

Treating Patients with Common Somatic Disorders

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Outline

1. Introduction

2. Rethinking Behavior Change

3. Personal Health Improvement

4. Profound Change



A Brief History

- Somatization is one of the oldest of all known psychological diagnoses.
- The first reference to this kind of phenomena appears about 1900 B.C. in Egyptian documents (women were affected with perplexing somatic complaints more often than men and concluded that a "floating uterus" was the culprit. It was also commented upon by the Greeks.
- In the 17th century, Thomas Sydenham believed a multifactorial process that included "antecedent sorrows" should be considered for both men and women.
- In its modern form, it was first defined by Briquet in France in 1859 to characterize a syndrome of multiple somatic complaints which he termed hysteria.



Working Definition

The tendency to experience and communicate somatic distress and symptoms; unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them., this tendency becomes manifest in response to psychosocial stress

Z.J. Lipowski (1988)



Who Are “Somatizing” Individuals?

- ❖ **Patients with chronic complaints without organic disease (psychosomatic conditions)**
- ❖ **Chronic disease patients who are coping poorly**
- ❖ **Patients with chronic psychological distress or moods which adversely impact their health**



Disease Model

For each ailment that doctors cure with medications (as I am told they do occasionally succeed in doing), they produce ten others in healthy individuals by inoculating them with that pathogenic agent a thousand times more virulent than all the microbes - the idea that they are ill.

- Marcel Proust (*Le Cote de Guermantes*)



Different Entities in DSM-IV

Conversion Disorder
Pain Disorder
Somatization Disorder (Briquet's Syndrome)
Undifferentiated Somatoform Disorder
Hypochondriasis
Body Dysmorphic Disorder
Somatoform Disorder NOS



Medically Unexplained Symptoms

- Medically unexplained symptoms is a term that is often used now in the literature
- Defined as those physical symptoms having little or no basis in underlying organic disease
- Seen as representing a broader concept, consistent with the presence of concurrent organic and psychiatric illness causing symptoms



Special Populations

❖ **Latin and Mexican American Populations**

Clinical epidemiologists have repeatedly noted that somatization is more often observed in Latin and Mexican American populations

❖ **Immigrant Populations**

Somatic symptoms often create tension between primary care providers and the immigrant patients they treat when providers fail to recognize the patients' understanding of illness as rooted in cultural beliefs, spiritual forces or political conflict. These tensions can become heightened when primary care providers offer somatizing immigrants testing and/or psychosocial interventions without recognizing how these symptoms would be treated in the patient's culture of origin

❖ **Underserved Populations**

Thoughtful health services researchers have noted that somatization will be overdiagnosed in delivery systems that provide care to underserved patients because these systems lack the resources to conduct the necessary testing to differentiate explained and unexplained symptoms

❖ **Abused Populations**

Clinical epidemiologists have noted that the number of physical symptoms a woman reports rises with increasing severity of violence. Even women who had experienced 'low-severity' violence were at higher risk for experiencing physical symptoms. This finding underscores the importance of screening for a history of abuse and violence in women with somatic symptoms.

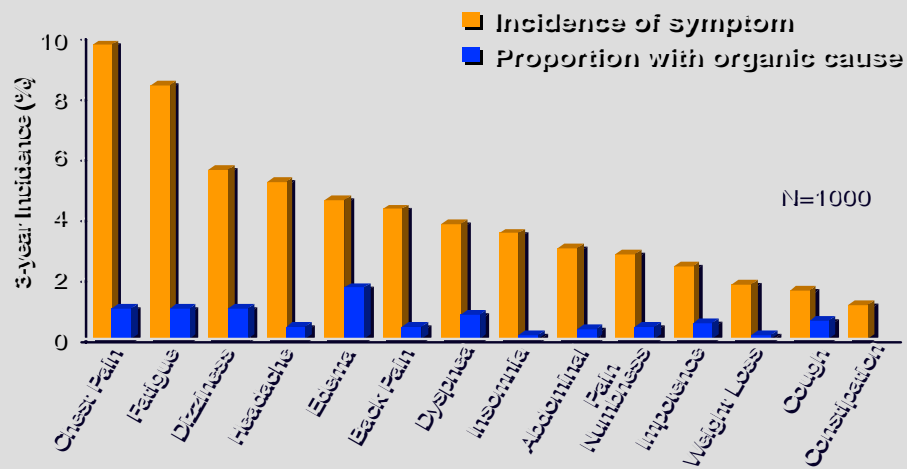
❖ **Managed Care Populations**

Medical historians note that somatizers may seek help more readily as sociocultural currents lower the symptom threshold for seeking help. These somatizing patients may feel forced to express their problems in an increasingly urgent manner to gain access to providers who are receiving greater incentives to reduce utilization. This observation underscores the particular importance of improving somatization detection and management in managed care populations.



14 Most Common Symptoms

The 14 Most Common Symptoms in Adult Medical Outpatients



Kroenke, *Am J Med*, 1989



Significant Disability

- ❖ Examination of 20 years of medical visits to ambulatory care at Kaiser demonstrated that 60% of the visits were by the “worried well” (Cummings, 1981).
- ❖ Up to 50% of patient visits to primary care include a primary or secondary psychosocial complaint (Katon, 1990).
- ❖ High utilization of medical care is associated with symptoms of depression, anxiety and somatic concern (McFarland, 1985).
- ❖ A retrospective review of more than 13,000 psychiatric consultations found that somatization disorder resulted in more disability and unemployment than any other psychiatric illness.



Primary Care vs. Mental Health

- Primary Care Clinicians are well placed to treat somatizing patients but many lack effective management knowledge
- About 50% of these patients refuse referral to mental health services
- 81% of Medically Unexplained Symptom patients were willing to have psychosocial treatment from their primary care physician



Possible Neurobiological Basis

- ❖ Somatization **"is related to inadequate inhibition of incoming sensory information."** That lack of inhibition stems in part from **"a defect in the nervous system that lets too much information through to a person's sense of awareness."**
- ❖ While most patients' nervous systems screen out incidental sensory information, "somatoform patients don't have that ability as well as the average patient."

New Ideas

Behavior Change in Patients



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Profound Change is Difficult

- ❖ Neurobiologists have demonstrated that only 1 out of 9 people will be effective in making a significant health-related change without the assistance of an intervention program that helps to facilitate deep, sustained change.



Cognition and Linguistics

- ❖ Mental structures (also known as paradigms, mental models or frames) are part of our “cognitive unconscious” that shape the way we see the world.
- ❖ The structure of our brain reflects what we know how to do and is reinforced by experience. This makes new learning and change difficult for many adults.
- ❖ These mental structures can be known to us through language which also allows us the means to develop new ones.



Collaborative Management

- ❖ Begins when patients and care providers define problems clearly.
- ❖ Care providers usually define problems in terms of
 - Diagnosis
 - Poor compliance with treatment
 - Continuation of unhealthy behaviors (e.g. smoking or sedentary life-style)
- ❖ Patients are more likely to define problems in terms of
 - Pain symptoms
 - Interference with functioning
 - Emotional distress
 - Difficulty carrying out treatments or lifestyle changes
 - Fears about unpredictable health consequences of illness
- ❖ Patients are more likely to benefit when these two perspectives are harmonized.



Generative Listening

“To listen fully means to pay close attention to what is being said beneath the words. You listen not only to the 'music,' but to the essence of the person speaking. You listen not only for what someone knows, but for what he or she is. Ears operate at the speed of sound, which is far slower than the speed of light the eyes take in. Generative listening is the art of developing deeper silences in yourself, so you can slow our mind's hearing to your ears' natural speed, and hear beneath the words to their meaning.”

-- Peter Senge



New Ideas Regarding Change

Emotional IQ

“Behavior change happens mostly by speaking to people’s feelings.”
- John Kotter

Think Different

“If you want to change, you have to change twice. You not only need to change the reality of your situation. You also need to change your *perception* of this reality.”
- Luc de Brabandere

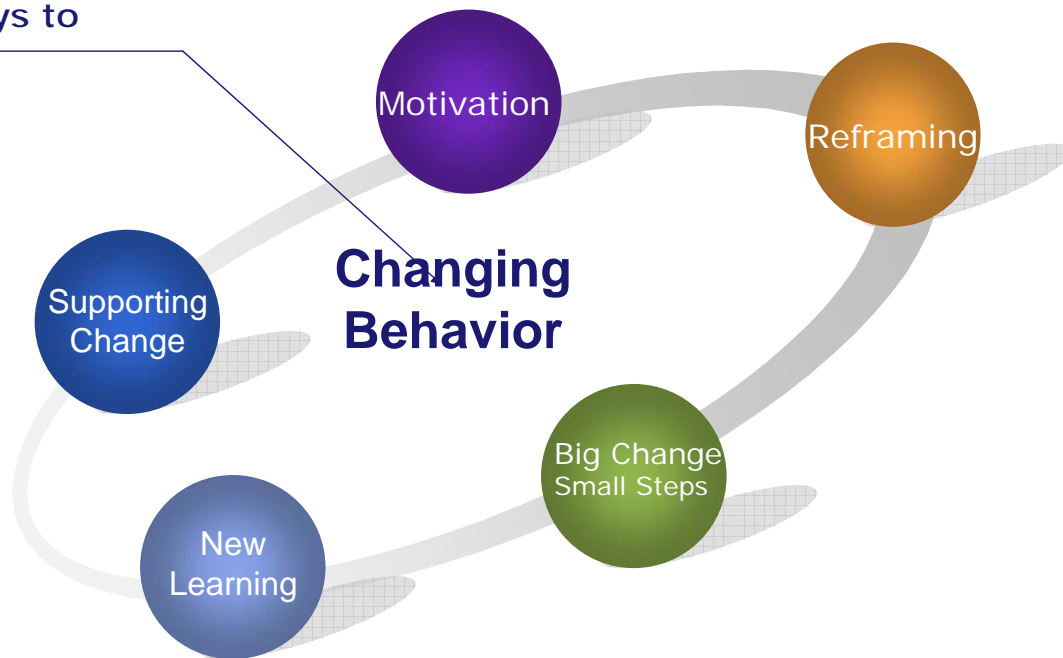
Radical Change

“Radical, sweeping, comprehensive changes are often easier for people than small incremental ones.”
- Dean Ornish, MD



Health Coaching

5 Keys to





Creative Tension

Suffering Gap

Vision: Where you want to be



- Observation
- Action
- Change

Current Reality: Where you are now

The Personal Health Improvement Program

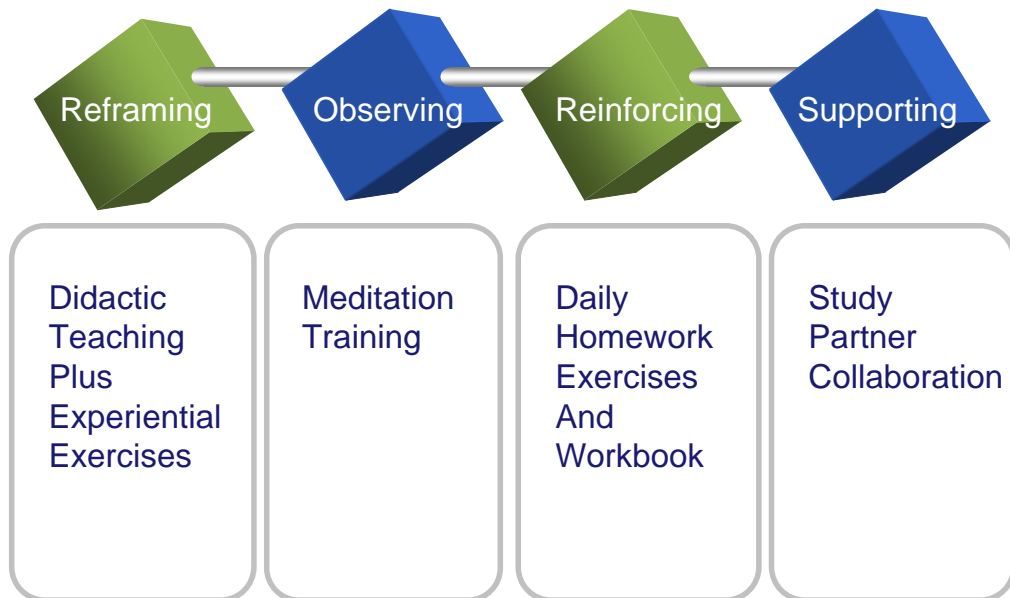
An Innovative Approach



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The Personal Health Improvement Program





A Clinically Effective Program

- ❖ PHIP structures learning in a way that effectively and efficiently facilitates participants to gain critical understanding and behaviors that are more constructive in ways that lead to personal transformation.
- ❖ Effectiveness of PHIP is not restricted by the patient's current medical condition and is effective across the continuum of health.
- ❖ Evidence is strong that PHIP leads to significant improvement in patients' well-being, satisfaction and observed changes in both behavior and personal effectiveness.



Program Features

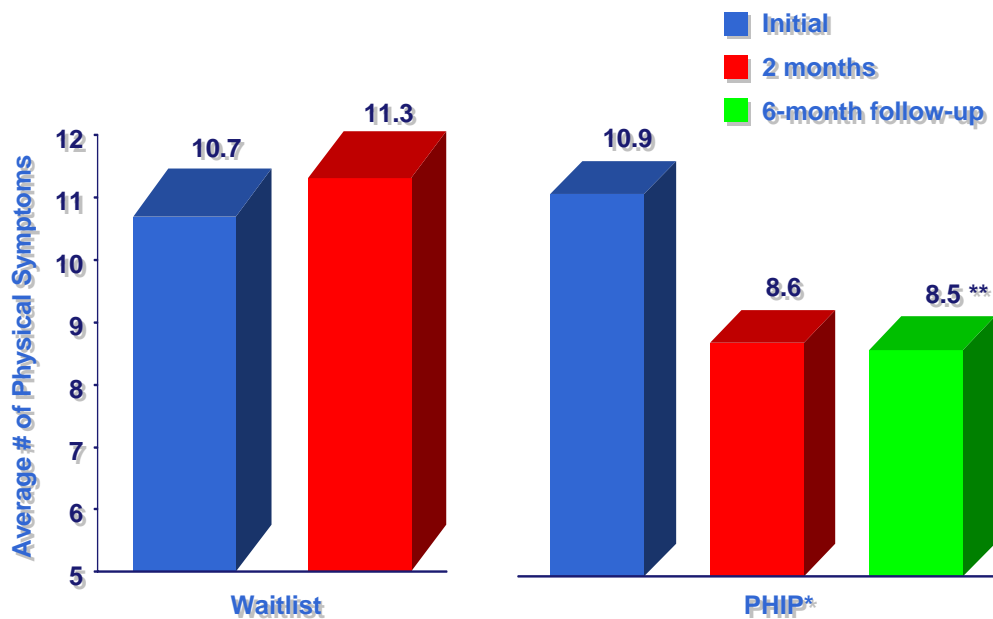
- ❖ Facilitated using a coaching model – focus on building awareness of triggers, moods, and behaviors
- ❖ Invites participants to explore the benefits and costs of their automatic reactions
- ❖ Helps participants focus on what they can control
- ❖ Provides opportunities to practice new actions that produce better results
- ❖ Helps participants look at the world in a less rigid fashion
- ❖ Builds skills to manage negative moods
- ❖ Helps participants get needs met in relationships



The Effectiveness of PHIP has been demonstrated in Seven Outcome Studies

- ❖ Comparison to a stress management class as control (Hellman, 1990)
- ❖ Comparison to waitlist control group (McLeod, 1992)
- ❖ Clinical evaluation in non-medical sites at HPHC (McLeod, 1996)
- ❖ Clinical evaluation outside HPHC (Health Care Partners, 1996; Kaiser Permanente, 1997)
- ❖ Comparison to waitlist control group for patients with irritable bowel syndrome (Glick, McClelland, & Budd, 1997)
- ❖ Clinical outcomes evaluation across seven health care organizations (Locke, et al. Poster presentation at APS annual meeting, Vancouver, 1999)
- ❖ Financial outcomes at NE Managed Care Company (Locke, Ford, McLaughlin, 2003)

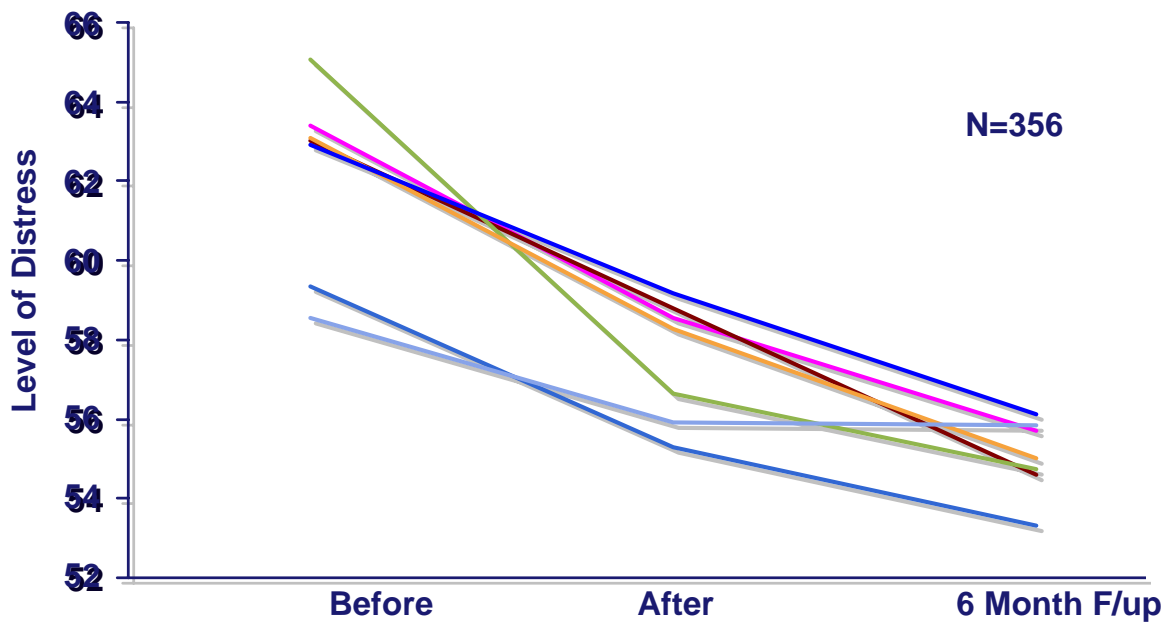
Physical Symptoms PHIP vs. Waitlist Control



N= 82
* Formerly Ways to Wellness
** $p < .01$
(McLeod, 1997)

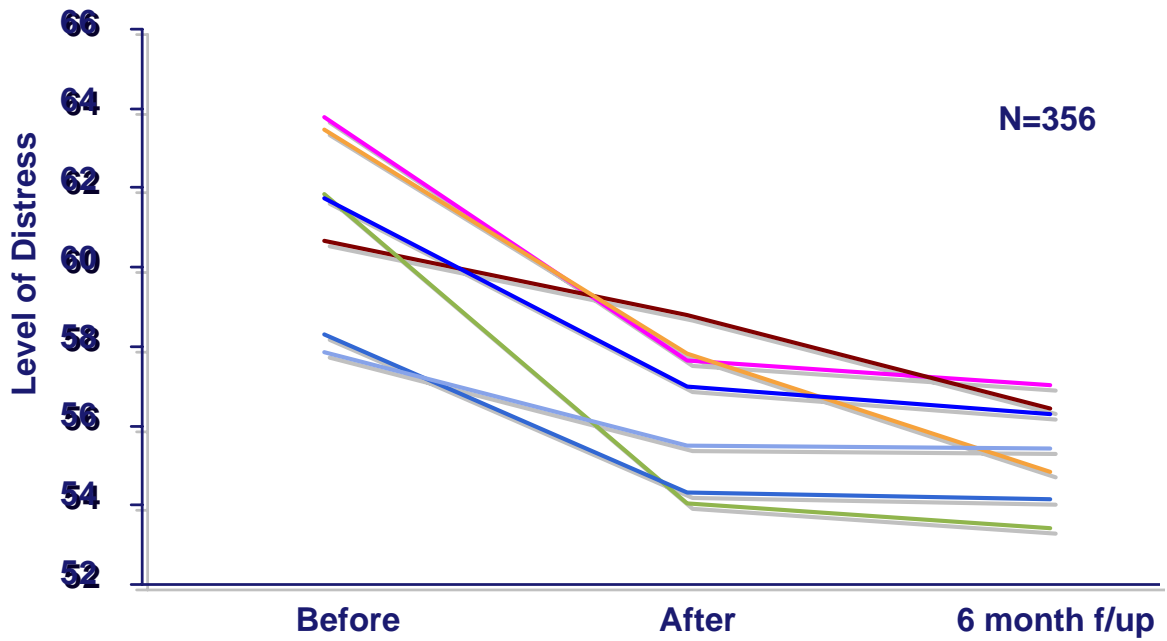
Anxiety

Brief Symptom Inventory (BSI)



Depression

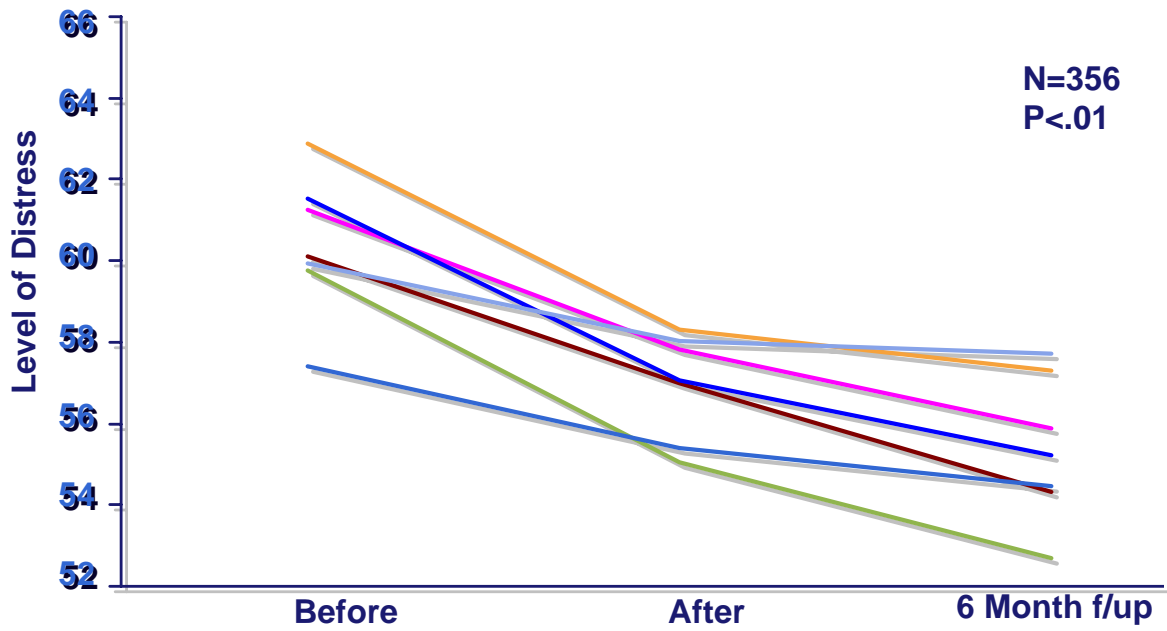
Brief Symptom Inventory (BSI)



Somatization

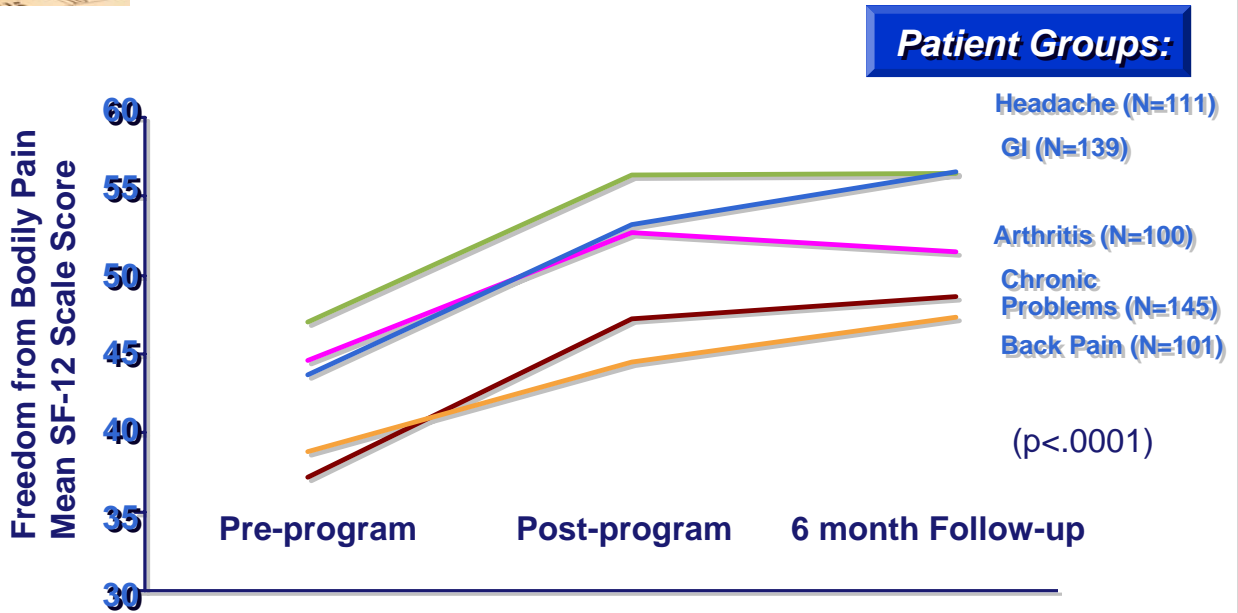


Brief Symptom Inventory (BSI)



N=356
P<.01

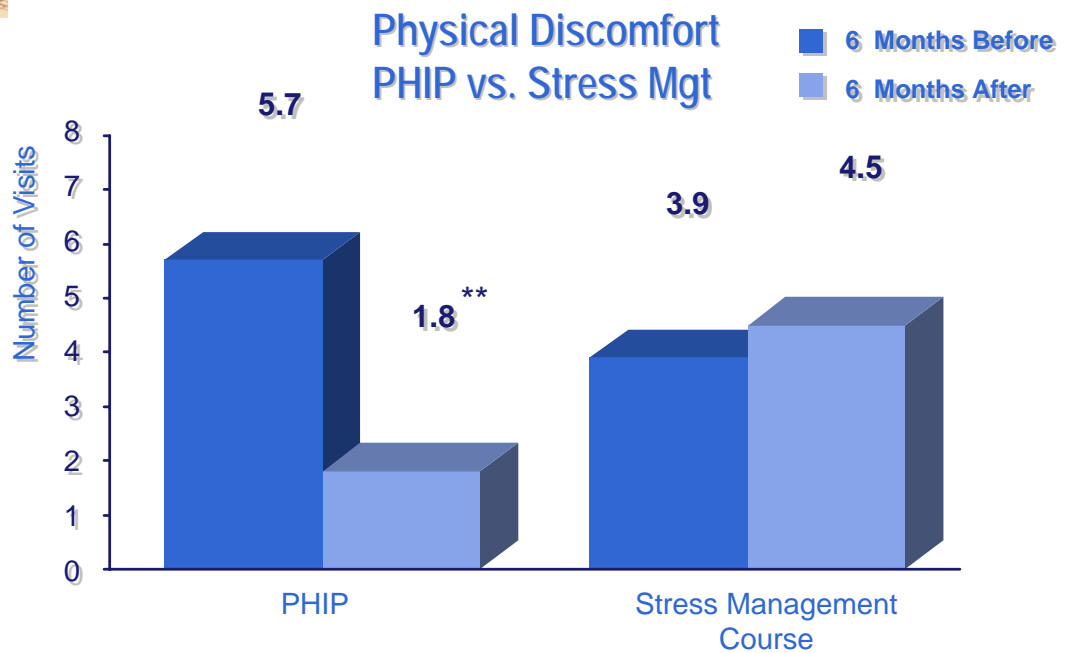
Sustained Improvement in Pain Scores



Source: PHIP Commercial Client Quality Assurance Data

Note: All Comparisons show significant improvement from Pre to Post Program: sustained at 6 months

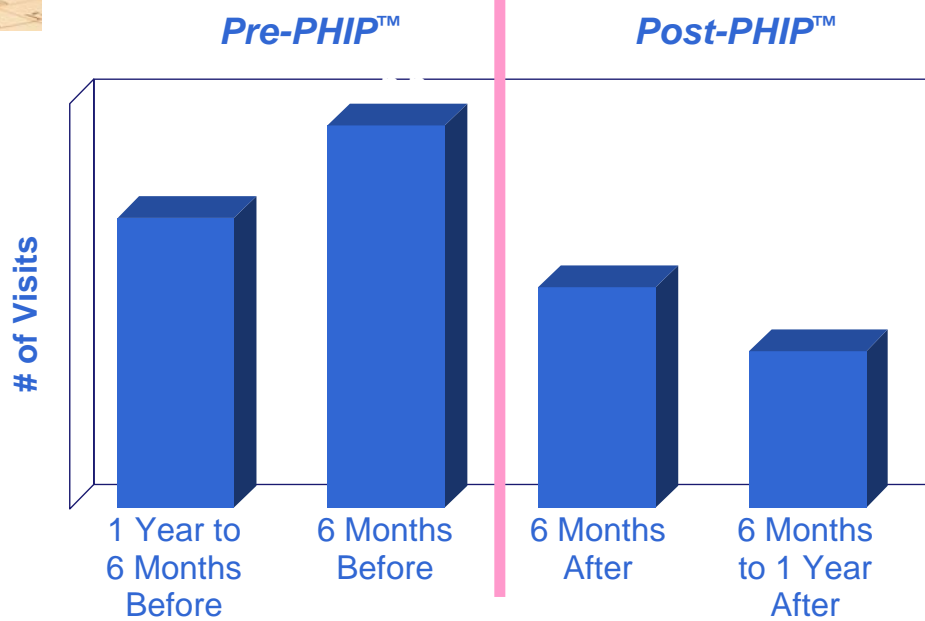
Medical Visits: PHIP vs. Stress Management



N = 46
***p* < .01
(Hellman, 1990)

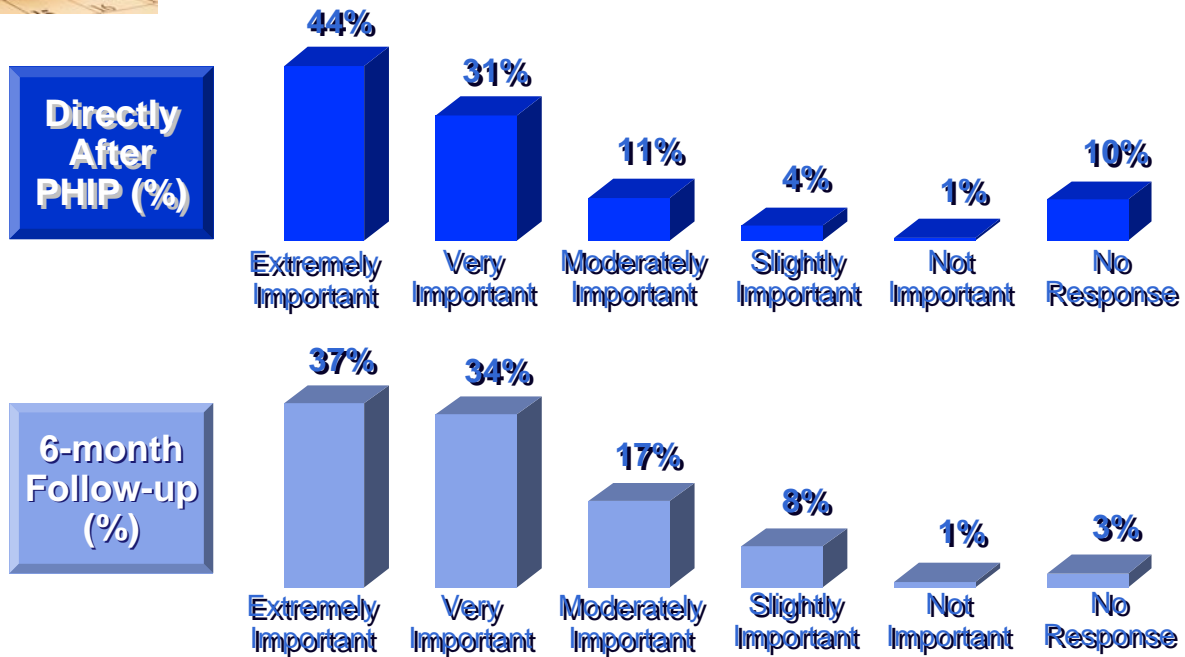


PHIP Outcomes: Sustained Reduction in Medical Visits



Source: McLeod C., Budd M. "HMO Practice," 1997

Patient Assessment Regarding Benefit of PHIP



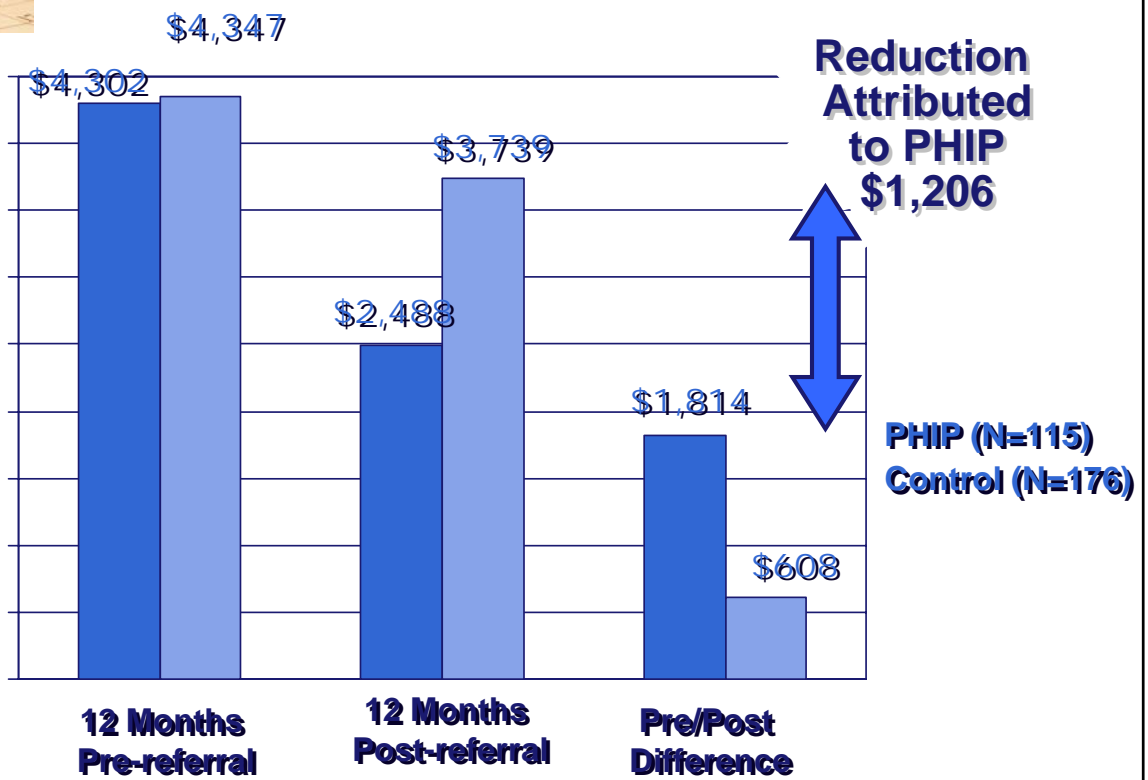


Health Care Utilization

- ❖ Drs. David Bates and Arthur Barsky at Brigham & Women's Hospital in their 2005 study have estimated that **roughly \$256 Billion of preventable utilization nationally** could be realized by effectively intervening in this patient population alone.

PHIP: Impact on Medical Expenditures

Reduction in Estimated Total Changes



Summary

Next Steps



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Ways to Wellness

- ❖ Helping people who are dissatisfied with current reality begins with acknowledging and validating their fears and anxieties and accepting their criticisms as valid.
- ❖ The opportunity to partner with these people is enormous but the journey is fundamentally difficult.
- ❖ There will be many fears that arise starting with fears of change and loss, fears of making mistakes and performing poorly and ultimately fears of the unknown.
- ❖ People need help in seeing that the path to solution lies not in changing the outside world but rather in deep, personal transformation. This profound change is the core challenge that the Personal Health Improvement Program effectively addresses.



New Learning

- ❖ For many adults much of learning is an illusion that involves mastering new rhetoric (e.g. new talk but old walk), grafts innovation onto existing knowledge and systems without working to change core processes and most critically the person's culture norms made up of beliefs, assumptions, habits and paradigms.
- ❖ Many people never effectively learn how to learn but rather memorize and mimic someone else's answers.



Profound Change

- ❖ In today's world ever changing conditions require that both individuals and organizations make profound transformational change on a much more frequent basis.
- ❖ Many adults go many years without ever learning anything new. It's no wonder then that so many of us struggle with the challenge to adapt and are dissatisfied with our lives in ways that impact our day-to-day health and well being.
- ❖ The price of change is also high and as a result we are too often tempted to resign ourselves to the status quo and rarely take on the challenges required to create a new, better reality.



❖ “By holding lightly to an attitude of gentle exploration, we can begin to lean into creative expansion. By replacing ‘No way!’ with ‘Maybe,’ we open the door to mystery and to magic.”

– Julia Cameron, *The Artist’s Way*, p. 95

Questions & Comments



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