SOMATOFORM DISORDERS

WHO ARE WE REALLY TREATING?
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SOMATOFORM DISORDERS
- Somatic complaints that suggest major medical maladies yet have no associated serious, demonstrable, peripheral organ disorder
- Psychological factors and conflicts that seem important in initiating, exacerbating and maintaining the disturbance
- Symptoms are not willfully controlled. Do not confuse this with malingering

MALINGERING
- Intentional production of false or grossly exaggerated physical symptoms, motivated by external incentives such as avoiding work, obtaining financial compensation, evading criminal prosecution or obtaining drugs.
- Differs from Factitious Disorder in that the motivation for the symptom production is an external incentive whereas in Factitious Disorder these are absent.
- Differs from Somatoform Disorders by the intentional production of symptoms and by the obvious external incentives associated with it.

CLINICAL SYNDROMES
- Hypochondriasis
- Pain Disorder
- Conversion Disorder
- Somatization Disorder
- Factitious Disorder
Pain Disorder

- Primary symptom is presence of pain in one or more sites that is not fully explained for by a physiological or neurological condition.
- Typical pain sites include back pain, headache, chronic pelvic pain, atypical facial pain.
- Person typically has long history of medical and surgical care, visiting health providers and requesting medications.
- Often suffer from addictions to narcotics.
- Major depressive disorder is often present in 25-50% of patients.

Hypochondriasis

- Results from a patient’s unrealistic or inaccurate interpretation of physical symptoms or sensations.
- One study demonstrated a 6-month prevalence of 4-6% in the general clinic population.
- Major depressive disorder and anxiety disorder often seen concurrently.

Somatization Disorder

- **Essential feature** is recurrent, multiple somatic complaints requiring medical attention but not associated with any physical disorder.
- **Diagnosis** requires a history of many physical complaints of several years' duration and a lifetime history which results in medical treatment or alteration in lifestyle.
- **Symptoms** cannot be explained by a known nonpsychiatric medical condition, or the resulting complaints or impairment must be excessive.
- **The subjective severity** of the symptoms must be sufficient such as to lead to seeking medical care, take medicine or change lifestyle.

Conversion Disorder

- Characterized by the presence of one or more neurological disorders, eg., blindness, seizures, paralysis, in the absence of demonstrable neurologic pathology.
- Can have onset of any age, including childhood but is most commonly seen in adolescence and early adulthood.
- Resolution is usually spontaneous, often in the context of psychotherapy.
Factitious Disorder

- Involves persons who intentionally cause themselves to become ill, sometimes desperately so, for the sole purpose of becoming a patient.
- Feign or produce illness in such a manner that the charade is rigorously concealed.
- Mislead the treating provider as to what interventions are needed.
- All of these actions appear to be voluntary in that the person is fully aware of the deception yet there is a sense that the person is out of control in a compulsively self-destructive way.
- Motivation for production of symptoms is unconscious.

Patient’s Illness Perception

- The identity of the illness: What does the patient think is wrong?
- The cause: Is the patient convinced that the condition is caused only by organically founded problems, are psychosocial factors of any importance or do other causes play a part?
- Time frame: Does the patient think it will be short-lived or fear a chronic condition?
- The consequence: Does the patient believe she/he will be able to work again, that she/he will be troubled or depend on a sickness benefit, etc.?
- Recovery and control: Does the patient believe she/he will recover and treatment will help? Does the patient feel she/he can control the illness to certain extent or is helplessness present?

Iatrogenic Factors in Somatizing

- Fear of missing a physical disease. May give rise to somatic overtreatment and cause the patient to suffer unduly and patient and society health care expenses to rise unnecessarily.
- Fear of complaints and prosecution may result in “defensive testing”.
- Lack of accessible psychiatric treatment may cause patient to continue to seek medical treatment to no avail.
- Lack of understanding of the nature and character of mental disorders and lack of knowledge about how to manage these disorders may lead to prompt acceptance of the patient’s insistence on examinations.
- Insufficient knowledge and skills
- Time pressure and fear of opening “Pandora’s box” may lead to reluctance to raise the problematic questions.
PATIENT-PROVIDER RELATIONSHIP

- Paternalism vs. Partnership
- Efficiency vs. Effectiveness
- Accusation vs. Acceptance

INTERVENTIONS FOR MANAGEMENT

- Focus on management, not cure
- Develop a therapeutic alliance and keep boundaries clear.
- Think “long-term”, not immediate results
- Treat associated psychological symptoms, i.e., depression, anxiety
- Engage other providers to maintain consistency in care

Example of a Behavioral Protocol

Behavioral Protocol for B.T.

This protocol has been developed with the assistance of health care team members who have been providing most of B’s medical care over the past year.

The goal of this plan is to provide B. with accurate and appropriate medical interventions when she comes to the ED. It is essential that unnecessary tests/medications prescribed be minimized. The rationale for this is that unless they are CLEARLY indicated, things such as medication side effects or untoward complications from intrusive procedures can be avoided.

The goal of the health care team should be to limit hospital admissions unless ABSOLUTELY INDICATED BY CLEAR AND OBJECTIVE DATA

Example of a Behavioral Protocol

Rules for Behavioral Programs

A. The program must be followed by all team members to ensure effectiveness. If a change is deemed necessary, it must be reviewed first by the primary team before implementing the change. Unless it is an emergency, changes to the program with NOT be made unilaterally.

B. Communication is essential amongst the team members to avoid staff-splitting and inadvertent reinforcement of B.’s somatic complaints.
Example of a Behavioral Protocol

Plan:

1. When B. comes into ED, the following will be ordered regardless of her reported symptoms: CBC, SMA-8, lactate, flat plate of the abdomen or KUB (as her typical reason for being in ED is abdominal pain) weight, vital signs.

2. B. will not be admitted until a minimum of 24 hrs has passed (unless clear medical illness shows otherwise) and until all the results are obtained and reviewed. She will not be admitted until the Admitting Physician has seen her.

3. Only objective data will be used to determine interventions. Example: if B. complains of diarrhea, no medications will be started until a staff person has actually seen the diarrhea.

4. If at all possible, limit the number of providers assigned to care for B. This will avoid staff-splitting and ensure consistency in approach.

5. If B. is admitted, it is the covering team’s responsibility to update the information in the pt. chart on a regular basis and it is the responsibility of the subsequent team members to review the information.