

SOMATOFORM DISORDERS

*** a diagnosis of exclusion ***

DEFINITION/THEORY:

- Disorders characterized by physical symptoms/physical disability that is not adequately explained by, or is out of proportion to, results of exam/tests. The etiology is considered to be that the person's psychological problems are manifesting as physical/medical complaints.

WARNING!!!

- Remember that people with psychiatric illnesses get medically ill as often (and in many cases *more* often) than the general population. However, despite our best intentions, it is easy to fall into the trap of assuming any complaint is a 'somatic complaint' if the patient's chart indicates a hx of somatoform disorder. Falling into that trap could lead to severe morbidity or mortality for your patient. Therefore, think long and hard before committing yourself to putting this dx in black and white in the chart. (FYI -- AAFP urges to be more assertive regarding the diagnosis).

SOMATOFORM DISORDERS:

Common Features:

- *Symptoms NOT intentionally produced or feigned (vs factitious or malingering)*
- *Symptoms NOT secondary to known medical condition or substance abuse*
- *Results in significant distress or impaired functioning*
- *Co-existing disorders: 60% depression / 50% anxiety disorder / 60% personality disorder*
- **Pain Disorder:** 10-15% (adults)
 - Often a history of real injury or illness
 - Often some physical/test findings that do explain *some* dysfunction or pain, but not to the level that the patient is describing/demonstrating (which per DSM is of 'significant severity' and associated with psychological factors)
- **Hypochondriasis:** 4% (general medicine patients)
 - Preoccupied with having a serious disease
 - Normal bodily functions or real symptoms are misinterpreted/catastrophized into being the sign of serious illness.
 - Even tests with normal results gives no lasting satisfaction for the patient, and the preoccupation persists
 - Not limited to just concern about appearance (vs body dysmorphic d/o)
 - ≥ 6 months duration minimum
 - Male = Female, often occurs later in life compared to somatization d/o, but still in young adulthood
 - Degree of insight important for prognosis
- **Conversion Disorder:** 0.01-0.3% (adults)
 - Pseudoneurologic syndrome -- deficits or symptoms of voluntary or sensory function (ie, non-epileptiform 'seizure' events, paralysis, blindness, etc)
 - Caution! Up to 10% of non-epileptiform patients also have epileptiform events!
 - Often of dramatic onset
 - Symptom initiation or exacerbation preceded by stressors
 - Symptom(s) not limited to pain or sexual dysfunction (often focuses on 1 symptom)
 - Often young, naïve, uneducated women – 'la belle indifference'
 - Often responsive to persuasion or suggestion
- **Body Dysmorphic Disorder:**
 - Preoccupation with imagined or exaggerated physical defects
 - Michael Jackson's nose

- (eating disorders get their own separate category in DSM)
- **Somatization Disorder:** 0.2% (adults)
 - Complaints begin < 30 years old, last for years, impair function
 - 4 pain symptoms in 4 different sites
 - 2 GI symptoms other than pain
 - 1 sexual symptom other than pain
 - 1 pseudoneurologic symptom
 - female:male 10:1
 - RARE (<1% of unexplained symptoms are actually somatoform d/o)!
- **Undifferentiated Somatoform Disorder:**
 - ≥1 physical complaint(s)
 - ≥ 6 months duration minimum
 - > 3 vague/exaggerated symptoms over a chronic course
- **Somatoform Disorder NOS**
 - Somatoform symptoms present, but not meeting criteria of any of the above
 - Examples, hypochondriases < 6 months, pseudocyesis (false belief of being pregnant associated with objective signs of pregnancy)

DIFFERENTIAL DIAGNOSIS = THINGS TO RULE OUT BEFORE LABELING WITH ANY OF THE ABOVE...

- Undiagnosed Medical Illness:
 - Zebras!!! Finally all that studying for Boards can pay off!
 - SLE, HIV, MS... (varied symptom presentation)
- Psychotic Disorder:
 - presentation is bizarre (this makes a big difference because Tx is very different)
- Psychological Factors Affecting Medical Illness:
 - Real medical illness, with measurable differences in severity if psychiatric symptoms also present
 - Tremor, IBS, IBD, PUD/GI acidity, etc.
- Factitious:
 - primary gain (ie, seeking the 'sick role') – patient is aware of their volitional role
 - intentional feigning or production of symptoms
 - Subtypes: *signs and symptoms predominantly psychological/physical/combined psychological and physical*
 - often present with poor wound healing, excoriations, infection, bleeding, GI ailment
 - patient often has some medical knowledge
 - Most severe: Munchausen or Munchausen by proxy
- Malingering:
 - secondary gain (ie, using the 'sick role' to obtain: money, disability claim, excuse from work, legal claim/prosecution (Ganser's Syndrome), obtaining Rx for illicit purposes, etc) – patient is aware of their volitional role
 - intentional feigning or production of symptoms (physical or psychological)
 - more common in men and healthcare workers
 - Red Flags - especially in combination (*but not pathopneumonic!*): medico-legal context, discrepancy b/w claimed problems and objective findings, lack of cooperation with eval or tx compliance, antisocial p.d., substance abuse (risk factor)

RISK FACTORS

- female
- previous injury or illness in self
- previous injury or illness in family
- some other significant exposure to illness or injury
- family hx of somatoform disorder
- hx of trauma/abuse
- alexithymia

GOALS FOR TREATMENT

- Reduce number of tests and procedures (especially invasive!)
 - in turn, this reduces the potential for false positives, unnecessary physical risk to the patient, and unnecessary cost to the patient and healthcare system
- Reduce number of visits and calls
 - healthcare resources are limited, so excessive demands can negatively impact many people, and unnecessary cost to the patient and healthcare system
- If the above is accomplished in the appropriate way, it is a potential indicator that the patient is doing better

TREATMENT

- Scheduled, Brief, Frequent PCP Office Visits:
 - First step is to meet them where they are. Initial frequency should be equal to the frequency the patient has been seeking unscheduled care. Can therefore follow any symptoms closely, ensure no life-threatening condition is developing, and the patient will not feel the need to escalate the complaints in order to be seen.
 - Treat like other patients in terms of taking history, doing physical exam, give usual standard of care health screenings → only if + findings, then proceed with tests based on those positive H&P findings. Otherwise you risk running into unnecessary false positive test results.
- Titration and Tapering:
 - Can first focus on reducing and discontinuing emergency visits and unscheduled phone calls (goal is for patient to get needs met at scheduled visits). Use patient's lead to guide pace of taper on scheduled visits.
- CBT (Group or Individual):
 - Stress mgmt, problem-solving, social skills training, targeting amplification and 'need-to-be-sick' features of somatization
- Psychiatric Evaluation
 - Rule out co-morbid conditions, and if present, treat as indicated
- Additionally:
 - Psychoeducation, light physical activity/exercise (goal 20 minutes three times/week), scheduled individual 'relaxation/pleasure time'
- Collaboration:
 - Can often be a battle b/w psychiatric provider and PCP in terms of who does what first and who takes primary responsibility of patient care. Both must work collaboratively with each other and the patient on what *IS* found.