Persistent physical symptoms: Descriptive or etiologically-oriented classification? Implications for treatment

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Thanks to mentors, co-workers, and patients:

Michael Sharpe

Developed Somatic Symptom Disorder

(DSM-5)

Emma Rehfeld

The first to treat Bodily distress syndrome

Per Fink

Developed Bodily distress syndrome

(ICD-11 PHC)

Torben Jørgensen

Unravels the causes of Functional Somatic Syndromes

Winfried Rief

Developed Chronic primary pain

(ICD-11)

COI:

None.

How do persistent physical symptoms present to health care professionals?

Somatization disorder

Irritable bowel syndro

Medically unexplained sympt

Fibromyalgia

Suppli *et al. BMC Public Health* (2018) 18:1360
https://doi.org/10.1186/s12889-018-6268-x

BMC Public Health

RESEARCH ARTICLE Open Access

Decline in HPV-vaccination uptake in Denmark – the association between HPV-related media coverage and HPV-vaccination

Camilla Hiul Suppli[1*], Niels Dalum Hansen[2], Mette Rasmussen[4], Palle Valentiner-Branth[1], Tyra Grove Krause[1] and Kåre Mølbak[3]

How do people, who suffer from persistent physical symptoms, look like?

What are persistent physical symptoms? Definition according to a recent article:

REVIEW ARTICLE

Persistent Physical Symptoms as Perceptual Dysregulation: A Neuropsychobehavioral Model and Its Clinical Implications

Peter Henningsen, MD, Harald Gündel, MD, Willem J. Kop, PhD, Bernd Löwe, MD, Alexandra Martin, PhD, Winfried Rief, PhD, Judith G.M. Rosmalen, PhD, Andreas Schröder, MD, PhD, Christina van der Feltz-Cornelis, MD, and Omer Van den Bergh, PhD, on behalf of the EURONET-SOMA Group

Psychosomatic Medicine, V 80 • 422-431 422 June 2018

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Table 1
Differences and similarities in criteria and concepts between different diagnostic constructs.

Bodily distress syndrome (BDS)	Somatic symptom disorder (DSM-5)	Somatoform disorder (ICD-10)	Functional somatic syndromes
Defined by physical symptom pattern	Defined by emotional and behavioural symptoms/characteristic	Defined by physical symptom pattern including emotional and behavioural symptoms/characteristics and exclusion of organic basis	Defined by a primary symptom, or a symptom pattern or/and assumed attribution (depending on the FSS)
Organic (CNS) based bodily symptoms	Bodily symptoms of any aetiology	Symptoms without organic basis (medically unexplained)	Organic based (CNS or peripheral)
Emotional or behavioural symptoms not necessary for the diagnosis but are prevalent and may be important for the treatment	Emotional or behavioural symptoms are crucial for the diagnosis	Includes worrying and preoccupation with physical health and bodily sensations	Fibromyalgia (FMS)
Medical and psychiatric differential diagnoses have to be excluded	No requirement of exclusion of a medical diagnosis, but of psychiatric differential diagnosis	Organic explanations and other mental disorders have to be excluded	Irritable bowel syndrome (IBS)
Suffering from symptoms of BDS	Suffering from emotional and behavioural trouble related to bodily symptoms or sensations	Suffering from medical unexplained symptoms and emotional/behavioural trouble	Chronic fatigue syndrome (CFS)
Cause unknown but emotional or physical stress and dysfunction in the CNS likely to be involved	Health anxiety and misinterpretation of bodily symptoms	Stress, emotional conflicts etc.	Multiple chemical sensitivity (MCS)
Challenge the mental/physical dichotomy thinking of medicine	A mental disorder	A mental disorder	Electric hypersensitivity (EHS)
Based on empirical studies	Consensus driven	Poor empiric basis, most consensus driven	Consensus driven, poor empiric basis with a few exceptions
			Etc.
			Etc.

P. Fink *Journal of Psychosomatic Research 97 (2017) 127–130*

Why is it so difficult to give people, who suffer from persistent physical symptoms, a meaningful diagnosis?

A clinical diagnosis is a powerful tool

Provides a label and gives
meaning to a person’s symptoms

Legitimizes the ”sick role”

Serves for communication issues
between healthcare professionals

Is a pragmatic tool to
guide treatment

The Journal of Rheumatology

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Fibromyalgia Wars

FREDERICK WOLFE

The Journal of Rheumatology April 2009, 36 (4) 671-678; DOI: https://doi.org/10.3899/jrheum.081180

Fibromyalgia is a bitterly controversial condition. It pits patients, pharmaceutical companies, some specialty physicians, professional organizations, and governmental agencies – groups with substantial political and economic power who benefit from the acceptance of FM – against the large majority of physicians, sociologists, and medical historians in what we call the “fibromyalgia wars”.

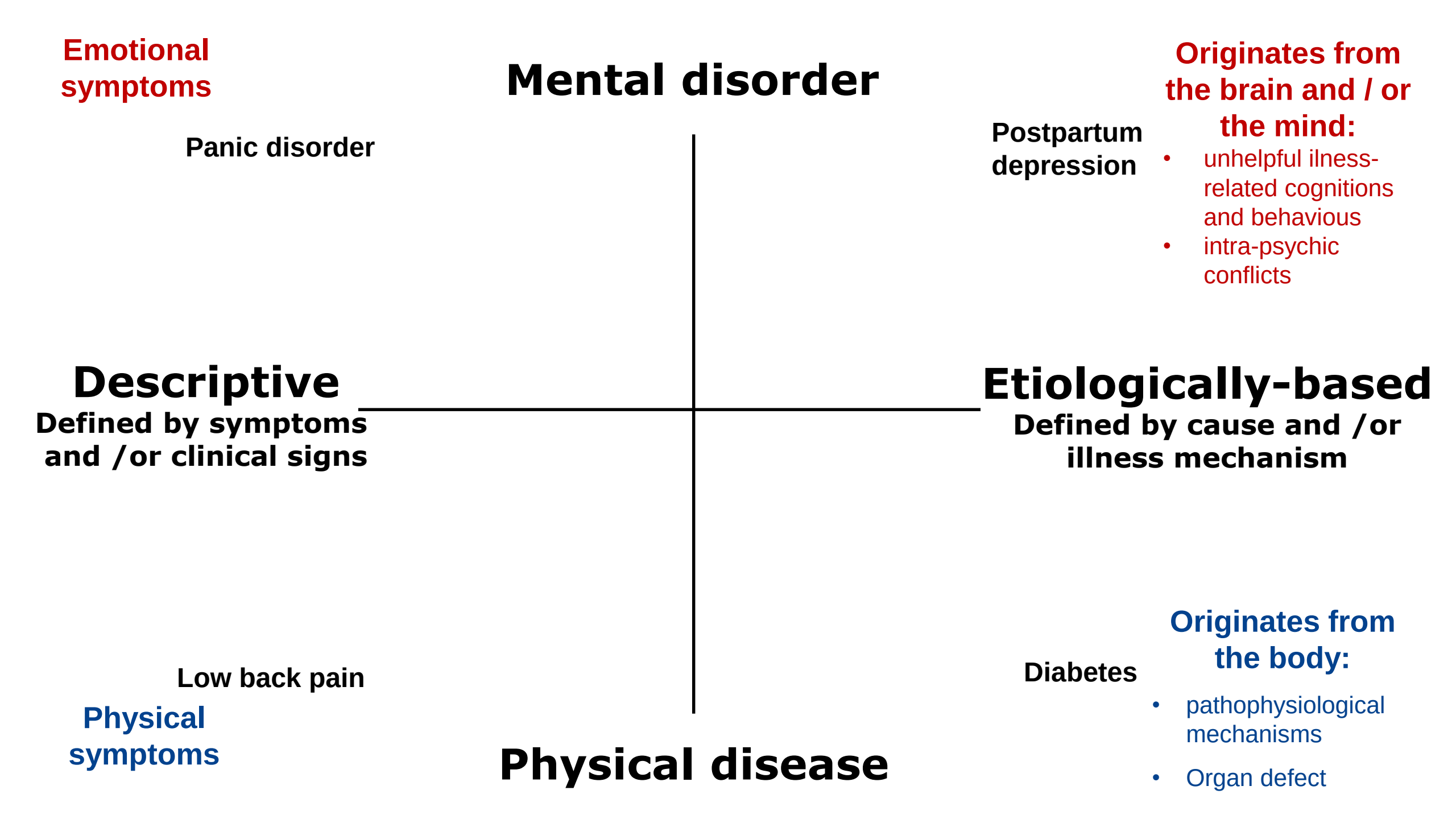
symptoms, and a single partially objective sign — tenderness on palpation[2]. Representing perhaps 2% to 4% of the adult population[3], patients with FM incur substantial direct and indirect medical

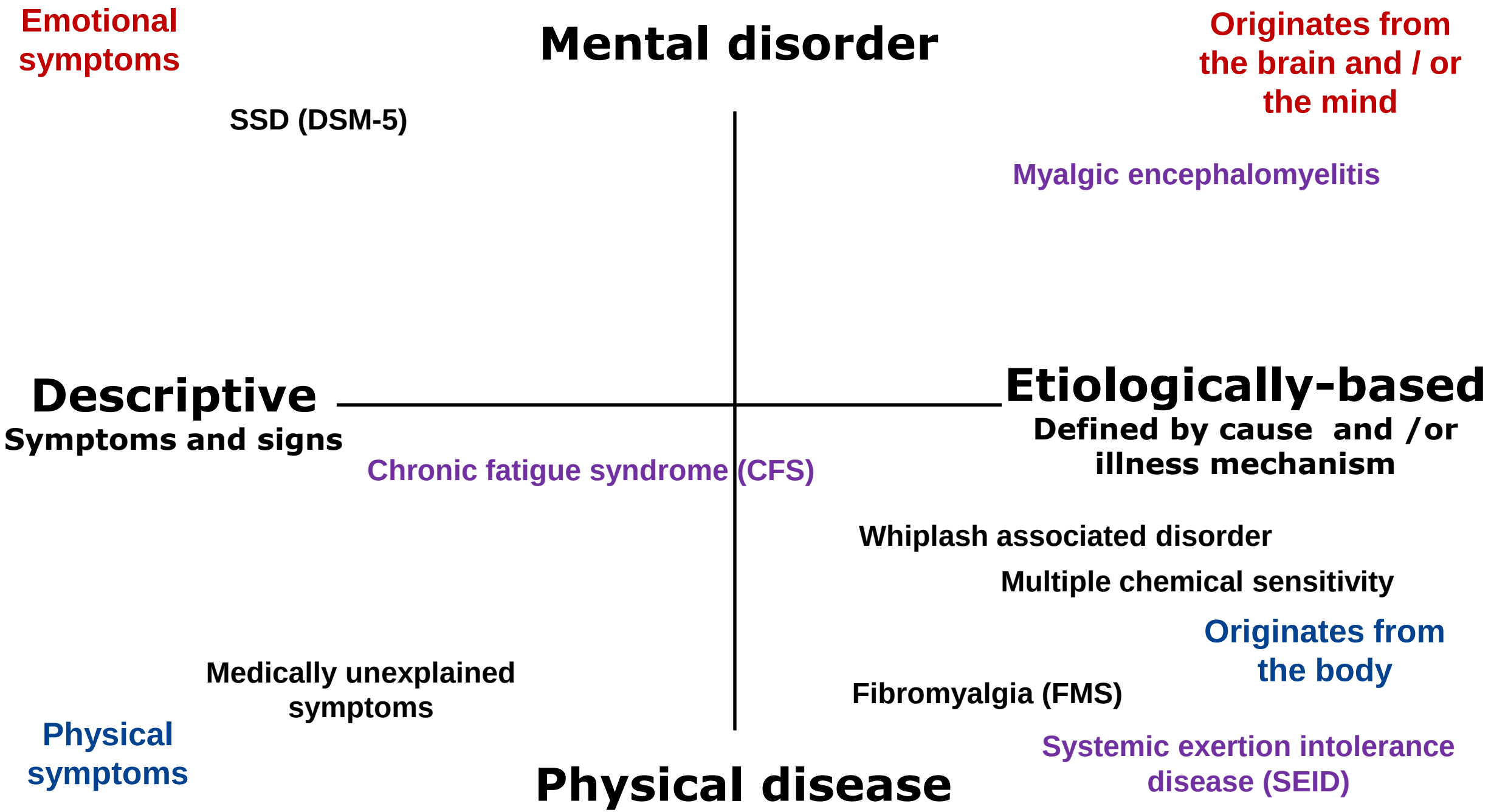
Print Share

Persistent physical symptoms:

Do you prefer a descriptive or an etiologically-oriented classification?

Do you prefer a mental or a physical diagnosis?


Emotional symptoms
Mental disorder
Panic disorder
Postpartum depression
Originates from the brain and / or the mind:
• unhelpful ilness-related cognitions and behavious
• intra-psychic conflicts
Descriptive
Defined by symptoms and /or clinical signs
Etiologically-based
Defined by cause and /or illness mechanism
Low back pain
Physical symptoms
Diabetes
Originates from the body:
• pathophysiological mechanisms
• Organ defect
Physical disease


Emotional symptoms
Mental disorder
Originates from the brain and / or the mind
SSD (DSM-5)
Myalgic encephalomyelitis
Descriptive
Symptoms and signs
Etiologically-based
Defined by cause and /or illness mechanism
Chronic fatigue syndrome (CFS)
Whiplash associated disorder
Multiple chemical sensitivity
Originates from the body
Medically unexplained symptoms
Fibromyalgia (FMS)
Physical symptoms
Systemic exertion intolerance disease (SEID)
Physical disease

Emotional symptoms

Mental disorder

Originates from the brain and / or the mind

SSD (DSM-5)

Descriptive
Symptoms and signs

Etiologically-based
Defined by cause and /or illness mechanism

Bodily distress syndrome (BDS)

Primary Pain
(IASP, adopted by WHA for ICD-11)

Whiplash associated disorder

Multiple chemical sensitivity

Originates from the body

Fibromyalgia (FMS)

Medically unexplained symptoms

Physical symptoms

Physical disease

Persistent physical symptoms:

"Our study also has important implications for clinical management: The **knowledge about etiological factors that is gained from our review has to be translated into explanatory models for single patients.** For each individual case the contribution of biological, psychosocial and healthcare factors has to be weighted, acknowledged, and discussed with the patient."

Schröder A. Kleinstäuber M. et al. *submitted*

"A **biopsychosocial model of interacting biological and psychosocial factors** in the predisposition, onset and maintenance of FMS symptoms is more appropriate than the dichotomy between a somatic disease and a mental (somatoform) disorder."

W. Häuser, P. Henningsen. Eur J Pain 2014; 18: 1052–1059

Why the Bodily distress syndrome diagnosis (in my opinion) solves many of the classification problems

Diagnostic criteria for BDS

1) ≥ 3 symptoms from at least one of the groups or ≥ 4 overall
2) Moderate to severe impairment
3) Relevant differential diagnoses ruled out
4) Duration ≥ 4 weeks? 6 months? 12 months?

Cardiopulmonary / autonomic symptoms

1. Palpitation / heart pounding
2. Precordial discomfort
3. Breathlessness without exertion
4. Hyperventilation
5. Hot or cold sweats
6. Dry mouth

Musculoskeletal symptoms

1. Pains in arms or legs
2. Muscular aches or pains
3. Pains in the joints
4. Feeling of paresis or localized weakness
5. Back ache
6. Pain moving from one place to another
7. Unpleasant numbness or tingling sensation

Gastrointestinal symptoms

1. Abdominal pains
2. Frequent loose bowel movements
3. Diarrhea
4. Feeling bloated/full of gas/distended
5. Nausea
6. Regurgitations
7. Burning sensation in chest or epigastrium

General symptoms

1. Concentration difficulties
2. Excessive fatigue
3. Headache
4. Impairment of memory
5. Dizziness

Fink P et al. Psychosom Med 2007;69: 30-39
Fink P & Schröder A. J Psychosom Res 2010;68: 415-426
Butz-Lilly A. et al. J Psychosom Res 2015; 78: 536-45

1. The BDS diagnosis solves (some of) the FSS overlap, and teaches symptom pattern recognition

DanFunD - Danish Study of Functional Disorders (www.danfund.org)

- The DanFunD cohort: N=9,656
  - 53.9 % (n=5203) females
  - Mean age: 52.5 (SD: 13.2)

Scientific symposium 20, Friday 10:30-12:00, Leeuwen Room I & II
T. Jørgensen et al.
Impaired lipid- and glucose metabolism in persons with various FSS points towards a common genesis

Dantoft T et al. Clin Epidemiol 2017;9:127-139

DanFunD
DANISH STUDY OF FUNCTIONAL DISORDERS

2. The BDS diagnosis takes the best from both the lumpers and the splitters

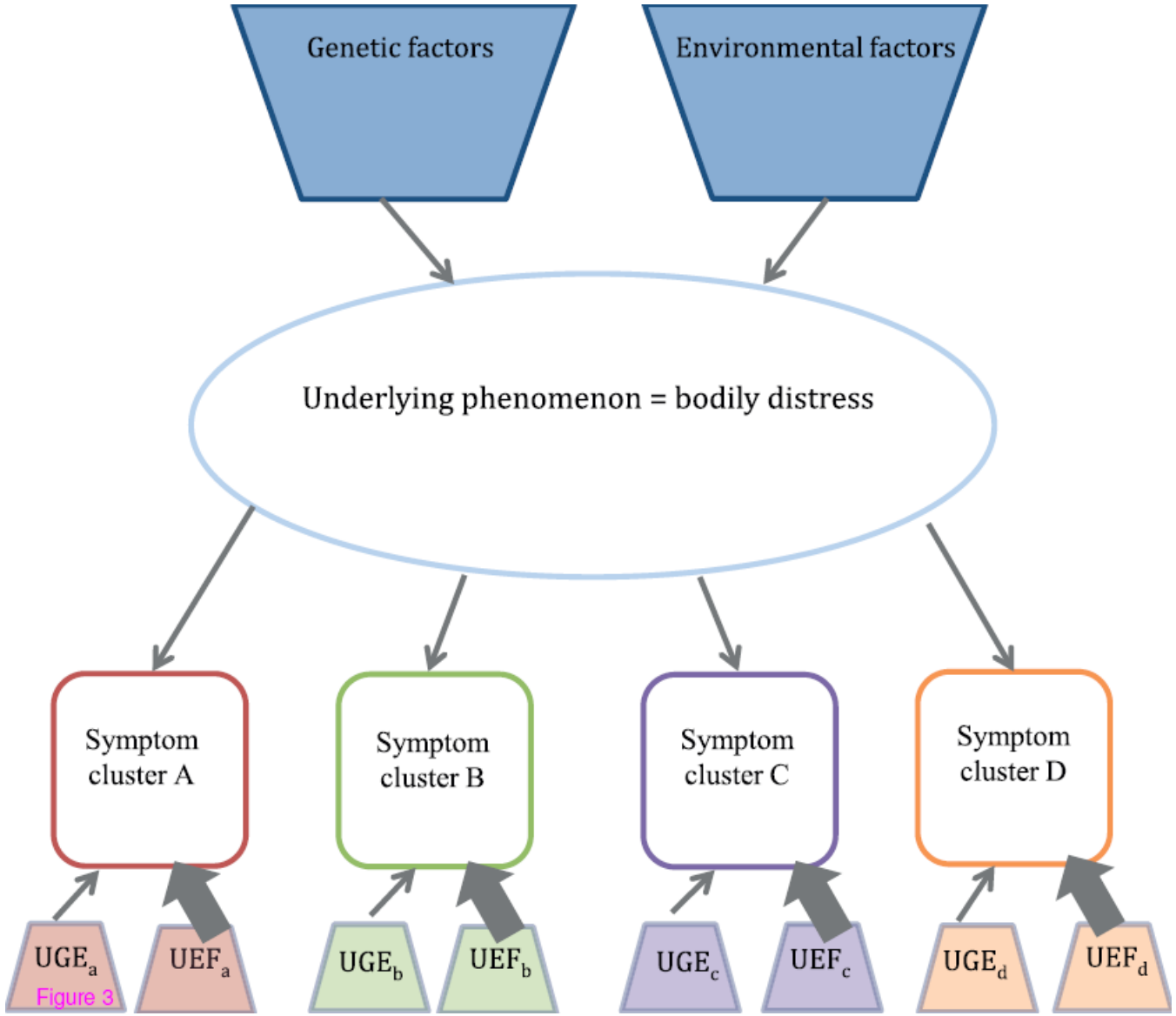


Figure 3

Bodily distress:

Pathophysiological responses to prolonged or severe mental and/or physical stress in genetically susceptible individuals.

Butz-Lilly A., Schröder A. et al. *BMC Family Practice* 2015; 16: 180

Schröder A & Fink P *Psych Clin North Am* 2011; 34: 673 - 687

Systematic umbrella review investigating the etiology of functional somatic disorders: Specific biological and psychosocial factors investigated in IBS, FMS, CFS / ME and SFD

3. The BDS diagnosis resists the question,
whether it should be understood
as a mental disorder or a physical disease.
While descriptive in it's approach,
the diagnosis is conceptually focussed on the
interplay of biological and psychosocial factors.

Schröder A. Kleinstäuber M. et al. *submitted*

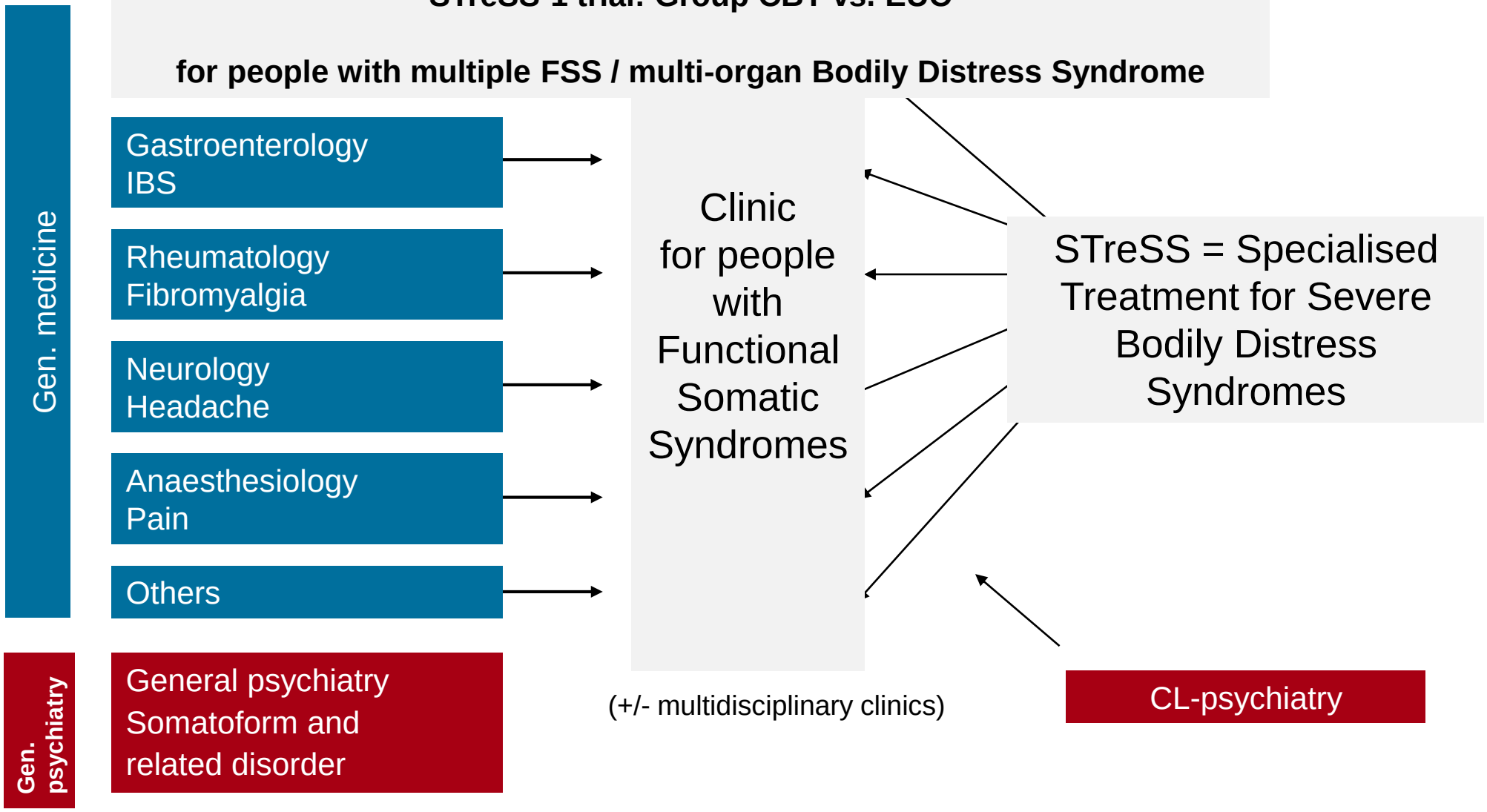
4. The BDS works well in both the clinic as well as in clincal research

- Easy to teach GPs and somatic specialists
- Have been used in four randomised clinical trials and one prospective clinical cohort study during the last 14 years
  - Schröder A et al. Cognitive- behavioural group treatment for a range of functional somatic syndromes: randomised trial. *Br J Psychiatry* 2012; 200: 499 – 507.
  - Fjorback L et al. Mindfulness therapy for somatization disorder and functional somatic syndromes — randomized trial with one-year follow-up. *J Psychosom Res* 2013; 74: 31 - 40.
  - Agger JL et al. Imipramine versus placebo for multiple functional somatic syndromes (STreSS-3): a double-blind, randomised study. *The Lancet Psychiatry* 2017; 4: 378–388.
  - Pedersen HF et al. Acceptance and commitment group therapy for patients with multiple functional somatic syndromes: a three-armed trial comparing ACT in a brief and extended version with enhanced care. *Psychol Med* 2019; 49: 1005-1014.
- Point of departure for patient education, for a new, common understanding of the persistent physical symptoms, and for further treatment.

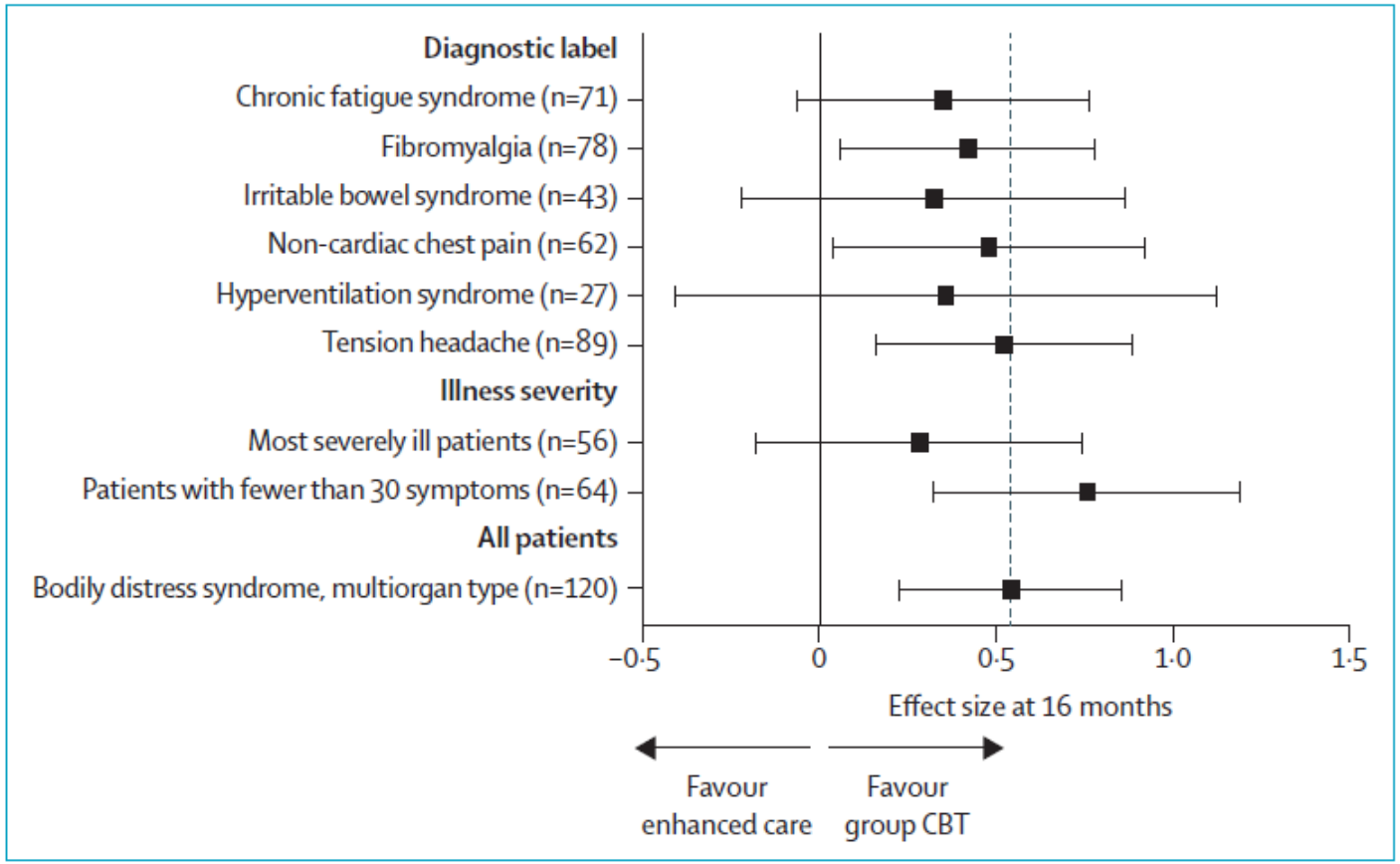
Organisational model

STreSS-1 trial: Group CBT vs. EUC

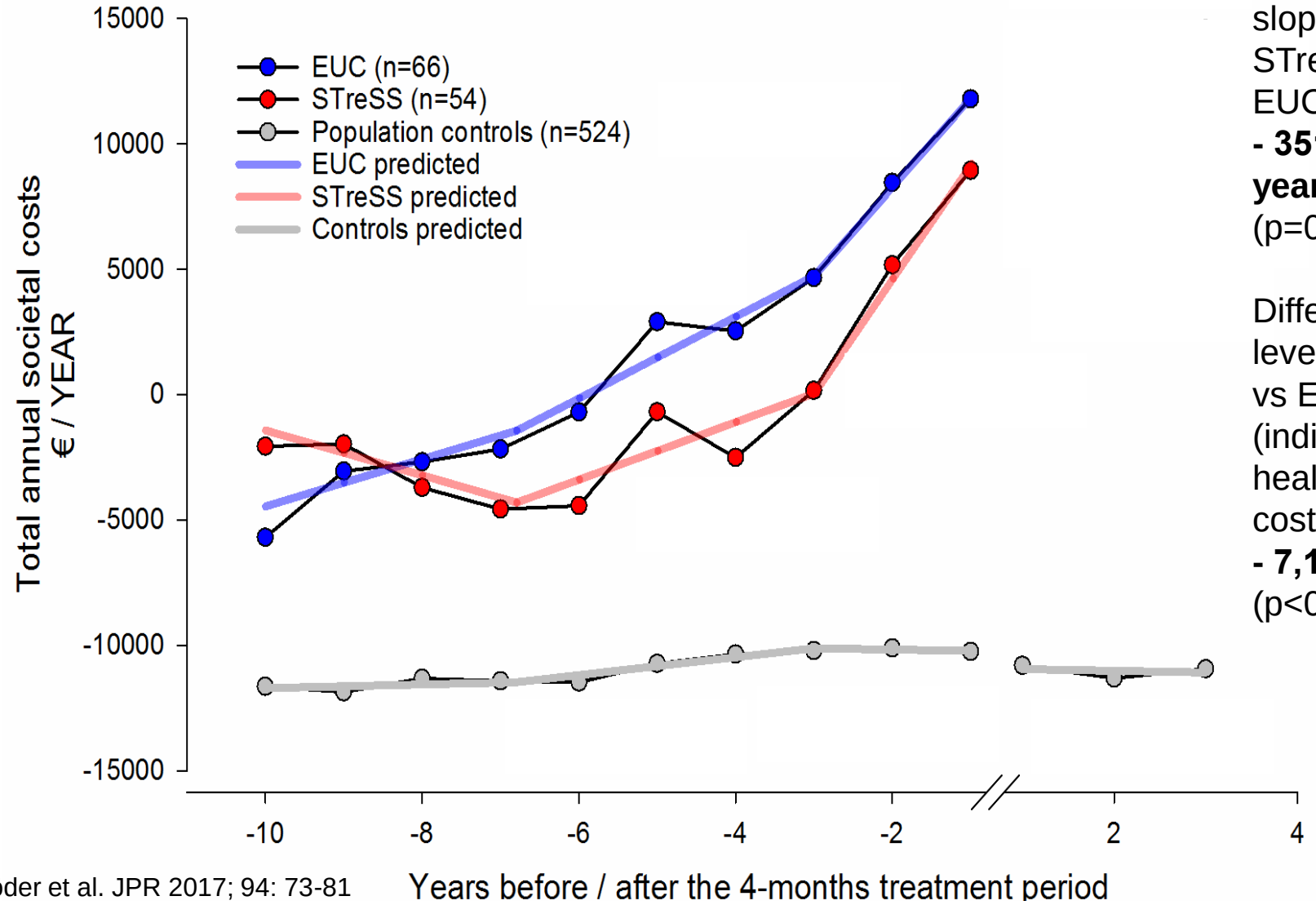
for people with multiple FSS / multi-organ Bodily Distress Syndrome



Type of FSS had no differential effect on outcome (but illness severity important)



Schröder et al. Lancet Psychiatry 2015



Schröder et al. JPR 2017; 94: 73-81

Difference in slope STreSS vs EUC:
- 3514 € / year
(p=0.006)

Difference in level STreSS vs EUC (indirect and healthcare costs):
- 7,184 €
(p<0.001)

Pharmacological treatment

STreSS-3 trial: Imipramine, compared with pill placebo, improves patients“overall health”

if supported by regular contacts with clinicians

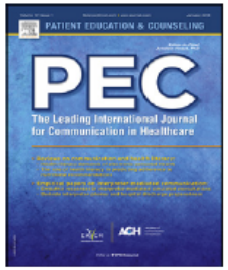
Agger JL., Schröder A. et al. *Lancet Psychiatry 2017*

Patient Education and Counseling xxx (2019) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou



"Understand your illness and your needs": Assessment-informed patient education for people with multiple functional somatic syndromes

H. Frølund Pedersen[a,*], A. Holsting[a], L. Frostholm[a], C. Rask[b], J.S. Jensen[a], M.D. Høeg[a], A. Schröder[a]

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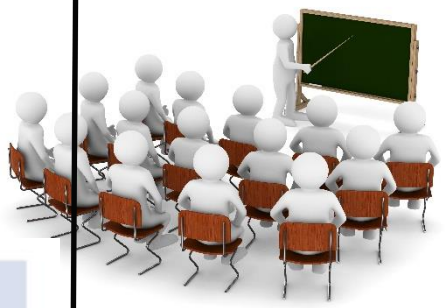
[b] Centre for Child and Adolescent Psychiatry, Aarhus University Hospital, Palle Juel-Jensens Boulevard 175, Entrance K, 8200 Aarhus N., Denmark

Questionnaire

Questionnaire

Questionnaire

Questionnaire



Element 1: Clinical assessment, 3-6 hours
1. Life-time interview (social events, on-set of symptoms, contacts to health care system)
2. Schedules for Clinical Assessment in Neuropsychiatry (SCAN interview)
3. Feedback: Diagnosis and information on t treatment options at the clinic
4. Shared decision making on treatment plan

Element 2: BDS school, 3 h
1. Introduction and patient e
   Why are you here? (ir
   What is BDS? Diagnc
   How do you explain I
2. How to manage BDS?
   Illness behavior and illness perceptions
   Homework: Graded exercise, sleep, or diet (patients choose one theme as homework)
   Lunch break (1 hour)
3. How to cooperate with social authorities
   Further treatment options: Module 2

Element 3: Follow-up consultation, 1.5 hours
1. Evaluation of treatment outcome, homework, and further need for treament at the clinic
2. Shared decision making on treatment plan
3. If referred to own GP: Written suggestions for further treatment are send to the GP

ACT

6 x 3 hours

8-10 patients

MBSR

9 x 3 hours

15- 20 pat.

Individual consultation: Treatment response?

General practitioner

Evaluation of the BDS school (n=144)

	***What do you think of the BDS school?***	True %	Partly true %	Not true %	Don't know %
1	I was treated well by the therapists who were responsible for the BDS school	95.1	4.2	-	0.7
2	My opinions and worries were taken seriously	87.5	9.0	-	3.5
3	I feel that the therapists know how they can help me	58.3	36.1	0.7	4.9
4	I learned something new and valuable at the BDS school	52.8	34.0	8.3	4.9
5	I want to work with the things I have learned	82.6	13.2	1.4	2.8

Individual statements about the BDS school

Themes:

- Being taken seriously by the health care system
- New understanding of own illness

”A fantastic experience coming at your department. Seems very professional and completely different than anything else I have experienced on my long journey through different departments (…)”

”I gained an insight into my life that i had not been aware of – or I wasn’t aware that I should look into that direction.”

”I did not at all feel that the website’s description [of BDS sufferers] was identical with what was wrong with me. But when the doctor described it, it made much more sense.”

”Understand your illness and your needs” - A pragmatic approach to the classification of Functional somatic disorders

(while we all wait for the final classification solution…)

DanFunD
DANISH STUDY OF FUNCTIONAL DISORDERS

lifelines

MY PERSONAL CASE FORMULATION **NAME:**_____

”Our study also has important implications for clinical management:

The knowledge about etiological factors that is gained from our review has to be translated into explanatory models for single patients.

For each individual case,

the contribution of biological, psychosocial and healthcare factors has to be weighted, acknowledged, and discussed with the patient.”

CARINA'S CASE FORMULATION

Vulnerabilty

Early life adversity, grown up too early
Difficulties to be in contact with own emotions and desires
Very ambitious, busy life

Triggering event

Recurrent sinusitis

Perpetuates and worsens

Continues her busy life
Boom and bust behaviour
Sleep problems
Health care system (lots of diagnostic work up without a clear result)
Frustration, anxiety

Illness

VIDEO

MY PERSONAL CASE FORMULATION NAME:_____

Vulnerabilty

Triggering event: Concussion

Perpetuates and worsens
Thoughts….
Behaviour….
Carried out by physiotherapists and occupational worker

Illness

Long-term effect of an interdisclipinary early behavioural intervention (*Get going after concussion*, GAIN[1]) on persistent post-concussion symptoms

- **Relative Risk** of having high symptom level at primary endpoint (3 months after treatment):

  0.6 (95% CI 0.4 – 0.9, p=0.008) in favour of GAIN

Scientific symposium 25, Friday 15:30-17:00, Mees Auditorium
Thastum MM et al.
Early intervention for persistent post-concussion symptoms: Results from a randomised trial

Median months after concussion

Thastum MM et al. *under review*

Key principles in the management of Functional Somatic Disorders

Conclusions:

Implications for treatment

At assessment and at the beginning of the treatment:

- Increase motivation and boost expectations for improvement / recovery:
  - make a (non-harmful) diagnosis
  - provide a clear illness model
  - ensure to understand your patient's / client's illness model(s))

Key principles in the management of Functional Somatic Disorders

During treatment:

- Build a strong collaborative (conscious) working alliance (If you are trained within psychodynamic therapy, build a strong unconscious alliance as well)
- Enhance awareness and acceptance of bodily sensations and emotions; Facilitate transition from implicit to explicit emotional processing (Richard Lane)
- Reduce pressure from outside (but do not join your patient's wars)
- Reduce uncertainty, lack of control, symptom catastrophizing
- Reduce fear avoidance beliefs and related behaviours
- Reduce dysfunctional interpersonal responses (helplessness, dependent on others, blame others, etc. - if you are trained, work in the transference relationship)

Web-Ressources

www.functionaldisorders.dk

www.neurosymptoms.org

https://www.awmf.org/leitlinien/detail/ll/051-001.html

www.recoverynorway.org

Thank you for your attention!