

Somatic Symptom Disorders, Related Conditions, and Dissociative Disorders

MSIII-Clerkship

Vanderbilt SOM

Stephen E Nicolson, MD

Medically unexplained physical symptoms (MUPS)

- Physical symptoms that prompt the suffer to seek health care but remain unexplained after an appropriate evaluation (Richardson and Engel, 2004)
- From 15-66% of chief complaints are unexplained.
- Diagnosis given is related to the specialty of the doctor.

MUPS – One syndrome or many?

- Dentistry - Temporomandibular dysfunction
- ENT - Idiopathic tinnitus
- GI - Irritable bowel syndrome
- Gynecology- Chronic pelvic pain
- Internal Medicine - Chronic fatigue
- Neurology - Complex regional pain
- Orthopedics – Chronic back pain
- Rheumatology - Fibromyalgia
- Toxicology – Multiple chemical sensitivity

MUPS – Consequences

- Physician frustration: 1/6 primary care visits are considered “difficult” (Hahn, 2001)
- “Dose-response” relationship between # of symptoms and physician frustration
- Impaired physician-patient relationship
- Patient dissatisfaction: psychosocial distress, decreased quality of life
- Increased rates of depression and anxiety
- Increased health care utilization - 9x higher medical costs

Somatoform Disorders (DSM-IV)

- Presence of physical symptoms that suggest a general medical condition, but are not explained by a medical condition.
- Not consciously produced or feigned
- Misinterpretation of normal physiological functions
- Increased bodily awareness
- Heightened health anxiety
- Psychosocial stress = somatic distress

Somatoform Disorders, general considerations

- Usually worsens in periods of stress, but the patient may not realize it.
- Alexithymia
- Functions served by the unexplained symptoms
 - Symbolic resolution of unconscious conflicts and an attempt to keep the conflicting memories out of consciousness.
 - Imposing punishment on oneself via disabling symptom for a forbidden wish or wrongdoing.
 - Removing oneself from an overwhelming life-threatening situation.

Somatization Disorder - Multiple physical complaints that result in medical treatment or significant impairment.

- Diagnosis – According to DSM-IV, must have had at least (occurring at anytime during the disturbance) four pain symptoms, two GI symptoms, one sexual, and one pseudoneurological symptom.
- Course –Typically begins in adolescence. Must begin before age 30. Onset is generally acute, symptoms resolving within two weeks. Recurrence is common.
- Risk factors – Female, low income, low education. Medical comorbidity exists in half.

Conversion Disorder- Symptoms involve those of motor or sensory function.

- A disturbance in bodily functioning that does not conform to CNS anatomy and physiology.
- Varied presentation: impaired balance or gait, paralysis, weakness, difficulty swallowing or speaking, loss of sensation or sight, seizures.
- Begins in adolescence or early adulthood.
- More common in females, low economic status, rural, low IQ, those with FH.

Pain Disorder - Pain in one or more anatomic sites is the focus

- The patient may have an underlying cause for the pain, but pain is disproportionate to underlying condition.
- Psychological factors are judged to be important in the presentation.
- Pain tends not fluctuate in intensity with changes in emotion, attention/distraction or administration of pain medications.
- Peaks in 4th and 5th decade (pain tolerance declines with age)
- Depressive symptoms occur in 60-100%.

Hypochondriasis

- Involves preoccupation with fears of having or contracting a serious illness
- Seen more often in primary care settings
- Incidence is equal in men and women
- Early adulthood onset
- Up to 80% have depression or anxiety
- Treatment involves regularly scheduled exams, CBT to learn distraction/modify distortions

Body Dysmorphic Disorder - preoccupation with perceived physical defect

- Thought to represent displacement of an emotional conflict
- Typically think about flaws 3-8 hours/day
- The patient is often ashamed to describe the complaint. Most often involves the face or head, genitals, breasts. Men may be using steroids.
- Likely to present to surgeon or dermatologist
- Risk Factors – More common in students, females. Comorbidity: 90% depression, 70% anxiety, 30% psychosis

Work up of Somatoform Disorders

- Rule out medical conditions, especially those with multiple organ system involvement: MS, HIV, SLE, AIP, thyroid disease, adrenal insufficiency.
- Rule out for secondary gain
- Investigate for any perpetuating factors
- Search for comorbid psychiatric symptoms – depression, anxiety, psychosis, cognitive impairments, substance abuse

Medical Tx of Somatoform Disorders

- Single identified treater (usually PCP or if inpatient, primary team) to avoid too many opportunities for complaints and unnecessary work-up
- Structure patient with scheduled visits (not PRN).
- Set limits for work-ups and outside contact.
- Reassure patient that dangerous conditions have been ruled out and confirm that appropriate monitoring will continue.

Psychiatric Tx of Somatoform Disorders

- Individual or group therapy can reduce utilization by 50%.
- Patients have difficulty with emotional expression, so introduce psychological issues slowly.
- CBT is most studied and helpful in reducing depressive symptoms.
- SSRI's have shown some benefit in patients with comorbid depressive symptoms.

Factitious Disorder - Patient produces symptoms or signs of medical or psychiatric illness in order to assume the sick role

- Intentionally produced, although maybe compulsive and not fully under patient's control.
- History is dramatic and can be detailed, though often inconsistent.
- Lack of secondary gain (economic, legal).
- Often associated with childhood abuse resulting in many hospitalizations - Hospital viewed as safe.
- Risk factors: childhood abuse, childhood illness, employment as medical paraprofessional, personality disorder

Factitious Disorder (cont.)

- Munchausen syndrome – severe form resulting in multiple hospitalizations at different facilities often in different cities.
- Pseudologia fantastica
- Factitious disorder by proxy - A person intentionally produces physical signs or symptoms in another person under the first person's care.

Factitious Disorder Hospital Course

- Weekend or late night admission
- They initially will heap praise upon the treatment team .“I know you will be the one to figure out what is wrong with me.”
- As tests come back negative and treatments are ineffective, medical team becomes frustrated.
- Patient feels threatened and acts out or has worsening of symptoms.
- Patient often signs out AMA when team suspects patient is inducing symptoms

Factitious Disorder - treatment

- No specific treatment shown effective
- Early identification
- Prevent iatrogenesis
- Beware of negative countertransference
- Be mindful of legal and ethical issues
- Address any psychiatric diagnosis underlying the factitious disorder diagnosis. Rarely allowed by the patient.

Malingering - Symptoms created for secondary gain

- Secondary gain could be pain meds, sedatives, insurance payments, evade family responsibilities, or escape legal repercussions.
- Presentation often involves vague complaints and history.
- Psychiatric symptoms may be unusual or too consistent (e.g. AH that are in another language or uninterrupted).
- Often presents with extremely impaired functioning despite little evidence of disease.
- May be uncooperative with exam, treatment.

Malingering - treatment

- Identification without placation
- Treat psychiatric comorbidity – substance abuse, substance withdrawal, antisocial personality disorder (not likely to be interested in treatment)

Dissociation - an experience where a person may feel disconnected from himself and/or his surroundings.

- Highly associated with traumatic experience
- Some consider it a defense mechanism
- Patients often feel a blurred sense of identity
- Depersonalization - A sense of being detached from yourself.
- Derealization - A perception of the people and things around you as distorted and unreal.
- Ganser syndrome - Characterized by the use of approximate answers

Dissociative Amnesia (with Fugue)

- Dramatic dissociative episode in which the patient travels physically away from home or work and fails to remember important aspects of their identification.
- Often the patient takes on new identification, personality and employment.
- Fugues tend to last from a few days to months.
- Rare. More common in wartime or after natural disasters.

Dissociative Amnesia

- Inability to recall important personal information, usually of traumatic or stressful nature.
- Patient is typically aware of a gap in their memory.
- Intact memory for other information.
- More common in young women.
- May be acutely related to trauma, but more often chronic.

Dissociative Identity Disorder

- Chronic dissociative disorder in which two or more distinct personalities (alters) determine the behavior of the patient at different times.
- Usually associated with a history of chronic severe sexual or physical trauma in childhood.
- Presentation – 5-9 times more common in women. Can develop in young children, but late adolescence and early adulthood onset is most common. Suicide attempts, substance abuse and other self-destructive behavior is common.

Depersonalization Disorder

- Persistent or recurrent episodes of detachment or estrangement from one's self.
- The patient may complain of feeling like he or she is in a movie, or is an automaton, or detached from their body.
- Transient depersonalization is normal.
- More likely to occur in adolescents and young adults. Decrease with age.
- Episodes last from hours to weeks.

Dissociative Disorders Work Up

- Rule out amnestic syndromes, especially Transient Global Amnesia (reversible anterograde and retrograde memory loss with retention of basic biographic information usually occurring in elderly or middle aged men, lasting several hours and likely related to TIA), sleepwalking, seizures, and delirium.
- Consider drug intoxications (especially hallucinogens, dissociative anesthetics, and designer amphetamines).

Dissociative Disorders Treatment

- Treatment is usually supportive in the acute phase as memory usually returns.
- Treat comorbid depression, anxiety, substance abuse.
- If related to trauma: therapy aimed at understanding painful memories/experiences .
- If DID, insight oriented therapy with goal of integration of personality.