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Multiple somatic symptoms in primary care: A field study for ICD-11 PHC, WHO's revised classification of mental disorders in primary care settings

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ABSTRACT

Objective: A World Health Organization (WHO) field study conducted in five countries assessed proposals for Bodily Stress Syndrome (BSS) and Health Anxiety (HA) for the Primary Health Care Version of ICD-11. BSS requires multiple somatic symptoms not caused by known physical pathology and associated with distress or dysfunction. HA involves persistent, intrusive fears of having an illness or intense preoccupation with and misinterpretation of bodily sensations. This study examined how the proposed descriptions for BSS and HA corresponded to what was observed by working primary care physicians (PCPs) in participating countries, and the relationship of BSS and HA to depressive and anxiety disorders and to disability.
Method: PCPs referred patients judged to have BSS or HA, who were then interviewed using a standardized psychiatric interview and a standardized measure of disability.
Results: Of 587 patients with BSS or HA, 70.4% were identified as having both conditions. Participants had an average of 10.9 somatic symptoms. Patients who presented somatic symptoms across multiple body systems were more disabled than patients with symptoms in a single system. Most referred patients (78.9%) had co-occurring diagnoses of depression, anxiety, or both. Anxious depression was the most common co-occurring psychological disorder, associated with the greatest disability.
Conclusion: Study results indicate the importance of assessing for mood and anxiety disorders among patients who present multiple somatic symptoms without identifiable physical pathology. Although highly co-occurring with each other and with mood and anxiety disorders, BSS and HA represent distinct constructs that correspond to important presentations in primary care.

1. Introduction

The World Health Organization (WHO) is currently developing the Eleventh Revision of the International Classification of Diseases (ICD-11). For the previous version of the classification, the ICD-10, WHO produced separate guidelines for the identification and management of mental disorders encountered in primary care settings, the ICD-10 PHC [1]. A WHO Working Group consisting of primary care physicians (PCPs) with a special interest in mental illness and mental health professionals with experience in teaching mental health skills to PCPs has proposed a revised classification of mental disorders for primary health care for ICD-11 (ICD-11 PHC) [2]. The ICD-11 PHC has been amended

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from the corresponding manual for ICD-10 in light of criticisms from experts in both primary care and mental health [2–5], and after considering feedback from focus groups of PCPs in eight countries [6]. This article reports on a cross-sectional descriptive field study conducted in five countries of the Working Group's proposals for disorder categories characterized by: 1) three or more somatic symptoms not considered by the treating PCP to have a medical basis; and 2) excessive and unjustified anxiety about health.

The ICD-10 PHC [1] contained a category called 'medically unexplained somatic complaints', defined by negative physical investigations and frequent visits to the PCP despite these negative findings. The development of the ICD-11 PHC provided an opportunity to re-think this description, drawing in part on research conducted in Denmark by Fink and colleagues [7,8], including a recommendation that three or more symptoms was a useful threshold for primary care populations [9]. Fink and his colleagues proposed a conceptualization of Bodily Distress Syndrome that emphasized the co-occurrence of symptoms falling into cardiopulmonary, musculoskeletal, and gastrointestinal clusters and explicitly linking these symptom clusters to 'functional' syndromes of non-cardiac chest pain, fibromyalgia, and irritable bowel syndrome. This conceptualization was subsequently expanded to include an additional cluster of 'general' symptoms (e.g., concentration difficulties, memory impairment, fatigue) theorized as corresponding to chronic fatigue syndrome [7,9]. Support for the notion that apparently distinct collections of somatic symptoms are united by underlying common features has been provided by a number of empirical studies [10–19].

The Working Group proposed that Bodily Stress Syndrome (BSS) replace the ICD-10 PHC concept of medically unexplained symptoms in the ICD-11 PHC, in part because it was seen as opening a more useful therapeutic dialogue with the patient. For the purpose of the present study, BSS was defined as being characterized by three or more somatic symptoms associated with distress and/or interference with daily functioning and not explained by a known physical pathology. The Working Group also proposed the inclusion of Health Anxiety (HA) in the ICD11-PHC, to replace the ICD-10 PHC category of hypochondriasis. As with BSS, this change was in part based on the greater usefulness of HA than hypochondriasis as a framework for intervention [20]. HA is characterized by either or both of: 1) persistent, intrusive ideas or fears of having illness that cannot be stopped, or can only be stopped with great difficulty; or 2) intense preoccupation with minor bodily sensations or problems that are misinterpreted as signs of serious disease. PCPs have indicated they consider this to be an important clinical presentation [6], but the extent to which HA is a separate phenomenon from BSS in primary care settings is unclear.

The objective of the present study was to examine how the proposed descriptions for BSS and HA corresponded to what was observed by working PCPs in a range of countries, and the relationship of BSS and HA to depressive and anxiety disorders and to disability. An important question addressed by the study was whether the overlap between BSS and HA and depressive and anxiety symptoms suggested that the presentation of multiple somatic complaints in primary care might reflect undetected psychological disorders [2].

Among patients identified as having BSS, the study also examined the occurrence of the symptom clusters emphasized in the Danish studies in order to evaluate whether these would be a useful basis for subclassification of BSS in the ICD-11 PHC.

The study was conducted in primary care centres in Brazil, China, Mexico, Pakistan, and Spain. Although not representative of the entire world, these countries include four large middle-income countries and encompass considerable diversity in language, culture, and resources. Approximately 70% of the world's population live in middle-income countries [21], so it was considered that results in these countries might provide more information about the global applicability of the ICD-11 PHC proposals than previous studies conducted in the U.S. or in single countries in Western Europe.

2. Method

The study sample included 587 patients from five countries being seen in routine primary care practice and identified by their PCPs as meeting the proposed ICD-11 PHC diagnostic requirements for BSS, HA, or both. Because the assignment of both diagnoses involves the consideration of other relevant medical information (e.g., physical pathology that may be contributing to symptoms) and sometimes requires knowledge of patients over time, it was considered that PCPs were in the best position to identify the patients of interest for this study.

Participating centres were located in Brazil (Rio de Janeiro and São Paulo), China (Hong Kong), Mexico (Zapopan), Pakistan (Rawalpindi), and Spain (Oviedo). Primary care centres included in the study were selected due to their interest and the availability of local resources and infrastructure to support their participation.

PCPs at participating centres who agreed to participate in the study were provided a single half-day training session using slides prepared by WHO, and allowing questions and discussion. Each participating PCP was asked to refer about 10 patients who they believed met the diagnostic requirements of BSS and/or HA based on the training session to the study. For patients who agreed to participate in the study, PCPs completed an Encounter Form for each patient referred, containing detailed information about the number and type of somatic symptoms currently experienced, including a list of 29 somatic symptoms based on the symptoms used in the Danish studies [7,9]. In assessing whether symptoms had a medical basis, participating PCPs were reminded to consider a range of diseases characterized by multiple somatic symptoms, such as multiple sclerosis, hyperparathyroidism, acute intermittent porphyria, myasthenia gravis, AIDS, systemic lupus erythematosus, Lyme disease, and connective tissues disease, in the differential diagnosis. The Encounter Form also included information about all other proposed diagnostic requirements of both BSS and HA, including distress and disability.

Patients who agreed to participate then underwent a structured diagnostic interview, the revised Clinical Interview Schedule (CIS-R) [22], administered by a Research Assistant. Research Assistants also administered the 12-item version of the WHO Disability Assessment Schedule, Version 2.0 (WHODAS 2.0) [23]. For patients who did not agree to participate, very general demographic information (age group and gender) and reason for refusal were recorded.

The CIS-R used the full diagnostic requirements in order to assign diagnoses of common mental disorders. These were modified according to the proposals for ICD-11 PHC. The primary modifications were a reduction of the duration requirement for current anxiety to 2 weeks rather than several months, in line with the duration requirements for depression, and the inclusion of a separate category of anxious depression, in which the requirements for both depression and current anxiety are met.

The version of the Bodily Stress Syndrome diagnosis used in this study was adapted for use in primary care settings from the proposed diagnosis of Bodily Distress Disorder proposed for the main ICD-11 [24] by creating a specific cutoff of at least three symptoms not explained by no known medical pathology that were associated with distress or impairment and eliminating the requirement that the PCP make a judgment about whether the attention devoted to the symptoms is 'excessive'. Patients with fewer than three symptoms are very common in primary care setting. Our focus group study [6] had indicated that PCPs preferred a specific symptom cutoff point and were reluctant to make a judgment about the subjective degree of attention paid by the patient to the symptoms.

All procedures used in this study were approved by the WHO Research Ethics Review Committee and by the appropriate local institutional review bodies. Data for the study were collected between October 2013 and March 2015. The protocol for the study can be found on the Psychiatry Research Trust website (http://www.psychiatryresearchtrust.co.uk/protocols/worldhealth.pdf).