Somatoform Disorders
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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
- Misdx 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
- 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

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

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 give 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, naive, 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 - 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!

- 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
- Malingering: patient often has some medical knowledge
- Most severe: Munchausen or Munchausen by proxy
Differential Diagnosis
- Undiagnosed Medical Illness
- Psychotic Disorder
- Psychological Factors Affecting Medical Illness
- Factitious
  - Malingering: secondary gain (e.g., obtaining 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

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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
- 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
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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

Additional Features of Treatment Plan:
- Psychoeducation, light exercise, relaxation, scheduled pleasurable activity
- Collaboration

Collaboration:
- Avoid battle b/w psychiatric provider, PCP, and subspecialties
- Work collaboratively with each other and the patient on what IS found, not on who needs to rule out x, y, and z first...