



Definition/Theory

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

WARNING!

- People with psychiatric illnesses get medically ill as often (and in many cases *more* often) than the general population
- Despite our best intentions, easy to assume any complaint is a 'somatic complaint' if the patient's chart indicates a hx of somatoform disorder
- Mis-dx can lead to severe morbidity or mortality for your patient
- 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

- 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

Somatoform Disorders

- Pain Disorder (10-15%)
- Hypochondriasis (4%)
- Conversion Disorder (0.01-0.03%)
- Body Dysmorphic Disorder
- Somatization Disorder (0.02%)
- Undifferentiated Somatoform Disorder
- Somatoform Disorder NOS

Pain Disorder

- Often a history of real injury or illness
- Often some physical/test findings that do explain *some* dysfunction or pain
- But evidence out of proportion to the level that the patient is describing/demonstrating *

* per DSM is of 'significant severity' and associated with psychological factors

Hypochondriasis

- Preoccupied with having a serious disease
- Normal bodily functions/real symptoms are misinterpreted and catastrophized into being the sign of serious illness.
- Tests with normal results gives no lasting satisfaction for the patient
- Not limited to just concern about appearance (vs. body dysmorphic disorder)
- ≥ 6 months duration minimum
- Male = Female, tends to start in young adulthood, but not as early compared to somatization d/o
- degree of insight important for prognosis

Conversion Disorder

- Pseudoneurologic syndrome:
 - deficits/symptoms of voluntary motor or sensory function
 - e.g., non-epileptiform 'seizure' events, paralysis, blindness, etc.
 - *Caution! Many can have both epileptiform and non-epileptiform events!*
- Often dramatic onset
- Often preceded by stressors
- Symptom(s) not limited to pain or sexual dysfunction (but can often focus on 1 symptom)
- Often young, naïve, uneducated women - 'la belle indifférence'
- Often responsive to persuasion or suggestion

Body Dysmorphic Disorder

- Preoccupation with imagined or exaggerated physical defects
- Michael Jackson's nose - case in point
- (eating disorders get their own separate category in DSM)

Somatization Disorder

- 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 disorder!

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, hypochondriasis < 6 months, pseudocyesis (false belief of being pregnant associated with objective signs of pregnancy)

Differential Diagnosis

Things to rule out!

Differential Diagnosis

- ❑ Undiagnosed Medical Illness
- ❑ Psychotic Disorder
- ❑ Psychological Factors Affecting Medical Illness
- ❑ Factitious
- ❑ Malingering

Differential Diagnosis

- ❑ **Undiagnosed Medical Illness:**
 - ❑ Zebras!!! Finally all that studying for Boards can pay off!
 - ❑ SLE, HIV, MS... (varied symptom presentation)
- ❑ Psychotic Disorder
- ❑ Psychological Factors Affecting Medical Illness
- ❑ Factitious
- ❑ Malingering

Differential Diagnosis

- ❑ Undiagnosed Medical Illness
- ❑ **Psychotic Disorder:**
 - ❑ presentation is bizarre (this makes a big difference because Tx is very different)
- ❑ Psychological Factors Affecting Medical Illness
- ❑ Factitious
- ❑ Malingering

Differential Diagnosis

- ❑ Undiagnosed Medical Illness
- ❑ Psychotic Disorder
- ❑ **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
- ❑ Malingering

Differential Diagnosis

- ❑ Undiagnosed Medical Illness
- ❑ Psychotic Disorder
- ❑ Psychological Factors Affecting Medical Illness
- ❑ **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

Differential Diagnosis

- Undiagnosed Medical Illness
- Psychotic Disorder
- Psychological Factors Affecting Medical Illness
- Factitious
- **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)
 - Intentional, aware feigning or production of symptoms (physical or psychological)
 - more common in men and healthcare workers
 - Red Flags - especially in combination (*but not pathognomonic!*): 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!)
 - reduces the potential for false positives, unnecessary physical risk to the patient, and unnecessary cost to the patient and healthcare system
- Reduce number of unnecessary visits and calls
 - healthcare resources are limited
 - excessive demands can negatively impact 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
- Titration and Tapering
- CBT
- Psychiatric Evaluation
- Additional Features of Treatment Plan
- Collaboration

Treatment

- Scheduled, brief, frequent PCP office visits:
 - Meet them where they are. Initial frequency = frequency the patient has been seeking unscheduled care
 - follow any symptoms closely, ensure no life-threatening condition is developing → patient will feel less need to escalate the complaints in order to be seen.
 - Standard of care: history, physical exam, usual health screenings → IF + findings, proceed with tests based on those.
- Titration and Tapering
- CBT
- Psychiatric Evaluation
- Additional Features of Treatment Plan
- Collaboration

Treatment

- Scheduled, brief, frequent PCP office visits
- **Titration and Tapering:**
 - Reducing and discontinuing emergency visits and unscheduled phone calls
 - Goal for patient to get needs met at scheduled visits
 - Use patient's lead to guide pace of taper on scheduled visits
- CBT
- Psychiatric Evaluation
- Additional Features of Treatment Plan
- Collaboration

Treatment

- ☐ Scheduled, brief, frequent PCP office visits
- ☐ Titration and Tapering
- ☐ **CBT:**
 - ☐ **Stress management, problem-solving, social skills training, targeting amplification and 'need-to-be-sick' features of somatization**
- ☐ Psychiatric Evaluation
- ☐ Additional Features of Treatment Plan
- ☐ Collaboration

Treatment

- ☐ Scheduled, brief, frequent PCP office visits
- ☐ Titration and Tapering
- ☐ CBT
- ☐ **Psychiatric Evaluation:**
 - ☐ **Rule out co-morbid conditions, and if present, treat as indicated**
- ☐ Additional Features of Treatment Plan
- ☐ Collaboration

Treatment

- ☐ Scheduled, brief, frequent PCP office visits
- ☐ Titration and Tapering
- ☐ CBT
- ☐ Psychiatric Evaluation
- ☐ **Additional Features of Treatment Plan:**
 - ☐ **Psychoeducation, light exercise, relaxation, scheduled pleasurable activity**
- ☐ Collaboration

Treatment

- ☐ Scheduled, brief, frequent PCP office visits
- ☐ Titration and Tapering
- ☐ CBT
- ☐ Psychiatric Evaluation
- ☐ Additional Features of Treatment Plan
- ☐ **Collaboration:**
 - ☐ **Avoid battle b/w psychiatric provider, PCP, and subspecialists**
 - ☐ **work collaboratively with each other and the patient on what *IS* found, not on who needs to rule out x, y, and z first...**