 2002

Psychological therapies

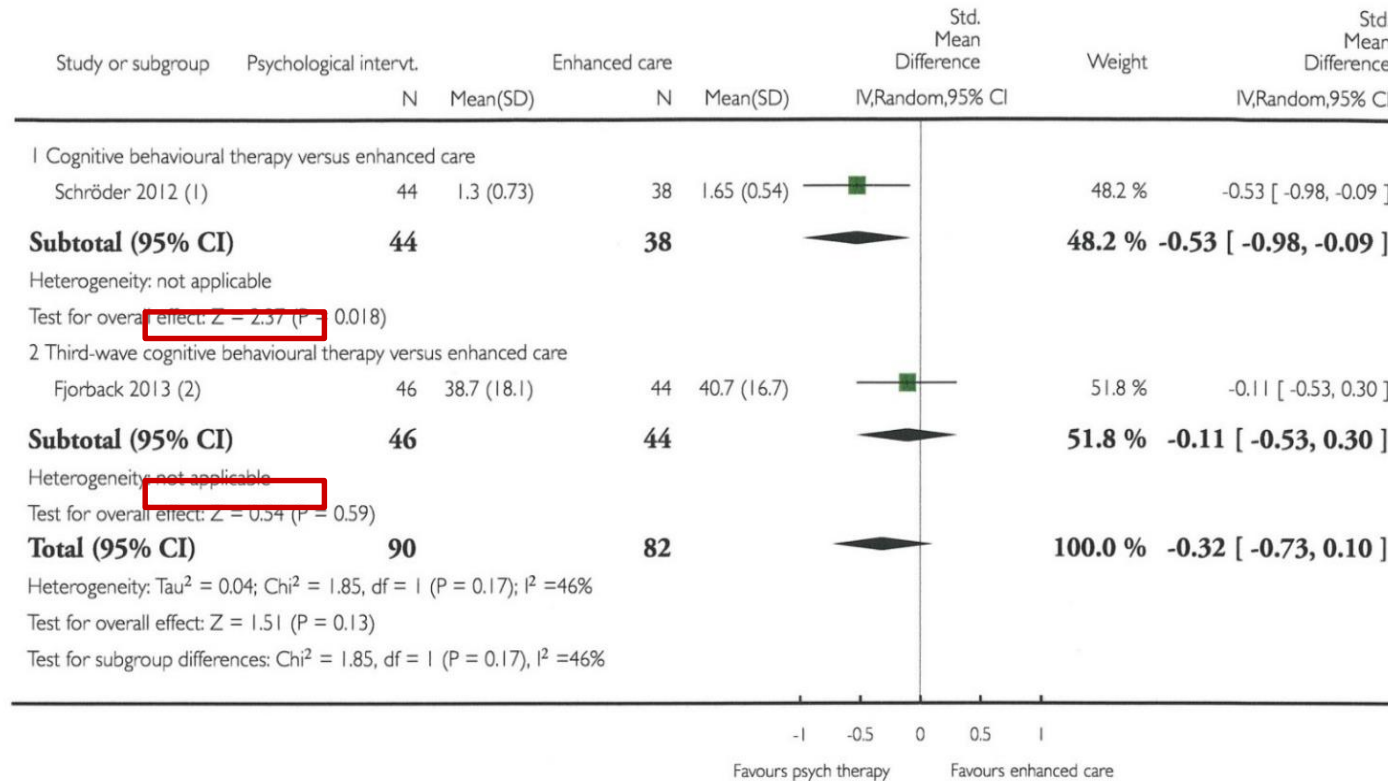
	Biological factors	Psychological factors	Social factors
Predisposing factors	<ul style="list-style-type: none"> • biological variabilities in nervous system • genetic factors affecting personality • disease 	<ul style="list-style-type: none"> • poor attachment to parents and others • coping style or personality style • tendency for specific cognitive biases 	<ul style="list-style-type: none"> • poor family functioning • childhood neglect or abuse
Precipitating factors	<ul style="list-style-type: none"> • physical injury, illness, or infection • abnormal physiological event or state (e.g. hyperventilation, sleep deprivation) 	<ul style="list-style-type: none"> • acute stress • perception of life event as negative or unexpected • depression or anxiety • acute dissociative episode • panic attack 	<ul style="list-style-type: none"> • difficult life events • symptom modelling (e.g. through personal contact or media)
Perpetuating factors	<ul style="list-style-type: none"> • deconditioning • neuroendocrine and immunological abnormalities similar to those seen in depression or anxiety • plasticity in CNS motor and sensory pathways (including pain) 	<ul style="list-style-type: none"> • the perception that their symptoms are out of their control • not being believed • anxiety • catastrophisation of symptoms • avoidance of symptom provocation 	<ul style="list-style-type: none"> • presence of a welfare system, social benefits of being ill • stigma of being mentally ill in society • fear/avoidance of work or family responsibilities

Analysis 2.3. Comparison 2 Psychological therapies versus enhanced care, Outcome 3 Severity of somatic symptoms > 1 year after treatment.

Review: Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults

Comparison: 2 Psychological therapies versus enhanced care

Outcome: 3 Severity of somatic symptoms > 1 year after treatment



Effect size
0.61

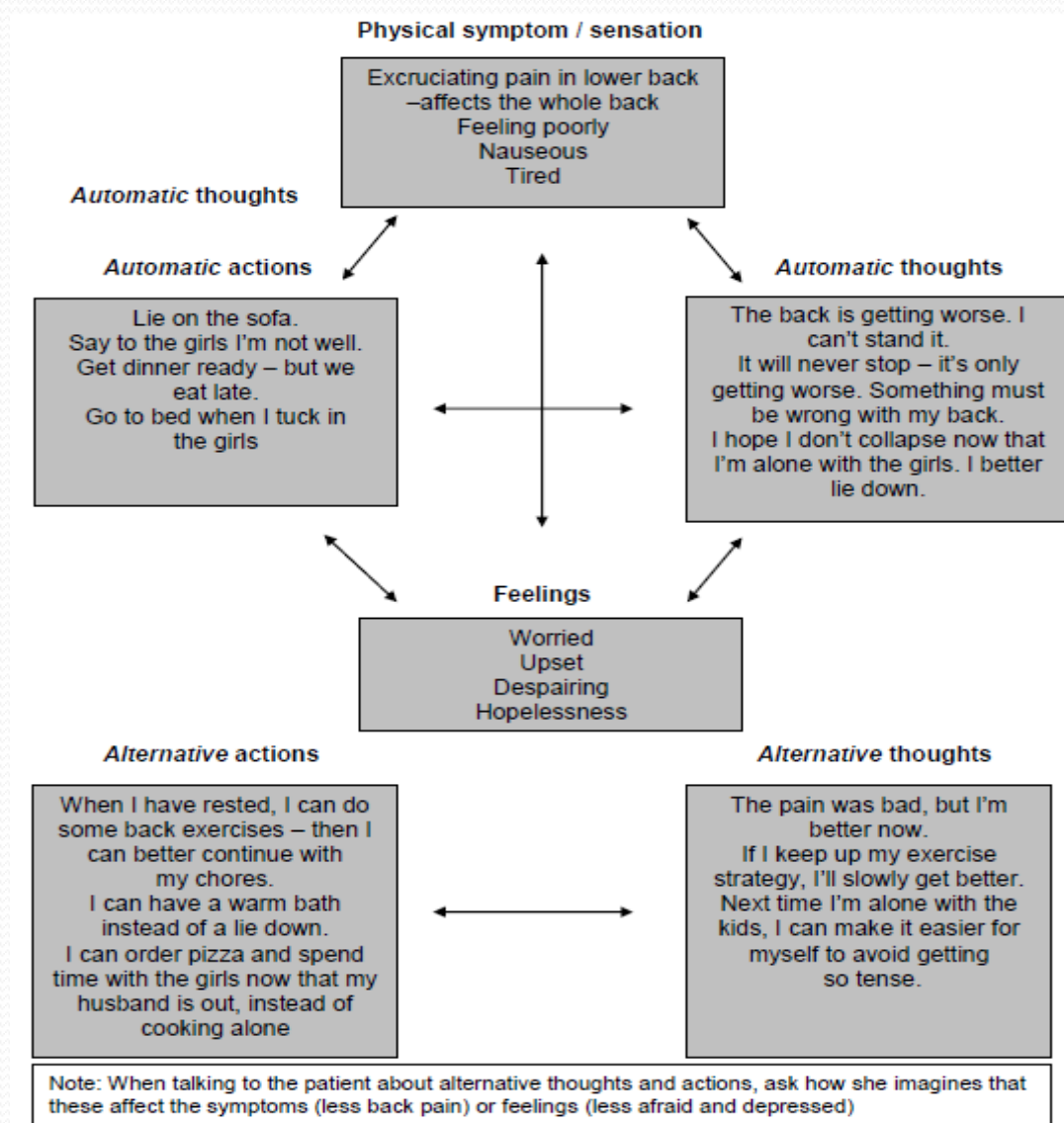
Van Dessel N et al. Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults

Cochrane Systematic Reviews 2014

Cognitive Behavioural Therapy

- Collaborative and time limited
- Maximise function and to minimise symptoms
- Face to face sessions with a specifically trained therapist once a week or fortnight
- 10-14 weeks (or longer if chronic symptom presentation)
- Emphasises the interaction of cognitive, behavioural, emotional and physiological factors in perpetuating symptoms
- Therapy starts with the assessment
- Patients are guided to discover new ways to manage symptoms, and often alternative ways of thinking and behaving
- Educational component
 - taught about the links between cognition, behaviour, emotion and physiological factors
 - taught about the common types of cognitive distortions
 - learning theory/habit forming
 - taught ways to recognise, monitor and track changes

An example of a cognitive model presented in therapy



Source: Fink, P,
Toft, T., Rosendale,
M., Psychosomatics
2002

Cognitive Behavioural Therapy

- Focus on understanding the individual's bodily symptoms, their interpretation, general illness perceptions, and stress responses
- Guided move from illness behaviour to health behaviour
- Behavioural activation
- Sleep, diet, exercise, and relationships
- Treatment of comorbid psychiatric diagnoses
- Relapse prevention

Real disorder

Impact of

Neurobiological basis

*Individual perpetuating factors (cognitive and behavioral)
Increasing healthy behaviour (individual treatment plan)*

*Relapse prevention / definition
of individual goals for the next months*

Specialised Treatment for Severe Bodily Distress Syndromes (STreSS)

Module	Week	Content and Objectives
1 st Module	1	Introduction to STreSS
2 nd Module	2	Bodily symptoms and their interpretation
3 rd Module	3	Illness perceptions. Stress response. Treatment goals.
4 th Module	4	Negative automatic thoughts and dysfunctional behaviours
5 th Module	6	Cognitive distortions and emotional awareness
6 th Module	8	From illness behaviour to health behaviour I
7 th Module	10	From illness behaviour to health behaviour II
8 th Module	12	Becoming your own therapist. Relapse prevention
9 th Module	16	How to maintain learned skills and coping strategies

Patient experience

Often very negative experiences. Common reasons include:

- Not feeling listened to
- Not enough time
- Feeling that their symptoms were being disbelieved or dismissed
- A sense that the doctor believed that there was an underlying psychological problem
- Not getting a chance to describe all their symptoms
- Not getting a chance to explain and discuss their beliefs about the cause and treatment
- Not being given an adequate explanation or diagnosis or any information

What elements of a biopsychosocial model can be adopted into initial medical contacts?

- Ask about their symptoms and “drain the symptoms dry”
- Don't dive into questions about psychological wellbeing – introduce the biopsychosocial model first
- Ask what the patient thinks is wrong and what should be done about it – to elucidate

Main elements of illness beliefs

Identity

Cause

Time frame

Consequences

Recovery and control

How to introduce the idea of the helpfulness of psychological treatment...

- May be useful to use a computer metaphor
- Nervous system isn't working properly
- If you were a computer its like having a software problem rather than a hardware problem
- You'd have to resolve it by reprogramming the computer, working out which programmes were causing the problem
- Humans are obviously more complex
- Our thoughts, behaviours, sensations, and emotions are our programmes
- This is where psychology comes in – help with retraining body and mind to work together, cope with symptoms

What to expect from your referral to psychology?



Key take home messages:

- Functional symptoms are common and can be disabling but are potentially reversible
- Functional symptoms are not 'all in the mind' but they are also 'not all in the body'
- Effective interventions do exist – CBT, exercise physiological approaches
- People want to be taken seriously
- Doctors can make a difference to the person's wellbeing through their attitudes and approach
- Continuity of care and the long term relationship helps
- Importance of understanding the biopsychosocial model

Guidance for health professionals on medically unexplained symptoms (MUS)

Making Sense of Symptoms Managing Professional Uncertainty Building on Patient's Strengths

January 2011

Medically unexplained symptoms are 'persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology'.

“Our remedies oft in ourselves do lie.”

All's well that ends well, William Shakespeare

Key learning points

- People want to be taken seriously – show you believe them.
 - Ask yourself and the patient “Am I hearing and understanding what you are trying to tell me?”
- Doctors *can* make a difference to the patient's well-being even when their symptoms are unexplained.
 - Concentrate on helping to manage symptoms and improve functionality
- Sometimes the only “therapy” needed may be the strength of your doctor-patient relationship – continuity of care and the long-term relationship helps.
 - Be pre-emptively reassuring, yet show you have an open mind and will continue to reassess
 - Explain rather than just ‘normalise’
- Be explicit about your thoughts, your uncertainties and your expectations of referrals to specialist care.
 - Proactively communicate with other clinicians

Despite having a strong suspicion that there is no serious medical problem, GPs worry about missing something serious and are often left with a sense of dissatisfaction with such cases. Patients may feel unsupported and confused. Such uncertainty often leads to extensive and unproductive investigations.¹

This guidance will highlight the importance of clinicians trusting, perhaps more than they do, their own psychological abilities and the strengths of their therapeutic alliance with their patients. This would help achieve better concordance between addressing the patients' fears and managing their own anxiety and uncertainty.²

When the body says stop



There are many causes for functional disorders.

Resources

- When the body says stop – for patients and families

http://funktionellelidelser.dk/fileadmin/www.funktionellelidelser.au.dk/patient_Pjecer/When_the_body_says_stop.pdf

- Neurosymptoms.org – for patients and families

- Medically Unexplained Symptoms – for providers

<https://www.rcpsych.ac.uk/mental-health/problems-disorders/medically-unexplained-symptoms?searchTerms=Medically%20unexplained%20symptoms>

- Whole Person Healthcare – referral list for mind/body psychotherapists

<https://wholeperson.healthcare/clinicians/>

Manual for Psychologists/Psychotherapists to work with mind/body issues

<https://www.en.auh.dk/departments/the-research-clinic-for-functional-disorders-and-psychosomatics/clinical-treatment/>

Manfred Beutel Wijo Kop
Wolfgang Söllner
Omervanden Bergh Marie Bendix
Paul Enck Andreas Schröder Ursula Werneke
Jordi Blanch Lisbeth Frostholm Timolde Hartman
Judith Rosmalen Turid Birgitte Boye Marco Lehmann
Chris Burton Meike Shedden-Mora Angelika Weigel
Winfried Rief Joanna Rymaszewska Chris Kenedi
Per Fink Christinavander Feltz-Cornelis
EURONET-SOMA
Anne Toussaint Krzysztof Malyszczak Arturs Miksons
Rainer Schäfert Maria Kleinstäuber Heribert Sattel
Sebastian Kohlmann Claas Lahmann
Michael Sharpe Ulrik Frederik Malt Harald Gündel
Arturs Acans Alexandra Martin Carsten Leue
Gunta Ancane Michael Witthöft Paul Hüsing
Peter Henningsen
Ksenya Khohlova
Bernd Löwe



Thank you

Chris Kenedi, MD, MPH
Physician and Psychiatrist
ckenedi@outlook.com

Kristy Bolter, PhD
Consultant Clinical Psychologist & Service Clinical Director
kristyb@adhb.govt.nz

Megan McEwen MSc (hons), PGDipSci (dist), BSc
Exercise Physiologist
megan@meganmcewen.co.nz