PainWeek®

Much Ado About Something: Pain and Somatic Symptom Disorder

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Train New Trainers (TNT) Primary Care Psychiatry (PCP) Fellowship

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Disclosure of Financial Relationships

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Has disclosed the following relationships with entities producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.

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Resolution of Potential Conflicts of Interest:
-All presented material is independent of industry produced content.
-Only material supported by published data and Evidence-based guidelines will be presented.

Learning Objectives

- Differentiate the DSM IV and DSM V criteria for somatic symptoms and somatoform disorders.
- Choose the best treatment for somatoform spectrum disorders.
- Describe how to effectively use CBT in patients who somatize.

Ouch…

- How many of you have patients who complain of pain over most (if not all) of their body?
- How many of you have patients who also have either depression or anxiety?
- How many of you have patients who get increased pain with increased stress, depression or anxiety?
- How many of you feel skilled in dealing with these patient encountered?

The “Difficult Patient Encounter”…

Anything to learn…?

- What is somatic symptom disorder and what happened to the somatoform disorders of DSM IV?
- What is the best treatment for somatic or somatoform spectrum disorders?
- How can providers most effectively use CBT in patients who somatize?

OUCH!

- 24 Y/O Spanish speaking female in the U.S. for three years
- Up until now, no past medical history
- Multiple presentations with complaints of:
- ***"I have pain everywhere…all over my body"***
  - Left 5th finger pain (no history of trauma)
  - Chest pain for "several hours or days" without radiation or known precipitants
  - Left anterior thigh pain (mainly constant)
  - Mild lower back pain that radiates to the neck (no trauma or precipitants)
  - Daily headaches…
  - Pain is so bad she has difficulty working as a cook

OUCH!

Exam

- Vitals – normal
- No *reported* depressed mood or anhedonia
- Blunted affect (mood incongruent) – intermittently tearful and guarded during the first 3-4 visits
- No suicidal/homicidal ideation
- No manic or psychotic signs or symptoms
- She seems mildly anxious

OUCH!

Exam

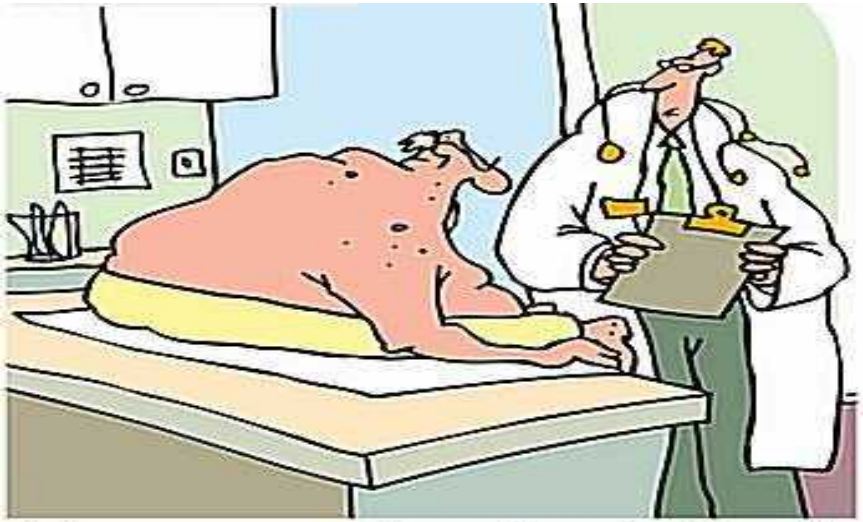
- HEENT: within normal limits (WNL)
- Neck: WNL
- CV: WNL – no point tenderness and no complaint of chest pain during all exams
- PUL: WNL
- ABD: WNL
- Muscular – skeletal: WNL (no complaint of back pain during exams)
- EXT: WNL except for global, moderate to severe point tenderness on left 5^{th} digit
- Neuro: WNL

OUCH!

Other studies

- X-ray of left 5th digit is normal
- Thoracic imaging is unremarkable
- TSH is normal
- Electrolyte panel is normal

UH, UH, UH, YOU WEREN'T LIFTING WITH YOUR LEGS WERE YOU?!



"There are some things they don't teach you in medical school. I think you've got one of those things."

Painfully Depressed

- How are things at home / work?
- What is the “number one biggest problem”?
- What happens to (unexplained somatic complaint) when (primary stress) occurs?

Painfully Depressed

Differential Diagnosis

- Major Depressive Disorder
  - Denied depression and anhedonia but patient has a persistent blunted affect
  - Cultural factors
- Unspecified Anxiety Disorder
- Somatic Symptom Disorder

Not All Unexplained Symptoms Are Tied to Psychiatry…

- Early 1980’s
- Unintended weight loss
- Malaise
- Leukopenia
- Nausea and vomiting

Thoughts?

Not All Unexplained Symptoms Are Tied to Psychiatry…

- Early 1970's
- Weird looking rash
- Malaise
- Asymmetric arthralgia's
- Heart conduction delays

Thoughts?

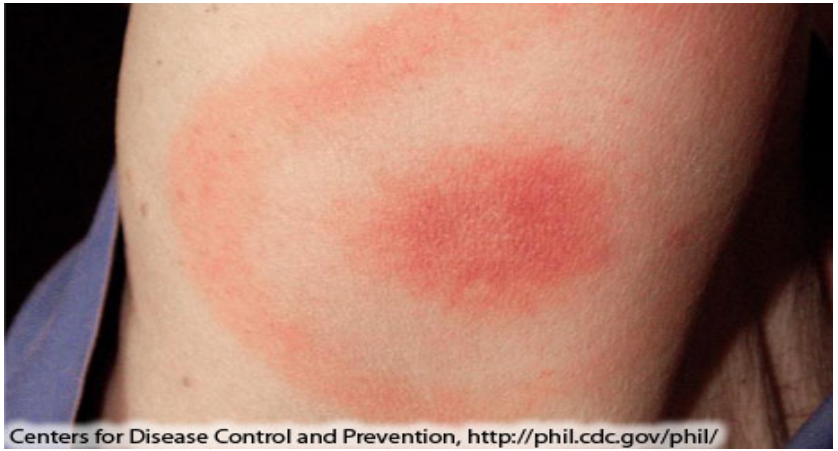


Table 8.1 Somatoform Disorders: Diagnostic Criteria

DSM-IV-TR	DEFINITION
Somatization disorder	• Many unexplained physical complaints before age 30 • Four pain, two gastrointestinal, one sexual, and one pseudoneurologic symptom
Undifferentiated somatoform disorder	• One or more unexplained physical complaints • Duration of at least 6 months
Conversion disorder	• One or more unexplainable, voluntary motor or sensory deficits • Directly preceded by psychological stress
Pain disorder	• Pain in one or more sites that is largely due to psychological factors
Hypochondriasis	• Preoccupation with a nonexistent disease despite a thorough medical work-up • Does not meet criteria for a delusion
Body dysmorphic disorder	• Preoccupation with an imagined defect in physical appearance
Somatoform disorder not otherwise specified (NOS)	• Somatoform symptoms that do not meet criteria for any specific somatoform disorder

Somatic Symptom DSM *5* Criteria

Somatic Symptom and Related Disorders

DSM-5*	DEFINITION
Somatic Symptom Disorder	• Distressing somatic symptoms that result in significant disruption of daily life. • Abnormal thoughts, feelings, or behaviors related to the somatic symptoms
Illness Anxiety Disorder (formerly hypochondriasis)	• Preoccupation with having or acquiring a serious illness • High level of anxiety about health disproportional to the real threat to health. • Excessive health-related behaviors or maladaptive avoidance.
Conversion Disorder (functional neurological symptom disorder)	• Altered voluntary motor or sensory function. • Symptoms are not due to a recognized neurologic or medical condition.
Psychological Factors Affecting Other Medical Conditions	• Psychological or behavioral factors adversely influence the course, treatment, or underlying pathophysiology of an existing medical condition.
Factitious Disorder	• Falsification of physical or psychological signs or symptoms • There is no obvious external reward for the deception.

From American Psychiatric Publishing, Inc. *Diagnostic and Statistical Manual of Mental Disorders, 5th ed*. Washington, DC: American Psychiatric Publishing, Inc.; 2013

Non-shared Diagnostic Features…

- Intentional versus unintentional production of symptoms
- Medical explanation of symptoms or health related anxiety
- Indicated as diagnosis of exclusion

Somatic Symptom Disorder

A. At least one somatic symptom that is distressing and causes significant disruption to daily life.

B. Excessive thoughts, feelings or behaviors related to somatic symptoms or associated health concerns as manifested by at least one of the following:

   1. Disproportionate and persistent thoughts about the seriousness of illness
   2. Persistently high level of anxiety about health or symptoms
   3. Excessive time and energy devoted to health or symptoms

C. Symptomatic state is persistent (>6 months)

Somatic Symptom Disorder

Specifiers:

1. With predominant pain
2. Persistent
3. Mild – Only one criteria B present
4. Moderate – Two or more criteria B present
5. Severe -- Two or more criteria B present and multiple complaints (or one very serious somatic symptom)

Somatic Symptom Disorder

- Symptoms may be specific or non-specific
- Authentic suffering and distress from the symptom(s) is the diagnostic and treatment focus, not the symptom etiology
- May be present in the context of a clearly defined medical illness
- Depression and anxiety are commonly coexistent

Somatic Symptom Disorder --- Associated Demographic Features

- Female
- Increased age
- Lower socioeconomic status
- History of sexual abuse
- Social stress
- Comorbid depression

Illness Anxiety Disorder (Formerly Hypochondriasis)

A. Preoccupation about having a serious *illness*

B. Somatic symptoms are *not* present

C. High level of associated anxiety

D. Excessive health-related behaviors or exhibits maladaptive avoidance

E. Illness preoccupation has been present for at least 6 months

F. Not explained by another medical or psychiatric disorder

- *Care seeking* or *care avoidant* types

Illness Anxiety Disorder (Formerly Hypochondriasis)

- Reassurance is not usually effective
- Illness becomes part of the patients identity
- These patient seen more frequently in the non-psychiatric setting
- High rates of medical utilization (often inappropriately so)

Conversion Disorder
(Functional Neurological Symptom Disorder)

A. One or more symptoms of altered voluntary motor or sensory function
B. Incompatibility between the symptom(s) and recognized neurological or medical conditions
C. Not better explained by another medical condition
D. They symptom(s) causes significant distress or impaired functioning

Conversion Disorder

Specifiers:

With weakness or paralysis

With abnormal movement

With swallowing symptoms

With speech symptoms

With attacks or seizures

With sensory loss

With mixed symptoms

Acute or persistent (6 month timeframe)

With or without psychological stressor

Psychological Factors Affecting Other Medical Conditions

A. A medical symptom or condition (other than mental disorder) is present

B. Psychological factors adversely affect the medical condition in one of the following ways:

   A. Influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition

   B. Interference with the treatment

   C. Associated well-established health risks

   D. Influence the underlying pathophysiology, worsening symptoms or necessitating medical attention.

Factitious Disorder

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception
- Presents as ill, impaired or injured
- Deception behavior is evident
- Not better explained by another disorder
- Specifiers:

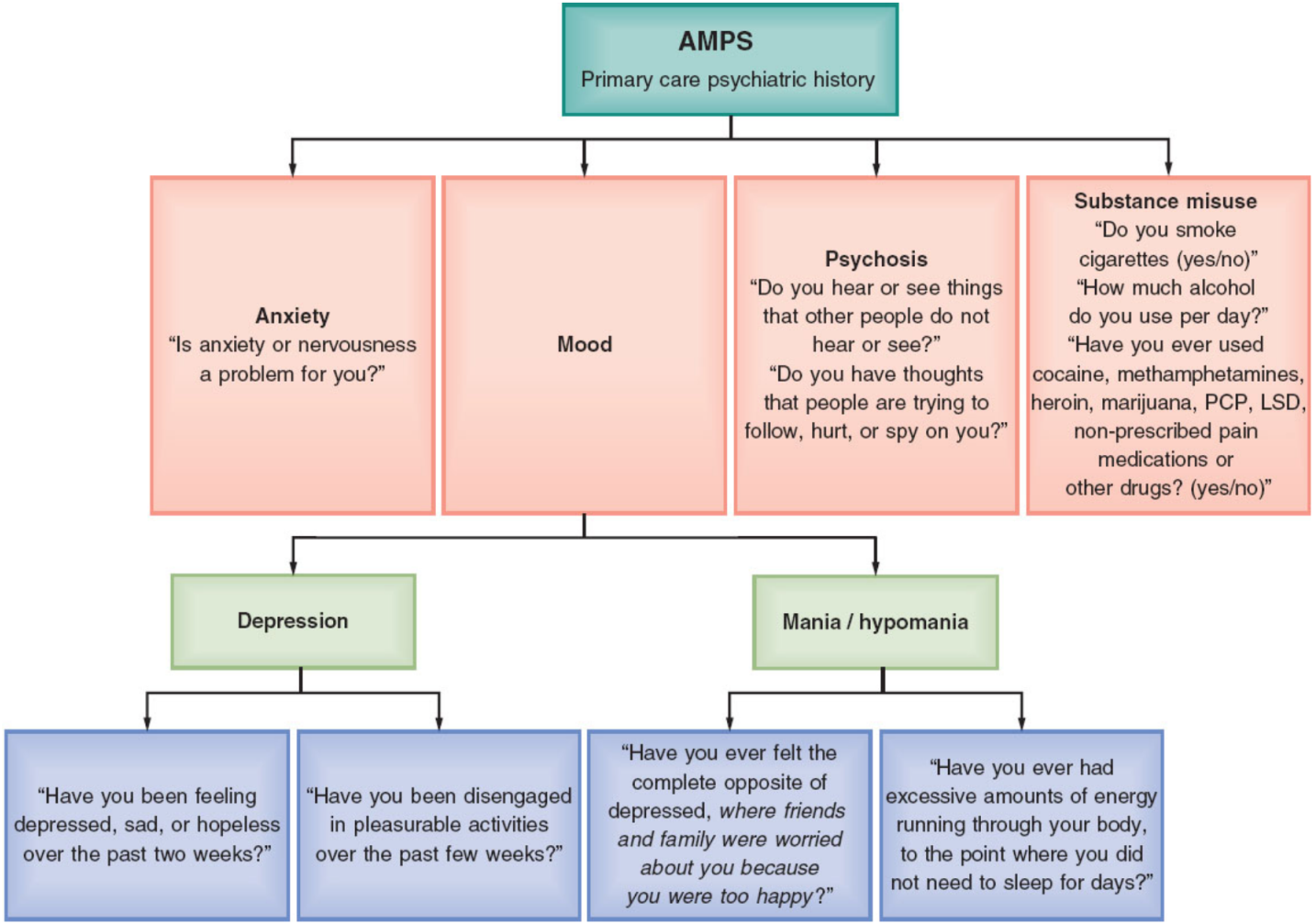
  Single, recurrent, imposed by self, imposed by another person

Other Somatic Symptom Related Disorders…

- Specified
  - Brief somatic symptom disorder (< 6 months)
  - Brief illness anxiety disorder (< 6 months)
  - Illness anxiety disorder without excessive health-related behaviors
  - Pseudocyesis – false belief of being pregnant
- Unspecified
  - Somatic symptom disorder without full criteria

How Do You Treat These Disorders???

"I have good news and bad news. The good news, you're not a hypochondriac..."



Primary Care Psychiatry 2nd Edition – McCarron, Xiong, et al.

CARE MD – Treatment Guidelines for Somatic Symptom and Related Disorders	
CBT/Consultation	• Follow the CBT treatment plan developed by the therapist and patient
Assess	• Rule out potential general medical causes for the somatic complaints • Treat comorbid psychiatric disorders
Regular visits	• Short frequent visits with focused exams • Discuss recent stressors and healthy coping strategies
Empathy	• "Become the patient" for a brief time. Acknowledge reported discomfort. • Spend more time listening to the patient, less time with tests. • Acknowledge patient's reported discomfort
Med-psych interface	• Help the patient self discover the "mind-body" connection. • Avoid comments like, "your symptoms are all psychological."
Do no harm	• Avoid unnecessary diagnostic procedures and specialist consultations. • Once a reasonable diagnostic workup is negative, feel comfortable with a somatic symptom disorder (or related) diagnosis and initiate treatment
From McCarron R. Somatization in the Primary Care Setting. Psychiatric Times. 2006; 23 (6): 32-34.	

TABLE 8.5 Side-Effects Profile of Antidepressant Classes

	SEXUAL DYSFUNCTION/ DECREASED LIBIDO	WEIGHT GAIN	SEDATION	CARDIAC
SSRIs	+++	+[a]	+/– [a]	0
SNRIs	+++	+/–	+/–	+ (↑ BP)
Mirtazapine	+	+++	++	+/–
Bupropion	0	0	0	+/– (↑ BP)

BP, blood pressure; ECG, electrocardiogram, abnormalities; SSRIs, selective serotonin reuptake inhibitors; TCA, tricycle antidepressants.

[a] Paroxetine and fluvoxamine are more likely to cause sedation and weight gain.

TABLE 8-4 First-Line Antidepressant Medications

CLASS	INITIAL DOSE (mg/day)[a]	THERAPEUTIC DOSE (mg/day)	PRACTICAL POINTERS FOR THE PCP[b]
Selective serotonin reuptake inhibitors (SSRIs)			
Sertraline	50	50-200	Serotonin and dopamine reuptake inhibition. Low drug interactions.
Paroxetine Paroxetine CR	20 12.5-20	20-60 25-75	High anticholinergic and antihistamine. Sedating, weight gain, and dry mouth. Short half-life. Drug interactions. Pregnancy–class D
Fluoxetine	20	20-60	Long half-life. Relatively inexpensive High chance for drug. interactions.
Fluvoxamine	50	50-300	Rarely used owing to high side effect profile
Citalopram	20	20-60	Low risk for drug interactions.
Escitalopram	10	10-20	Low risk for drug interactions.

TABLE 8-4 First-Line Antidepressant Medications (continued)

CLASS	INITIAL DOSE (mg/day)[a]	THERAPEUTIC DOSE (mg/day)	PRACTICAL POINTERS FOR THE PCP[b]
Serotonin norepinephrine reuptake inhibitors (SNRIs)			
Venlafaxine XR	37.5	75-300	Serotonin & norepinephrine reuptake inhibition. Sometimes used as an adjunct for chronic pain. Caution in those with HTN. Short half-life. Reduce dose with renal insufficiency.
Desvenlafaxine	50	50-100	Same as above (structurally similar to venlafaxine)
Duloxetine	30	30-60	Dual action on serotonin and norepinephrine receptors. FDA approved the fibromyalgia and diabetic peripheral and neuropathic pain. Sometimes used for chronic neuropathic pain.

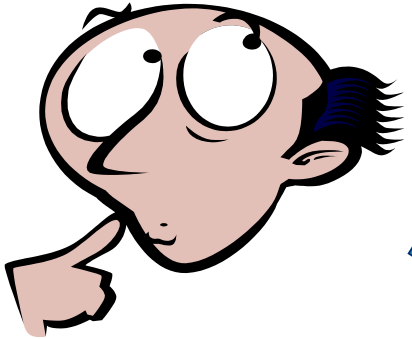
TABLE 8-4 First-Line Antidepressant Medications (continued)

CLASS	INITIAL DOSE (mg/day)[a]	THERAPEUTIC DOSE (mg/day)	PRACTICAL POINTERS FOR THE PCP[b]
Other			
Bupropion	75-150	300-450	Likely dual action on dopamine and norepinephrine receptors. Contraindicated with seizure and eating disorders. Can worsen anxiety disorders. Less side effects with longer acting formulations.
Bupropion SR	100	300-400	See above.
Bupropion XL	150	300-450	See above.
Mirtazapine	15	15-45	Increase central serotonin and norepinephrine activity (possibly through presynaptic ?$_{2-}$ adrenergic receptor inhibition). Decreased frequency of sexual side effects. Increased sedation and sleepiness at mainly lower doses.

Depression
Treatment with CBT

5HT, DA, NE

FEEDBACK



DYSFUNCTIONAL THINKING
"ALL OR NONE THINKING"

FEELINGS &
SOMATIC COMPLAINTS

Emotions Specify feelings rate 1-10 (10 rated as most intense)	Automatic Thoughts "What is running through your head" (not an emotion or feeling)	Rational Response Why is the automatic thought inaccurate (be specific)?	Outcome Rerate feeling using 1-10 scale
"Sad" 8/10	"My pain will never go away"	• "Not true – I am working hard with my doctor so my pain will get better over time." • "Never is a strong word to use."	"Sad" 5/10
"Angry" 9/10	"Everyone thinks I'm faking my pain"	• "My doctor listens to me and everyone is a lot of people!" • "I know my family is trying to understand my pain and depression."	"Angry" 3/10
"Anxious" 9/10	"Nobody will ever figure out what is wrong with me and there is no reason to go on living"	• "I know I have somatic symptom disorder and doing my CBT homework will only help me." • Sometimes I feel like dying but I know I want to live."	"Anxious" 4/10

FIGURE 23-1 Sample dysfunctional thought record. CBT, cognitive behavioral therapy.

Self-Assessment

What is the best way to treat most somatic symptom disorders?

A. Supportive psychotherapy

B. Cognitive behavioral therapy

C. Dialectical therapy

D. Optimizing exercise habits

E. None of the above

Self-Assessment

Which is the best antidepressant to treat somatic symptom disorders?

A. Zoloft

B. Prozac

C. Cymbalta

D. Lexapro

E. None

Self-Assessment

32 Y/O female presents with anxiety related to her strong held belief she will soon die from a heart attack. Her father died from heart disease at the age of 83. The patient notes "sharp pings of pain over the heart that is worse with movement". No other medical or psychiatric conditions.

Which of the following is *not* a somatic symptom disorder?

A. Factitious disorder

B. Hypochondriasis

C. Illness anxiety disorder

D. Conversion disorder

Questions???