Morning Report: Somatic Symptom Disorder and Other Related Disorders

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Case

- CC: “I usually get depressed around the holidays”

- WF is a 56 yo AAM with a h/o of schizophrenia, HTN, DMII, and OSA who presented from Augusta, GA seeking inpatient psychiatric admission due to SI and depression of several days duration. He endorses AVH of commands to harm himself and seeing dead people. If he were to commit suicide he would do so via overdose

Differential Diagnosis?

1.
2.
3.
4.
5.

Case

- Throughout the interview he provides little detail regarding his hallucinations, depressive symptoms, and suicidality.

- In admissions it was noted that he presented with two neatly packed suitcases and his home CPAP machine.

Mental Status Exam

Appearance: A 56 yo AAM who appears his stated age; well-dressed and well-groomed wearing a sweater, bracelet, watch, and several rings; he can be seen speaking on the phone in a jovial manner.

Attitude: calm, very straightforward, answers with paucity of detail and superficially, though without clear evasion,

Activity: no evidence PMA/PMR

Speech: tone is clipped, appropriate in volume, rate, and prosody

Thought Process: logical, coherent, goal-directed, and future oriented; no disorganization

Associations: no evidence of loosening

Mental Status Exam (cont.)

Thought Content: persecutory delusions of being followed in GA

SI/HI: calmly endorses suicidal ideation with a plan but no intent; denies HI

Perception: calmly endorses AH of voices instructing him to kill himself; visual hallucinations of dead people

Mood/Affect: Mood is “depressed”; Affect is somewhat blunted, remains emotionally neutral whenever discussing traumatic experiences and concerning symptoms

Judgment and Insight, Orientation, Attention Span and Concentration, Language, and Fund of Knowledge are unremarkable

Differential Diagnosis?

1.
2.
3.
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Hospital Course

- Outside medical records revealed he had several similar presentations to multiple hospitals in Atlanta, the VA in Augusta, and a hospital in Pensacola, FL during which he stayed for approximately 4 days. He was discharged with resolution of his symptoms without pharmacologic changes or ECT.

- His symptoms were ameliorated on hospital day 4. He was discharged on hospital day 5 back to GA.

Somatic Symptom and Related Disorders

- Somatic Symptoms Disorders
- Illness Anxiety Disorder
- Functional Neurological Symptom Disorder
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder,
- Malingering
- Other Specified Somatic Symptom and Related Disorder
- Unspecified Somatic Symptom and Related Disorder

DSM IV vs. DSM V

- DSM IV emphasized medically unexplained symptoms
- Reinforces mind-body dualism
- Overlapping definitions

- DSM V emphasizes positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms) rather than the absence of a medical explanation for somatic sypmtoms
- Affective, cognitive, and behavioral components now included in criteria
- Can accompany medical disorders

Somatic Symptom Disorder (Somatoform Disorder)

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
   - Disproportionate and persistent thoughts about the seriousness of one's symptoms.
   - Persistently high level of anxiety about health or symptoms.
   - Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

- **With predominant pain** (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:

- **Persistent:** A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

- **Mild:** Only one of the symptoms specified in Criterion B is fulfilled.
- **Moderate:** Two or more of the symptoms specified in Criterion B are fulfilled.
- **Severe:** Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

Clinical Features

- high level of medical care utilization, which rarely alleviates the individual's concerns
- may seek care from multiple doctors for the same symptoms
- often seem unresponsive to medical interventions
- new interventions may only exacerbate the presenting symptoms
- some individuals with the disorder seem unusually sensitive to medication side effects
- some feel that their medical assessment and treatment have been inadequate.

Somatic Symptom Disorder: Clinical Features

- Patients believe they have a serious disease that has not yet been detected and they cannot be persuaded to the contrary.
- May be specific or non specific
- May represent normal bodily sensations or discomfort that does not generally signify serious disease
- The disease may change
- Convictions persist despite negative laboratory results, benign course of disease, and appropriate reassurance.
- Not delusional
- Suffering must be real!
- Difficult to redirect

Are these delusions?

- A delusion is a fixed, false, belief that is not shared by others. They can be bizarre or nonbizarre.
- individual's beliefs that somatic symptoms might reflect serious underlying physical illness are not held with delusional intensity but the individual's beliefs concerning the somatic symptoms can be firmly held.
- In delusional disorder, somatic subtype, the somatic symptom beliefs and behavior are stronger than those found in somatic symptom disorder.
- Absence of other psychotic symptoms in SSD
- Usually bizarre, idiosyncratic, and out of keeping with their cultural milieus in DD
- Delusion of infestation, dysmorphophobia, foul body odors

Somatic Symptom Disorder: Treatment

- Psychotherapy: individual and group
- Frequent regular physical exams
- Invasive of therapeutic procedures only in the presence of objective data
- Pharmacotherapy targeting any associated psychiatric or medical diagnosis

Illness Anxiety Disorder

A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Illness Anxiety Disorder

Specify whether:

- **Care-seeking type:** Medical care, including physician visits or undergoing tests and procedures, is frequently used.
- **Care-avoidant type:** Medical care is rarely used.

Illness Anxiety Disorder

- New to DSM V
- There are few or no somatic symptoms and persons are primarily concerned with the idea they are ill.
- Or people who have a medical illness with anxiety out of proportion to diagnosis and who assume the worst outcome imaginable
- Cannot have fixity of a delusion
- Cannot be about be distress about appearance

- https://www.youtube.com/watch?v=bv26dLnbi9g
- https://www.youtube.com/watch?v=_-E6aQIfN6g

Functional Neurological Symptom Disorder (Conversion Disorder)

A. One or more symptoms of altered voluntary motor or sensory function.
B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
C. The symptom or deficit is not better explained by another medical or mental disorder.
D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Functional Neurological Symptom Disorder (Conversion Disorder)

- *Specify* symptom type:
- **(F44.4) With weakness or paralysis**
- **(F44.4) With abnormal movement** (e.g., tremor, dystonic movement, myoclonus, gait disorder)
- **(F44.4) With swallowing symptoms**
- **(F44.4) With speech symptom** (e.g., dysphonia, slurred speech)
- **(F44.5) With attacks or seizures**
- **(F44.6) With anesthesia or sensory loss**
- **(F44.6) With special sensory symptom** (e.g., visual, olfactory, or hearing disturbance)

Functional Neurological Symptom Disorder

- Judged to be caused by psychological factors because the illness is preceded by conflicts or other stressors
- Not explained by a neurological condition
- NOT INTENIONALLY PRODUCED
- Not caused by substance abuse
- Gain is psychological
- High comorbidity with neurological disorders

Functional Neurological Symptom Disorder

- Paralysis, blindness, and mutism are the most common conversion disorder symptoms
- A/w passive aggressive, dependent, antisocial, and histrionic personality disorders
- Depressive and anxiety disorder symptoms accompany
- Sensory: anesthesia, paralysis, and paresthesia especially in extremities
- Motor: abnormal movements, gait disturbance, weakness, and paralysis
- Seizure Symptoms:

Functional Neurological Symptom Disorder

- *La Belle Indifférence* - lack of concern about the nature or implications of the symptom
- Primary Gain – keeping internal conflicts outside their awareness
- Secondary Gain – tangible benefits from being sick
- Identification – modeling of the symptoms of someone important to them

Functional Neurological Symptom Disorder

- Hoover's sign, in which weakness of hip extension returns to normal strength with contralateral hip flexion against resistance
- Marked weakness of ankle plantar-flexion when tested on the bed in an individual who is able to walk on tiptoes;
- Positive tremor entrainment test. A unilateral tremor may be identified as functional if the tremor changes when the individual is distracted away from it. This may be observed if the individual is asked to copy the examiner in making a rhythmical movement with their unaffected hand and this causes the functional tremor to change such that it copies or "entrains" to the rhythm of the unaffected hand or the functional tremor is suppressed, or no longer makes a simple rhythmical movement
- In attacks resembling epilepsy or syncope ("psychogenic" non-epileptic attacks), the occurrence of closed eyes with resistance to opening or a normal simultaneous electroencephalogram (although this alone does not exclude all forms of epilepsy or syncope).
- For visual symptoms, a tubular visual field (i.e., tunnel vision)

Psychological Factors Affecting Other Medical Conditions

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

B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
   - The factors have 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.
   - The factors interfere with the treatment of the medical condition (e.g., poor adherence).
   - The factors constitute additional well-established health risks for the individual.
   - The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.

C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

Factitious Disorder Imposed on Self

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
B. The individual presents himself or herself to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Factitious Disorder Imposed on Another (By Proxy)

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- The individual presents another individual (victim) to others as ill, impaired, or injured.
- The deceptive behavior is evident even in the absence of obvious external rewards.
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Malingering

- Malingering is differentiated from factitious disorder by the intentional reporting of symptoms for personal gain (e.g., money, time off work). In contrast, the diagnosis of factitious disorder requires the absence of obvious rewards(Ford 2011).

Case

- JG is a 37 yo CF with a history of IBS, fibromyalgia, borderline personality disorder, PTSD, and multiple conflicting prior psychiatric diagnoses who presents for 1 week of worsening SI with a plan to overdose. She has multiple acute stressors related to family, eviction, and a URI. She has multple chronic stressors related to her fibro and IBS.
- Has a pan-positive review of systems for mania, depression, dissociative episodes, nightmares, flashbacks, non-descript auditory and visual hallucinations, and non-specific SI. Denies substance abuse/use
- The patient expressed a variety of somatic complaints including pain in all of her joints, lower abdominal pain in a vertical line, nausea, diarrhea, and multiple food intolerances.
- She claims to be here to pursue ECT and refuses psychiatric medications due to multiple GI complaints and intolerances in the past

Other Data:

- She made a series of exaggerated statements throughout the interview such as “when I get stressed my intestines bleed”, “how do I get rid of imaginary friends?”, and “if my husband accidentally brushes up against me in my sleep I sometimes hit and choke him”
- Came to VPH with a packed suitcase
- Review of records reveals she has been seen by multiple sub-specialties for a variety of complaints over the last 5 years. All without identifiable etiology for complaints other than fibromyalgia and IBS

Past History

- Psych:
  - Inpatient: Multiple hospitalizations at VPH as well as community facilities, most recently at VPH in Jan 2014 with same presentation. Seen by the consult service multiple times.
  - Outpatient: Seen multiple providers and now at Center for Integrative Health
  - Suicide Attempts: Multiple via overdose and also “tried to get the cops to shoot me”; history of cutting
  - Extensive history of physical and sexual abuse as a child and adolescent. “gang rape” as a child

- Denies Sub A hx, withdrawal, head injury, seizures, family hx, or legal history.

Past History

- Medical:
  - Fibromyalgia
  - IBS
  - GERD
  - Migraines
  - Gestational Hypertension
  - Fibrocystic Breast Disease
  - Pancreatitis x 2
  - Pyelonephritis
  - PE/DVT after OD
  - Hypothyroidism
- Surgical:
  - Cholecystectomy
  - Tonsillectomy
  - L ureter reimplantaion
  - 4 complicated SVD
  - Multiple EGD/Colonoscopies
  - R knee surger
  - R shoulder surger
- Allergies:
  - Saferous
  - Maxalt
  - Lamictal
  - Fanapt
  - Geodon
  - Morphine
  - Nicotine
  - Milk
  - Eggs
  - Wheat
  - Corn
  - Amitriptyline
- Meds
  - Ambien 10mg
  - Ativan 1mg BID
  - Bentyl 1-2 TID
  - Levothyroxine 88mcg
  - Prazosin 4mg
  - Cymablta 60mg
  - Topamax 100mg qHS

Mental Status Exam

Appearance: A 37 yo CF who was found seated in a chair, dressed casually, but wearing heavy eye makeup. Appears older than stated age. Good Hygiene

Attitude: demonstrative, labile, skeptical, and solipsistic

Thought Process: Circumstantial

Thought Content: fixated on somatic symptoms and food/dietary concerns

SI/HI: endorses both

Perception: non descript AVH

Mood/Affect: Mood is “depressed”; affect is labile and irritable when discussing somatic illness but remains emotionally neutral when discussing traumatic and distressing content related to psychiatric symptoms.

Activity, Speech, Associations, Judment/Insight, Orientation, Memory, Attention, Lang, and FoK are unremarkable.

Physical Exam

Hospital Course:

- Day 1: Complained of abdominal pain, N, and joint pain. Dietary consult # 1. :Labs WNL
- Day 2: Complained of abdominal pain and migraine. ECT consult
- Day 3: Complained of abdominal pain and migraine. Dietary Consult #2. UA WNL
- Day 4: Complained of abdominal pain, arm swelling, and joint pain.
- Day 5: Complained of arm swelling, abdominal pain, joint pain, and migraine. Medicine Consult. Labs WNL
- Day 6: Complained of Abdominal pain, arm swelling, migraine, and dietary concerns.

Hospital Course

- Day 7: Complains of constipation;
  - IM Consult Note: Joint pain not attributable to Fibromyalgia; Abdominal pain = functional abdominal pain; arm asymmetry = not pathologic
- Day 8: Complains of arm swelling, abdominal pain, joint pain, and migraine.
- Day 9: Complains of arm swelling, abdominal pain, joint pain, and migraine.
- Day 10: Complained of arm swelling, abdominal pain, joint pain, and migraine. Request discharge for lack of concern of medical problems

Differential Diagnosis

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