SOMATIZING: WHAT EVERY FAMILY DOCTOR NEEDS TO KNOW

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Faculty/Presenter Disclosure

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- **Jon Davine** has not received any funding for this program.

Mitigating Potential Bias

- Dr. Jon Davine

- I have received no funding from anyone for this presentation.
- Any meds I discuss are based on reviews of the literature
- My honoraria have been received from academic institutions, medical societies, and family medicine groups

“For each ailment that doctors cure with medications (as I am told they do occasionally succeed in doing), they produce ten others in healthy individuals by inoculating them with that pathogenic agent a thousand times more virulent than all the microbes - the idea that they are ill.”

- Marcel Proust
(le cote de guermantes)

Objectives

1. Appreciate the range of diagnoses that make up “Somatic Symptom and Related Disorders (DSM-V)
2. Understand the range of conscious and unconscious mechanisms involved in these disorders.
3. Be aware of treatment modalities for these disorders both psychopharmacolgic and psychotherapeutic.

Straw Poll

- Who thinks they have “somatized” in their life?

Introduction

- Somatizing is a very common human experience
- 80% of us have somatic sensations in any week
- If this becomes primary mode of behaving, this becomes a somatoform disorder
- Estimated that somatoform disorders may cost 10- 20% of medical budgets in USA
- 10-30% of patients with somatic complaints that present to family doctors, have no adequate physical cause to explain the complaint

Somatization

Lipowski (1988) “The tendency to experience and communicate somatic distress and symptoms; unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them…, this tendency becomes manifest in response to psychosocial stress…

“Shared Care” Important

- Family doctors well placed to treat somatizing
- About 50% of patients refuse referral to mental health services
  - *But* 81% of MUS patients were willing to have psychosocial treatment from their primary care physician
- The buck stops here!

Mind-Body Link

- Examples of mind-body link
  - Tension headache
  - Butterflies in the stomach
  - “Tension chest-ache”
  - “Tension leg-ache”
  - “Tension __“
- Important to acknowledge patient’s symptoms
  - “your pain is real, it is not imagined, and it’s not in your head”
  - “We simply know that stress can play a role in producing these symptoms”

Three Forms of Somatizing

- Medically unexplained symptoms (MUS)
- Hypochondriacal somatization
  - Bodily preoccupation and worry about having a serious illness
- Somatic presentations of psychiatric disorders e.g. Depression, Panic
  - Kirmayer and Robbins’91

Somatization “Unconscious”-DSM-V

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder

Somatic Symptom Disorder

- One or more somatic symptoms which distress and disrupt life
- Excessive thoughts, feelings or behaviours related to these somatic symptoms
- Symptoms persist for more than six months

- Specifiers:
  - With predominant pain (previously pain disorder)
  - Persistent (severe symptoms, >6 months)
  - Mild
  - Moderate
  - Severe

Conversion Disorder

- Affects voluntary motor or sensory function.
- Linked to psychological stressors.
- Specify:
  - With weakness or paralysis
  - With abnormal movement
  - With swallowing symptoms
  - With speech symptoms
  - With attacks or seizures
  - With anesthesia or sensory loss
  - With special sesnory symptoms
  - With mixed symptoms

- “Bachelors Degree”

Conversion Disorder - Characterization

- Usually acute onset
- Symptom duration is often relatively brief, usually within two weeks if stressor is removed or addressed
- Otherwise, may go on for years
- Few studies on course of illness

Conversion Disorder – Medication

- Meds not necessary
- For patients able to identify psychological stressors, appropriate psychotherapy can be very helpful

Somatic Symptom Disorder with predominant pain (prior Pain Disorder)

- Associated with psychological factors.
- Associated with both psychological factors and a general medical condition.
- Pain disorder associated with a general medical condition (not a psychiatric diagnosis).
- “Bachelor’s Degree”

Somatic Symptom Disorder with predominant pain – Treatment Options

- Muscle relaxation techniques
- Psychotherapy
- Medication

Somatic Symptom Disorder with predominant pain – Psychotherapy

- CBT
- Challenge cognitions
- “This pain is not damaging my body”
- “I can continue activities, even in some mild pain. I don’t have to stop.”
- Behaviorally activate: e.g. gardening 15 minutes twice/week, then increase

Somatic Symptom Disorder with predominant pain - Medication

- Try antidepressants, e.g. Nortriptyline or Amitriptyline, at doses of 10-50 mg po qhs
- These can help pain and possible sleep
- Try Trazodone 25-50 mg po qhs for sleep

Somatic Symptom Disorder with predominant pain – Medication Cessation

- If possible, withdraw narcotics, sleeping pills, tranquilizers
  - These meds can worsen depression, which can worsen the experience of pain (or other symptoms).
  - Do it slowly over time
- If unable to stop, at least try to lower dose
- Give the patient some control in tapering
  - Which pill
  - Which dose
  - How quickly

Somatic Symptom Disorder (Undifferentiated Somatoform Disorder)

- At least six (6) months
- One (1) or more physical complaints
- “Master’s Degree”

- This is now “Somatic Symptom Disorder”

- Specify if:
- persistent
- mild, moderate or severe

Somatic Symptom Disorder (Undifferentiated Somatoform)

- Chronic fatigue syndrome, Fibromyalgia, Irritable Bowel Syndrome
- Has never been shown thus far to have a biological cause
- In studies, there is felt to be a major psychiatric co-morbidity
- Try not to dichotomize:
  - “Perhaps a % of both, thus may work on psychological side to see how far this takes us.”

Illness Anxiety Disorder (Hypochondriasis)

- Preoccupation with having a serious illness
- Somatic symptoms are not present or only mild
- This if there is a symptom occurring with excessive thoughts and behaviours, this will be subsumed under “Somatic Symptom Disorder”

Illness Anxiety Disorder (Hypochondriasis) – Treatment

- Literature discusses link to OCD spectrum
  - E.g., intrusive thoughts, repetitive checking behaviours
  - Would then use CBT and OCD medication
- May evolve into overvalued ideas, and ultimately delusions
  - Delusional disorder, somatic type
  - Would then use neuroleptics

Illness Anxiety Disorder (Hypochondriasis) – Treatment Efficacy

- Recent RCT compared CBT and paroxetine to placebo
- In the intent to treat analysis, only CBT differed significantly from placebo
- In the completed analysis, both paroxetine and CBT differed significantly from placebo
  - (Greeven et al, Am J of Psych ’07)

Case – Betty

- 32 year old woman
- Mother had breast cancer
- Her own fears

Body Dysmorphic Disorder (BDD) - Definition

- Preoccupation with an imagined defect in appearance
- If a slight anomaly is present, concern is markedly excessive

BDD - Epidemiology

Prevalence:

Dermatology Clinic: 12% of patients had BDD (Phillips '00)

Cosmetic Surgery Clinic: 6-8% (Sarven et al, '98)

Patients with OCD: 8-37% have co-morbid BDD

General Population: 0.7% (Faravelli '97)
1.1% (Bienvenu et al, '00)
2.2% (Mayville '99)
13% (Bibby '98)

- Male:female 1:1
- Usually starts in Adolescence (Phillips et al '97)

BDD – Common Sites of Preoccupation

- Preoccupations usually involve face and head, skin, hair, nose, overall body
- Women
  - Breasts, legs
- Men:
  - Genitals,“muscle dysmorphia”. This is now a specifier.
  - May use anabolic Steroids (Pope ‘97)

BDD – Characteristics

- Can resemble OCD, link with obsessive spectrum disorders. Specifier would be “good or fair insight”
- Think about flaws 3-8 hours per day (Phillips ‘96)
- Compulsive behaviours - checking appearance, grooming, seeking reassurance repetitively, may repetitively seek surgery.
- Can go on to overvalued ideas and frank delusions. This would be specified as “absent insight/delusional beliefs” or perhaps “fair insight” for overvalued ideas

Case - Bill

- 32 year old man
- Fears about size of genitals

BDD- Tx

- 100 people treated x 14 weeks with escitalopram (open label)
- 81% of completers responded
- 67% of treated subjects responded (including dropouts)

- Thus, significant response to meds

- (Phillips et al, Am. J of Psych, Sept. 2016)

BDD--Tx

- 58 responders then randomized to continued treatment with escitalopram vs. placebo for 6 months (RCT)
- 18% relapsed with escitalopram, 40% with placebo
- Time to relapse was longer with escitalopram
- 36% of citalopram subjects showed continued improvement over the 6 months

- Thus effective, and may want to continue treatment for at least 6 months

- (Phillips, et al, Am. J of Psych, Sept. 2016)

BDD - Screening

- Suggest to plastics, dermatology clinics:
  - “How do you feel this is affecting your life?”
  - “How do you feel the procedure will help you?”

Somatizing – “Conscious”

- Factitious Disorder (Munchausen’s Syndrome)
- Malingering

Malingering

- Consciously done
- Easily identifiable goals – drugs, money, legal issues
- Link to Anti-Social Personality Disorder

Factitious Disorder Imposed on Self

- Intentional production or feigning of physical or psychological signs or symptoms
- The motivation for the disorder is to assume “the sick role”
- External incentives for the behaviour (such as economic gain, avoiding legal responsibility, or improving physical well-being as in malingering are absent

- Specify:
- Single episode
- Recurrent episodes

Factitious Disorders Imposed on Self – Common Presentations

- Infection (can be fatal septicemia)
- Impaired wound healing
- Bleeding
- Hypoglycemia
- Seizures
- Rashes
- Fever (flu)
- Connective tissue disease
- Vomiting, diarrhea
  - (Feldman et al ‘94)

Fictitious Disorder Imposed on Self – Conscious Part

Either:

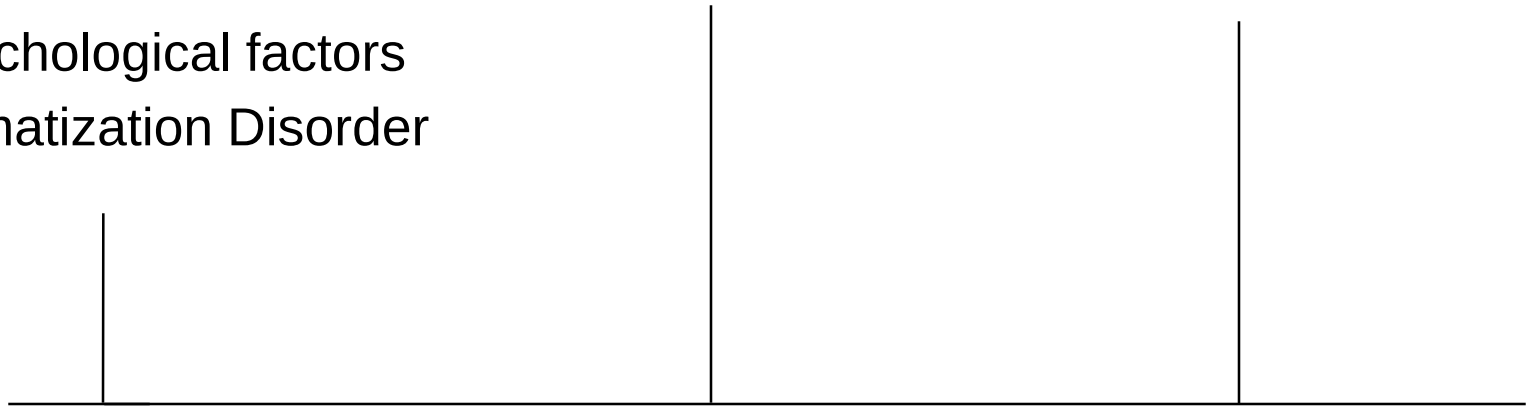
- Lying or exaggerating signs and symptoms
- Knowingly tampering with samples or tests
- Manipulation of ones body to produce positive tests results

The Spectrum

Conversion Disorder
Pain due to
Psychological factors
Somatization Disorder

Factitious Disorder

Malingering



Unconscious

Conscious

(Adapted from Nadelson et al., 1979)

Reich *et al.* (1983)

- Study Population:
  - 41 cases
  - 39 females, 2 males
  - Average age 33, most single
  - 28 / 41 medical jobs
  - “Immature, Dependent Personalities”
- Results
  - Confronted – worked well
  - Only 4 of 33 wanted psychotherapy
  - Only 1 of 33 pursued
  - No systematic evaluations on the efficacy of psychotherapy

Factitious Disorder Imposed on Self

- Overall prognosis is poor
  - Few admitted
- Very few pursue any psychotherapy
- Anecdotal case reports of successful treatments

Factitious Disorder Imposed on Another

- Factitious Disorder (Munchausen) by proxy
- 90% of perpetrators are mothers
- Usually involves infants, toddlers
- Psychologically needs to assume the sick role, this time vicariously.

POP QUIZ

- If you fake having a seizure because you want to get your insurance policy $millions, this would be called:

- MALINGERING

POP QUIZ

- If you faked having a seizure, not because of any apparent monetary gain, but rather for some unconscious reason to get cared for in hospital, this would be called:

- FACTITIOUS DISORDER

POP QUIZ

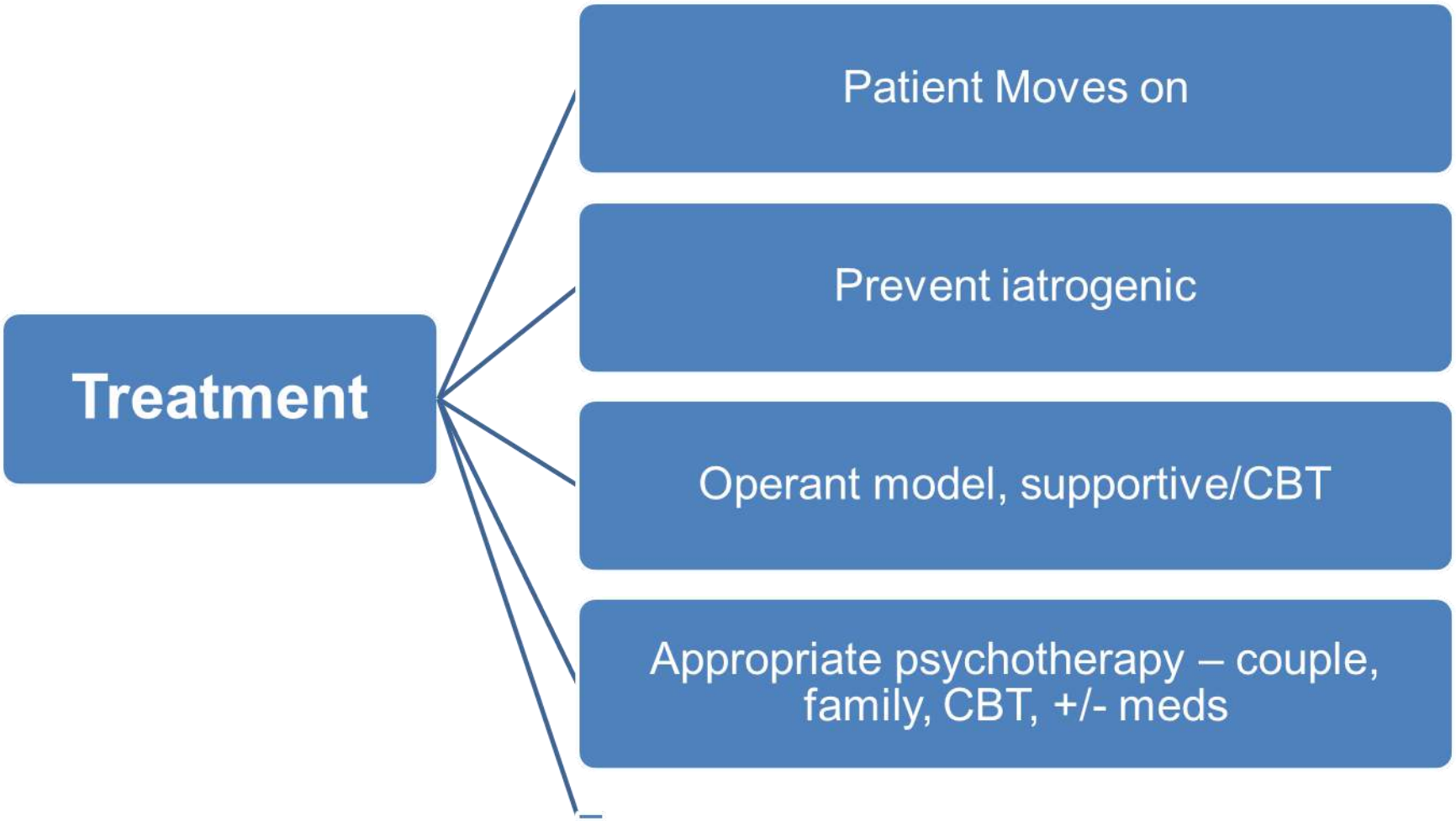
- If you had a seizure, which to you felt very real, but this was felt to be due to stress you were under and not any organic pathology, we would call this:

- CONVERSION DISORDER

Somatization 2^0 to Psychiatric Illness

- Depression
- Panic Disorder (aka “the great imitator”)
- Generalized Anxiety Disorder
- OCD
- Delusional Disorder, Somatic type

Treatment Outcomes



Assessment

- Appropriate medical work-up (“Boy who cried wolf”)
- Make a respectful mind-body link up early on

Treatment

- See patient at regular intervals
- Avoid E.R., other dispersal of care
- If consultant to be used, contact beforehand
- Judge progress by improvement in level of function
  - “Cure” is unlikely
  - Allow for relapses

Reference

- Lipowski, ZJ. Somatization: the concept and its clinical application. American Journal of Psychiatry 1988;145: pp1358 – 1368.

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