

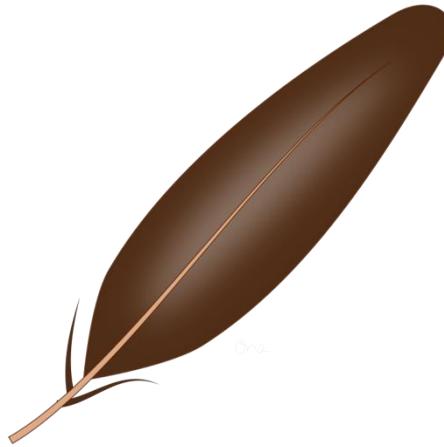
Responding To Patients' Behavioral Health Needs In General Medical Settings: Health-Related Anxiety and Somatic Symptom Disorders

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Disclosure

- The presenter has no financial arrangement related to the content of this continuing education activity.



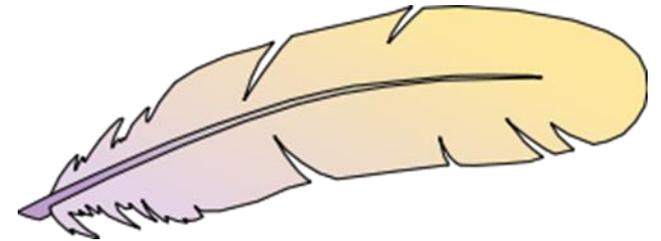
Objectives

At the completion of this activity, participants will be able to:

- List the key features of diagnoses within the new DSM-5 category of Somatic Symptom Disorders
- Apply knowledge of somatic symptom disorders and anxiety disorders to understand patient behavior in general medical settings.
- Apply strategies to assist patients with health-related anxiety and somatic symptom disorders with a plan for self-care or further treatment.

Participant Survey

- What is your work setting?
 - Primary Care
 - Specialty Care
 - Emergency Department or EMS
 - Medical/Surgical hospital
 - ICU
 - Health Promotion
 - Behavioral Health
 - Social Work
 - Other, please specify:



Participant Survey

- What is your current position?
 - Physician or mid-level provider
 - Nursing
 - Medical Support/Medical Assistant
 - Manager/director
 - Administrative Support
 - Community Health Worker or Health Education
 - Behavioral Health Clinician or Social Worker
 - Other, please specify:



Why address behavioral health in general medical settings?

- Nearly 45% of ED patients screened positive for a DSM-IV diagnosis
- 13% of ED patients not presenting with psychiatric complaints screened positive for suicidal ideation.
- Only 41% of people with a mental disorder use mental health services in any given year.
- The median length of delay from symptom onset to seeking behavioral health treatment is 10 years.
- 18% of all general hospital discharges have a BH disorder coded as a secondary condition.
- 18% of cardiac patients met criteria for PTSD 6 months after cardiac surgery.

Why address behavioral health in general medical settings?

- BH conditions significantly affect treatment adherence and health outcomes. For example, depression is associated with:
 - Poor glycemic control in diabetes;
 - Reduced survival for cancer patients;
 - Higher mortality after a heart attack.
- Health care providers and staff have unique potential to encourage patients to:
 - Access appropriate behavioral health care;
 - Engage in self-help and other support strategies

Somatic Symptom and Related Disorders (DSM-5)

- Previous research with DSM-IV Somatoform Disorders found persons with these disorders may represent the most common type of mental disorder within primary care populations, with prevalence findings ranging from 10 – 24%.
- Somatic symptom and related disorders are encountered more commonly in primary care and other medical settings than in psychiatric and other mental health settings.

Somatic Symptom and Related Disorders (DSM-5)

- **Somatic Symptom Disorder**
- **Illness Anxiety Disorder**
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder
- Other Specified Somatic Symptom And Related Disorder
- Unspecified Somatic Symptom And Related Disorder

Somatic Symptom and Related Disorders – Causal and Cultural Factors

- Etiological factors include:
 - Genetic and biological vulnerability (e.g., increased sensitivity to pain);
 - History of traumatic experiences;
 - Social learning history (e.g., attention obtained from illness, lack of reinforcement of non-somatic expressions of distress);
 - Cultural/social norms that devalue and stigmatize psychological suffering as compared with physical suffering.
 - Presence of psychosocial stressors, combined with atypical response to stress.
- Cultural factors affect diagnosis and treatment, including how individuals:
 - Identify and classify bodily sensations
 - Perceive illness;
 - Seek medical care;
 - Are provided medical care.

DSM-5 criteria for Somatic Symptom Disorder

- 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).

Somatic Symptom Disorder

- DSM-5 shifts emphasis to positive symptoms and signs instead of the previous focus on absence of a medical explanation for somatic symptoms.
- Key feature is presence of distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms.
- A distinctive characteristic of individuals with somatic symptom disorder is the way they present and interpret their somatic symptoms in terms of affective, cognitive, and behavioral responses.
- Somatic symptom disorder frequently co-occurs with diagnosed medical disorders.

Somatic Symptom Disorder

- Estimated prevalence is 5-7% in general population.
- May be more common in older adults, but likely to be underdiagnosed.
- Among children:
 - Likely to be a single prominent symptom;
 - Most common are recurrent abdominal pain, headache, fatigue, and nausea
 - More behavioral manifestation, less worry;
 - Parental response may either buffer or exacerbate symptoms.

Somatic Symptom Disorder

- Somatic symptoms without an evident medical explanation are not sufficient to make this diagnosis.
- The individual's suffering is authentic, whether or not it is medically explained.
- The symptoms may or may not be associated with another medical condition.
- The disorder is associated with marked impairment of health status.
- High levels of worry about illness may appear similar to Generalized Anxiety Disorder, but the content of worry is principally focused on somatic concerns.
- Often associated with a high level of medical care utilization.
- Associated with elevated risk for depression and anxiety.

DSM-5 criteria for Illness Anxiety Disorder

- A. Preoccupation with having or acquiring a serious illness.
- B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
- C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
- D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
- E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
- F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Illness Anxiety Disorder

- Differential diagnosis must consider possible underlying medical conditions, including neurological or endocrine conditions, occult malignancies, and other diseases that affect multiple body systems.
- Diagnosed if thorough evaluation fails to identify a serious medical condition that accounts for patient's concerns.
- Individuals with illness anxiety disorder have minimal somatic symptoms and are primarily concerned with the idea they are ill.
- Concern may be derived from a nonpathological physical sign or sensation, but distress emanates not primarily from the physical complaint but rather from anxiety about the meaning, significance, or cause of the complaint.
- Physician's attempts at reassurance and symptom palliation generally do not alleviate the individual's concerns and may heighten them.

Illness Anxiety Disorder

- Because they believe they are medically ill, individuals with illness anxiety disorder are encountered far more frequently in medical than in mental health settings.
- They generally have elevated rates of medical utilization but do not utilize mental health services more than the general population.
- Patient may resist a referral for behavioral health care.
- Approximately one-third to one-half of individuals with illness anxiety disorder have transient symptoms.
- Prevalence estimates range from 1.3 – 10%

Question:

Somatic Symptom Disorder and Illness Anxiety Disorder have in common:

- A. Moderate to severe somatic symptoms are present.
- B. Persistently high level of anxiety about health.
- C. Maladaptive avoidance of healthcare settings.
- D. Co-occurring panic attacks.

Question:

Individuals with Somatic Symptom Disorder are likely to:

- A. Be motivated by opportunities for secondary gain.
- B. Have strong emotional reactions to health-related situations.
- C. Experience suffering and distress due to symptoms.
- D. Both B and C.

Treatment Approaches - Somatic Symptom and Related Disorders

- Because of historical focus on lack of medical explanation, patients regarded these diagnoses as pejorative and demeaning, implying that their symptoms were not “real.” This created an immediate barrier to treatment.
- Treatment begins with the recognition that these conditions involve maladaptive goal-directed behavior that specifically involves symptoms or signs of a medical illness that cause the individual significant distress.
- Thinking functionally and behaviorally helps clarify these conditions as abnormal illness behaviors that create functional impairment.
- Patients with health anxiety may be more willing to accept behavioral health treatment if delivered in a medical setting.

Treatment Approaches – The 5A's

- Assess
- Advise
- Agree
- Assist
- Arrange

Somatic Symptom and Related Disorders: ASSESS

- Differential diagnosis based on thorough medical and psychological evaluations.
- Genuine interest in patient's problems, symptoms, and functional impairments.
- Detailed functional assessment of
 - Physical symptoms
 - Triggers
 - Safety behaviors
 - Fears and maladaptive beliefs
 - Occupational and social functioning
 - Stressors

Somatic Symptom and Related Disorders: ADVISE

- Provide patient with information about treatment options
 - Medication, e.g. fluoxetine
 - Stress management strategies
 - Cognitive coping strategies
 - Exposure therapies

Somatic Symptom and Related Disorders: AGREE

- Ask the patient what they are willing to attempt, what they would like to try first and what seems achievable.
- Work toward a small, early success to build confidence for more challenging interventions.
- Use motivational enhancement, values discrepancy and patient/provider alliance to develop the patient's commitment to changing health-related thoughts, behavior and emotions.

Somatic Symptom and Related Disorders: ASSIST

For the **Patient**:

- Stress coping skills
- Patient education, e.g. autonomic nervous system
- Cognitive intervention:
 - Cognitive disputation
 - Worry control
 - Exposure

Somatic Symptom and Related Disorders: ASSIST

For the **Provider:**

- Shift focus to ongoing care instead of cure.
- Manage health anxiety as a chronic condition, managing symptoms and supporting functional capacity.
- Set a regular schedule for follow up visits and conduct a routine exam at each visit.
- Avoid saying “nothing is wrong” or reassuring that “everything is fine.” Do state when a diagnosis is ruled out, and offer alternative explanations, such as greater than average sensitivity to physical sensations which are real, but not necessarily dangerous.
- Help patient shift from striving for certainty of being disease-free, to managing symptoms and functioning well.
- Avoid diagnostic procedures and aggressive medical or surgical intervention unless clearly indicated.

Somatic Symptom and Related Disorders: ARRANGE

- Establish a schedule for regular patient visits with the primary care provider and behavioral health provider.
- Establish coordination and communication between the two providers, the schedule and focus of visits.
- With patient improvement, decrease frequency of visits.
- If additional mental health needs are identified and patient trust has been established, consider additional treatment goals or referral as needed.

Question:

To care for patients with health anxiety, primary care providers can:

- A. Manage health anxiety as a chronic condition.
- B. Explore all medical options for the patient to become symptom-free.
- C. Establish a regular schedule for follow-up visits.
- D. Both A and C.

Instill hope by adopting a recovery and resilience perspective

- Persons with behavioral health challenges can live full, rewarding lives within their family and community.
- Symptoms may fluctuate in severity or remit entirely.
- Functional abilities can increase even if symptoms are still present.
- Change processes may be nonlinear.
- Change processes gain a positive trajectory when a person develops resilience:
 - Building upon strengths;
 - Creating access to supports;
 - Fostering a holistic approach to health and wellness.

How to assist – more ideas for the PCP

- Listen nonjudgmentally
 - Key **nonverbal skills** to show you are actively listening:
 - Attentiveness
 - Comfortable eye contact
 - Open body posture
 - Being seated
 - Sitting next to the person rather than directly opposite
 - Refocus attention from computer, writing, etc.
 - Focus on understanding symptoms for what they are, e.g.:
 - Safety behaviors
 - Avoidance
 - Defensiveness
 - Empathize with emotions the person is feeling about his or her beliefs and experiences.
 - Take care not to make assumptions; ask first.

How to assist – more ideas for the PCP

- Encourage self-help and other support strategies, for example:
 - Exercise, hobbies, other activities
 - Relaxation and Meditation
 - Support groups
 - Family, friends, faith, and other social networks
 - Community groups and cultural activities

Being Effective

- Consistently support the patient over time
 - Identify a simple action step the patient is likely to successfully complete, and build it into the care plan.
 - Support patient behavior that builds recovery.
 - Support patient behavior that builds resilience.
 - Team communication
 - Appropriate documentation
 - Dealing with staff turnover

Being Effective

- Make effective referrals
 - Prepare ahead
 - Collect and organize info
 - Utilize social services and “local experts”
 - Ask the patient about their interest and comfort level
 - Give encouragement and information
 - Follow up, re-evaluate and try again if necessary
 - Take advantage of available consultation
- Use a team approach
 - Utilize individual strengths
 - Divide tasks such as screening, referrals, resource info
 - Consider capacities of specific disciplines
 - Establish leadership/management support

Get more training -



www.MentalHealthFirstAid.org

A screenshot of the Mental Health First Aid USA website homepage. The page features a navigation bar with links for 'BLACK DOG RIDE', 'TAKE A COURSE', 'BECOME AN INSTRUCTOR', 'ABOUT', and 'NEWS & UPDATES'. A 'FIND A COURSE' button is prominent. The main content area includes a description of the training, a list of topics taught (e.g., signs of addictions, 5-step action plan), and buttons for 'DONATE TO BLACK DOG RIDE' and 'DONATE NOW'. A testimonial is visible at the bottom.

USA
MENTAL HEALTH FIRST AID

BLACK DOG RIDE TAKE A COURSE BECOME AN INSTRUCTOR ABOUT NEWS & UPDATES

WHAT YOU LEARN
COURSE TYPES
ADULT
YOUTH

Sign up for a class near you
FIND A COURSE

responders,
members in

Mental Health First Aid.
DONATE TO BLACK DOG RIDE

Mental Health First Aid is an in-person training that teaches you how to help people developing a mental illness or in a crisis.

Help us train more veterans and first responders in Mental Health First Aid.
[Support Black Dog Ride.](#)

DONATE TO BLACK DOG RIDE

Sign up for a Mental Health First Aid class near you
FIND A COURSE

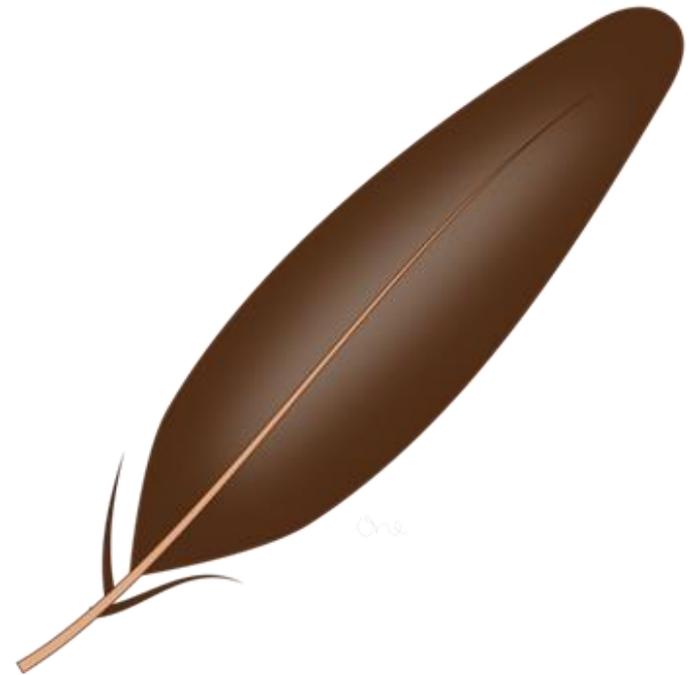
Ready to become a Mental Health First Aid instructor?
[Apply for Instructor Training](#)

DONATE NOW

USA

“ I've taken regular first aid, and I've used both, but certainly the opportunities to use Mental Health First Aid are much more abundant.”

Questions? Comments?



References

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5 (5th ed.). Washington, D.C.: American Psychiatric Association
- Gerstenblith, T.A. & Kontos, N. (2016) Somatic Symptom Disorders. In Stern, T. A., & Massachusetts General Hospital. *Massachusetts General Hospital comprehensive clinical psychiatry* (Second edition.). London: Elsevier.
- Hunter, C.L., Goodie, J.L., Oordt, M.S. and Dobmeyer, A.C. (2009). Integrated Behavioral Health in Primary Care. Washington DC: American Psychological Association.
- Kessler, R.C., Berglund, P.A., Demler, O., Jin R. and Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 62, 593-602.
- Mental Health Association of Maryland, Missouri Department of Mental Health, and National Council for Behavioral Health (2013) Mental Health First Aid USA, Revised First Edition.
- National Council for Behavioral Health and Missouri Department of Mental Health (2015) Mental Health First Aid USA Eight Hour Teaching Notes, Revised.
- Summergrad P. and Kathol, R.G., Eds. (2014). Integrated Care in Psychiatry. New York: Springer.
- Woolfolk, R.L. & Allen, L.A. (2007). Treating Somatization: A Cognitive-Behavioral Approach. New York: Guilford.