Somatic Symptom and Related Disorders: A Primer for Primary Care Providers

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What Exactly Are Somatic Symptom Disorders?

A group of disorders in which the primary symptoms are “distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms”

DSM 5, APA Press 2013, p 309
MUPS: Medically Unexplained Physical Symptoms

- Broader Term that encompasses Somatoform disorders
- Defined as “complaints of physical symptoms or signs for which there is no adequate objective pathophysiologic evidence to explain the distress”\(^1\)
- Secondary MUPS: Patients with primary psychiatric disorder experienced as a physical symptom (e.g., Major Depression and Vegetative Symptoms)

\(^1\) Neimark, G, Caroff S. et al. Psychiatric Annals, April 2005
\(^2\) Issac ML, Paauw, DS Medically Unexplained Symptoms Med Clin N Am 98(2014) 663-72
Is there only one syndrome?

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Syndrome</th>
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</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>Irritable Bowel</td>
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<tr>
<td>Gynecology</td>
<td>Chronic Pelvic Pain</td>
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<tr>
<td>Rheumatology</td>
<td>Fibromyalgia</td>
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<tr>
<td>Cardiology</td>
<td>Non-Cardiac Chest Pain</td>
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<tr>
<td>Neurology</td>
<td>Non-Epileptic Seizures</td>
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<tr>
<td>Pulmonology</td>
<td>Respiratory Hyperventilation Syndrome</td>
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<tr>
<td>Infectious Disease</td>
<td>Chronic Fatigue Syndrome</td>
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How Common?

- Difficult to measure; heterogeneous group of disorders; PCPs have different levels of receptivity
- Meta-analysis (7) cohorts: Prevalence Rates
  - 11-21% in younger adults
  - 10-20% in middle aged
  - 1.5 -13% in older age
- MUS show wider ranges – but still lower after age 65

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1 Hilderink, PH, Collard R et al “Prevalence of Somatoform Disorders and Medically Unexplained Symptoms in Old Age Populations in Comparison with Younger Age Groups: A Systematic Review” Ageing Research Reviews 12 (2013) 151-6
"Ten of the most common problems with which adult patients present in primary care (chest pain, fatigue, dizziness, headache, swelling, back pain, shortness of breath, insomnia, abdominal pain, and numbness) account for 40% of all visits, but primary care doctors can identify a biological cause for the concern in only 26% of these patients"
Conscious versus Unconscious

- Factitious Disorder ("Munchausen")
- Malingering
- Somatic Symptom Disorders
Somatic Symptom Disorders: “Unconscious”

- Conversion Disorder (Functional Neurologic Symptom Disorder)
- Somatic Symptom Disorder
- Illness Anxiety Disorder (formerly Hypochondriasis)
- Psychological Factors Affecting Other Medical Conditions
- Body Dysmorphic Disorder (Now included in Obsessive Compulsive and Related Disorders)
- Pain Disorders (excluded from DSM 5 – Folded into Somatic Symptom Disorders)
Why would anyone want to be sick?
Sorry I spent all day Googling how to kill my boss and get away with it.
The concept of these three was as a direct result of Sigmund Freud’s psychoanalytical theory.
Key Concept #1: The sick role is the solution
Key Concept #2:

It’s always a flawed solution
Factors that influence illness behavior:

- Genuine organic pathology
- Modulation of symptoms by co-morbid depression or anxiety
- Process of perception and symptoms interpretation
- Reactions of others (family, friends, etc)
- Iatrogenic processes
- Insurance, compensation, and disability systems

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Conversion Disorder

- Neurologic Deficit - Sensory or Motor
- Acute Onset in Response to Stressor
- Psychologically Unsophisticated
- Generally Dramatic (Pseudoseizures)
- Can Co-exist with True Morbidity
- Poor Prognosis if not Resolved Quickly
33 yo SWF med evac’ed to London with abdominal pain, fainting spells, and urinary incontinence

Multiple specialty examinations WNL

Acute onset of various symptoms involving various organ systems

History of previous sexual assault: never reported

Work involves working with law enforcement in a developing country with poor vetting process for police officials
Key Clinical Signs

- Pseudo neurological symptoms (pain, LOC, incontinence)
- Young age
- History of unresolved traumas; new triggers?
- Resistant to mental health referral
- Striking lack of affect: “La belle indifférence”
- Early life modeling of illness behavior
Psychogenic Seizures

- One of the only psychogenic syndromes that can actually be proven/disproven (split screen EEG)
- **Myth:** Many (30-60%) of patients with pseudoseizures also have epilepsy
- **Reality:** only 9-13% do
- Significant correlation of childhood trauma (all domains)

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1. Adapted from Benbadis SR “Psychogenic Seizures and Psychogenic Symptoms” Presented at “USF, 5th Annual Conference: Keys to Neuropsychiatric Care” 2007
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Somatic Symptom Disorder

- One or more somatic symptoms that are distressing or result in significant disruption of daily life
- Excessive thoughts, feelings, or behaviors related to the symptoms
  - Disproportionate and persistent thoughts
  - Persistent high level of anxiety about health problems
  - Excessive time and energy devoted to these concerns
- Persistence (typically greater than 6 months)
- Specify:
  - Predominant Pain (previously pain disorder)
  - Persistent
  - Mild, Moderate, Severe
Clinical Case Correlate

- 42 year old WF EFM self refers to HU with multiple complaints over a several month period. Reports from community regarding problem relationships between her and others at post/children’s school.

- Patient defers all blame for problems on others (difficult co-residents, unfair teachers, exploitive friends etc.)

- HU nurse gradually alarmed at time and resources related to multiple medical appointments.

- Over time complaints increase in significance: malaria, toxic shock syndrome, persistent diarrhea. Requests frequent specialist appointments in community: cardiology, infectious disease etc.
Multiple psychosocial stressors

History of serious problems that are difficult to identify but impossible to ignore

Once medications prescribed or diagnoses given; other physicians (especially psychiatrists) are unwilling to overrule specialists

Treatment team feels helpless; unable to deny care on medico-legal grounds. Energy, time, and money taken away from other patients
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Illness Anxiety Disorder

- Pre-occupation with having or acquiring a serious illness
- **Somatic symptoms are absent or mild**
- Chief component is anxiety about health
- Variable course - 65% develop a chronic, fluctuating course
- Generally later age of onset than Somatoform
- Misinterpretation of bodily symptoms - “Does this mean I have cancer?”

Starcevic V. “Hypochondriasis and Health Anxiety” Conceptual Challenges” BJ Psych 202 (1) 7-8, 2013
Clinical Case Correlate

- 40 yo MWM s/p CABG 12 years earlier
- No prev MH treatment – but taking SSRI
- Routinely monitors breathing and when he notes any change becomes concerned that he may be having a stroke or brain hemorrhage
- Over time health concerns generalized: any unexpected body sensation (esp in upper body) would lead to anxiety and seeking medical care
- Describes chronic anxiety and worry from “the moment he awakes”; refuses to travel abroad because he does not trust care outside the UK

Surawy, C McManus F “Mindfulness-Based Cognitive Therapy (MBCT) for Health Anxiety (Hypochondriasis): Rationale, Implementation, and Case Illustration” Mindfulness 6(2) 382-92, 2015
Key Clinical Signs

- Disabling anxiety/fear prominent
- Can be associated with previous illness or trauma
- Reassurance generally not helpful; even negative radiological and laboratory studies explained to patient have minimal impact
- Best approach is often supportive listening by primary care physician; frequently “concerns about physical symptoms become a major way of interacting”¹

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Psychological Factors Affecting Other Medical Conditions

- There is a medical condition present
- Co-morbid psychological or behavioral factors adversely impact the medical condition and lead to increased risk of suffering, death, or disability
- Should be a clear connection between the mental health issue and the increase in morbidity of the medical problem
- Typical examples:
  - Anxiety exacerbating asthma
  - Denial of need for treatment of acute chest pain (really any condition!)
  - Diabetic patient mis-using insulin to lose weight
Clinical Case Correlate

- 64 yo WF seen in consultation in ICU

- Despite evidence of GI bleed is refusing endoscopy and other treatments; very fearful that she “is going to die”

- Evaluation reveals husband died of pancreatic cancer and “this is how they found out”

- Eventually agrees to procedure but is not reassured by positive outcome and continues to call and present with non specific GI symptoms as an outpatient for the next several months
Key Clinical Signs

- Clear medical illness present

- Psychological (anxiety/denial) and behavioral (refusing the procedure) creating significantly increased medical risk

- Focus needs to be on the underlying source of the behavior (often, but not always, fear)

- Separating out the psychological issue and dealing with that is the best approach – rather than getting into a power struggle over what the provider thinks is best from a medical standpoint.
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Body Dysmorphic Disorder

- Preoccupation with an imagined defect in appearance
- Repetitive Behaviors (mirror checking, excessive grooming, skin picking) or Mental Acts (comparing appearance to others)
- Significant distress, e.g., limiting face to face contact with others, frequent consultations for surgery etc.
- Belief in defect borders on delusional; must not be confused with Anorexia Nervosa despite some shared characteristics
Conscious vs. Unconscious

- Factitious Disorder ("Munchausen")
- Malingering
- Somatic Symptom and Related Disorders
Carl Friedrich von Munchausen 1720-1797

- Retired German Calvary officer widely known as an “entertaining raconteur”
- Tall tales written by another, Eric Raspe, among the most successful books ever written with many editions since first published in 1785
- Baron Munchausen was embarrassed at the loss of his privacy and died “a morose and embittered recluse”
Abenteuer und Reisen des Freiherrn von Münchhausen

MIT ILLUSTRATIONEN VON GUSTAVE DORÉ
Factitious Disorder

“Munchausen’s Disease”

- Conscious Feigning of Symptoms in service of unconscious needs
- “Train Track Abdomen”
- Chronic Course - Can exacerbate during stressful life situations
- High Co-morbidity with Borderline Personality
- New distinction (DSM V): Factitious Disorder Imposed on Self and Factitious Disorder Imposed on Another
Historical Perspectives
Historical Perspective: Railway Spine

- Liverpool Manchester Railway opened in 1830
- Multiple accidents in the early years
- Many claims for those with minimal injuries and many non-specific complaints
- First attempts to link psychological trauma with physical sequelae published in 1860s
- 30 years prior to “Studies in Hysteria” and 50 years prior to description of “Shell Shock” in WWI veterans
“There is indeed no class of cases in which medical men are now so frequently called upon to give evidence in the courts of law as those which involve the many intricate questions that arise in actions for damages against railway companies for injuries of the nervous system alleged to have been sustained by passengers in collisions; and there is no class of cases in which more discrepancy of surgical opinion may be elicited”

John Erichsen 1881-1886
Surgeon to Queen Victoria
Treatment Options

All patients with complaints should be properly assessed for any possible organic etiology.
I TOLD YOU I WAS SICK

B. P. ROBERTS

MAY 17, 1929
JUNE 18, 1979
Never say “it’s all in your head” – always respect the patient’s complaint

Regular routine visits with the medical physician are important

Avoid excessive lab tests and procedures

Try to shift attention away from the physical complaints and to the current life issues

Symptoms are not “either” physical or psychological – they are both
Treatment Options: Conversion Disorder

- Early identification crucial
- The longer the patient lives with the symptom and the sick role the harder it will be to treat
- Best approach is a benign intervention that allows the patient to “save face” and give up the symptom
Treatment Options: Somatoform Disorder

- Supportive listening
- Regular visits with physician
- Antidepressants have been shown to be helpful; especially noradrenergic (TCAs and SNRIs) and pregabalin (Lyrica)
- Recent studies have shown promise with Cognitive Behavioral Therapy
Treatment Options: Factitious Disorder

- Very difficult to treat; patients wary of psychiatrists and will not comply with referrals
- Significant co-morbidity with Borderline Personality Disorder
- Key is to develop relationship and dialog that isolates physical symptoms
- Some authors have observed that Factitious Disorder symptoms will wax and wane over time in response to stress and are not always chronically worsening
Good Prognostic Factors

- Younger age
- Ability to grasp and discuss abstract concepts
- Access to multi-disciplinary providers (primary care physician, pain specialist, physical therapy etc)
- Previous high level of functioning
Poor Prognostic Factors

- Chronicity
- Disordered family and interpersonal relationships
- Financial gain as a result of illness
- Successful use of illness as a solution in the family
- Concrete thinking
Current Perspectives

- Meta analysis of 13 randomized, placebo controlled studies
- 9 TCAs, 3 SSRIs, SAMe*
- Patients were more than four times as likely to report overall improvement, and reported moderate reductions in individual symptoms, particularly pain

*(S-adenosylmethionine)

- 102 trials; nearly 15,000 patients
- Most studies small with methodologic problems
- Trials with > 100 patients showed slight superiority of SNRIs and Lyrica over placebo
- **Bottom line:** "Benefits of pharmacological treatments in FMS are of questionable clinical relevance and evidence for benefits of non-pharmacological interventions is limited. A combination of pregabalin or SNRIs as pharmacological interventions and multicomponent therapy, aerobic exercise and CBT as non-pharmacological interventions seems most promising for the management of FMS"

Excellent Review: Clauw, DJ Fibromyalgia: A Clinical Review JAMA 2014;311(15) 1547-55
Cochrane Review 2014

- Pharmacologic: Slight improvement compared to placebo for SSRI/SNRIs and Natural Products (low to very low quality)
- Non-Pharmacologic: CBT reduced somatic symptoms compared with usual care or waiting list but small effect and differed between studies (low to moderate evidence)
- Studies typically small with problem methodology. One key observation in the non-medication trials was that many patients with somatic disorders will not accept or participate in psychological treatments

http://www.cochranelibrary.com/topic/Mental%20health/Somatoform%20disorders/
Patient Centered Care: NURSing the emotion

- Naming It
- Understanding it
- Respecting it
- Supporting it

Smith R Lein C et al “Treating Patients with Medically Unexplainable Symptoms in Primary Care” J Gen Int Med 2003;18:478-89
Assessment as an Intervention

- **Predisposing Factors**: Childhood illnesses, early life trauma, modeling of illness behavior, levels of social stress and support
- **Precipitating Factors**: Psychiatric disorders, social, fiscal, or occupational stress, changes in level of support
- **Perpetuating Factors**: Decreased activity and weight gain, social isolation, secondary financial gain
What do I do in real life?

- Conversion Disorders need med evac
- All others:
  - Investigate complaints – but minimize morbidity (same applies to prescriptions – do not cause iatrogenic symptoms!)
  - Regularly scheduled meetings – even if there is no active complaint
  - Set limits gently – but firmly
  - Set time aside to discuss non-medical topics (family, work, adjustment to living overseas, etc.)
Questions? YoungSA1@state.gov