Somatic Symptom Disorders: Diagnosis and Treatment

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09 February 2017
Disclosure

• Commercial support – None

• Grant support
  • National Institutes of Health
  • Mayo Clinic

Off-label medication use

• No medications are approved to treat somatic symptom disorders.
Overview

1. What we think we think.
2. Watch your language.
3. What it is, not what it’s not.
4. Treat the untreatable.

“Patients want an explanation for their suffering, but do not want to be laughed at, or worse, considered to be insane.”

- Carl Westphal, 1871
Thought Question:

Compared to patients whose symptoms are explained by a medical condition, individuals with medically unexplained symptoms

1. Rate their physical well-being as poorer
2. Are less satisfied with medical care
3. Utilize more medical services
4. Are much more likely to have histories of childhood adversity
5. All of the above
6. None of the above
Medically explained vs. unexplained
Is that the right question?

• Population-based study, 9 patient populations, 5 countries, N=28,377
  • Total number of symptoms predicted:
    • Poorer health status
    • Greater healthcare utilization

• Specialty clinic study, UK Cardiology, GI, Neurology, N=292
  • Total number of symptoms (top quartile, >9) predicted:
    1. Lower physical well-being (SF-36)
    2. Greater utilization - # medical visits (NHS chart review)
    3. Poorer satisfaction with MD’s explanation of symptoms

The explained versus unexplained dichotomy was NOT significant.

Tomenson, et al., Br J, Psych, 2013;
Creed, Psych Clin N Am, 2011
Medically explained vs. unexplained
Is that the right question?

- Tertiary psychosomatic medicine clinic (Mayo Clinic)
  - 154 Patients, 1930 symptoms (12.5 symptoms/patient)
- 60% of patients had at least one medically unexplained symptom
- 90% of patients had at least one medically explained symptom
  - Only 10% had no medically explained symptoms

- Explained vs. unexplained
  - No difference in disability – work, home, social life
  - No difference in depression, anxiety, illness anxiety

Most patients have a MIX of “explained” and “unexplained” symptoms.
The dichotomy matters NOT for disability and psychiatric morbidity.
The dichotomous hierarchy

- Faulty logic of “Medically Unexplained”
- When does B = Not A?

It is impossible to define anything solely by what it is not!
20th Century

B = Not A

21st Century

A, B, C (and U) may exist in any combination and develop in any order

Explained

Unexplained

“rule out”

Psychiatric

Structural (including cellular) Metabolic

Functional

“rule in”

Dieterich, Staab, Brandt, “Functional (psychogenic) dizziness” in Hallett et al., eds., Functional Neurologic Disorders, 2017
Classifications of Somatic Symptom Disorders

**DSM-5**
- Somatic symptom disorder
- Illness anxiety disorder
- Conversion disorder (Functional neurologic symptom disorder)

**ICD-11 draft**
- Bodily distress disorder
- Hypochondriasis
- Dissociative
  - Motor disorder
  - Sensation disorder
  - Sensorimotor disorder
  - Amnesia

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http://apps.who.int/classifications/icd11/browse
Somatic Symptom Burden (SSB)

Two parts

1. Number of physical symptoms regardless of cause
   - Linear relationship to several poor outcomes
     - Physical well-being
     - Medical Utilization
     - Satisfaction with care

2. Sense of symptoms being burdensome
   - Not yet well characterized

   • Measures
     - PHQ-15 (SSS-8) -- “How much have you been bothered …”
     - Somatic Symptom Experiences Questionnaire (SSEQ)
     - Somatic Symptom Disorder B-criterion Scale (SSD-12)
       - Cognitive, affective, behavioral symptoms

Illness Anxiety

• Three key elements
  1. Body vigilance
     • Excessive amount of a good thing
  2. Catastrophic thinking about illness
     • Causes – hypochondriacal worries
     • Consequences – common and overlooked
  3. Inability to be reassured
     • Unable to tolerate medical uncertainty

• Validated measures
  • Health Anxiety Inventory
  • Whiteley index

Salkovskis, Psychol Med 2002;
Fink et al., J Psychosom Res, 1999
Cumulative Plot

- Cumulative Number of Subjects
- Self-report score

- PHQ
- GAD
- SHAI

- normal
- mild
- moderate
- mod-severe
- severe

Staab JP et al., presented
Treatment

• Education – first and foremost
  - Patients, family members, colleagues
  - Bring them into the 21st century

• Watch your language, help patients with theirs
  - “It’s not all in my head”
    - Somatic symptom burden
  - “I’m not a hypochondriac”
    - Body vigilance, worry, distress about uncertainty
  - “I know it has to be something medical.”
    - Functional XXX disorder
Treatment

• Somatic symptom disorder
  • DSM-III/IV somatization, undifferentiated somatoform disorders
  • Review (34 controlled trials, variable size and quality)
    ★ Consultation letter from psychiatrist/psychologist to primary care clinician identifying presence of SSD.
  • Refocuses medical care
    • Away from acute “find & fix” approach
    • Away from polypharmacy
    • Emphasizes rehabilitation and recovery
    • Behavioral and lifestyle management
    • Allows for proper medical diagnoses and treatment

Kroenke K, Psychosom Med, 2007
Treatment

• Somatic symptom disorder

  1. Cognitive behavior therapy
  2. Short-term psychodynamic psychotherapy
     Both therapies ↓ symptoms, distress, disability
  3. Antidepressants – as symptom modulators
     • TCAs, SNRIs, (mirtazapine) > SSRIs
     • Headache disorders – migraine and tension type HA
     • Chronic pain – neuropathic pain, fibromyalgia
     • Visceral hypersensitivity – functional GI disorders

*Abbass, et al., Psychother Psychosom, 2009*
*Sumathipala A, et al., Br J Psych, 2008*
Treatment

• **Somatic symptom disorder**
  • With predominant pain

• Multidisciplinary pain rehabilitation programs
  • Focus on ability not disability, activities not symptoms
    • Recovery not relief!
  • Behavioral activation – with proper pacing
  • Relaxation
  • Distress management
  • Exercise
  • Psychotherapy over pharmacotherapy
Treatment

- Illness anxiety disorder
- Focused CBT
  - RCT of 187 patients with DSM-IV hypochondriasis
    - 102 CBT – 6 sessions & letter to primary MD
    - 85 treatment as usual
  - 6 and 12-month follow-up
  - CBT group had:
    - Lower levels of hypochondriacal beliefs and behaviors
    - Lower levels of illness anxiety
    - Better functioning in social roles and IADLs
    - But NO change in somatic symptoms

Barsky & Ahern, JAMA, 2004
Treatment

- Illness anxiety disorder
- Mindfulness-based cognitive therapy
  - RCT of 74 patients with DSM-IV hypochondriasis
  - 36 MBCT – 6 sessions & letter to primary MD
  - 38 treatment as usual (unrestricted services)
- 12-month follow-up
  - MBCT group had:
    - Lower levels of illness anxiety
    - Fewer sustained diagnoses of hypochondriasis (50% vs 76%)

McManus et al., JCCP, 2012
Treatment

- Illness anxiety disorder
- SSRIs – Naturalistic follow-up after two small studies
  - 18 months after 16-week RCT
    - CBT (N=33) versus paroxetine (N=29)
    - Initial positive outcomes were sustained equally well
  - 4.5 years after RCTs – pooled data
    - Various SSRIs, mostly fluoxetine (N=58)
    - Initial response: SSRI vs. placebo: 54% vs. 24%
    - Follow-up: 60% did not meet DSM-IV hypochondriasis
    - Partial adherence predicted poorer outcome

Greeven et al., J Behav Ther Exp Psychiatry, 2009;
Conclusions

1. It’s not what we thought.
   • Abandon the concept of “medically unexplained.”
   • Rule in, not rule out

2. Watch your language.
   • It’s all “real.”
   • Structural/metabolic, functional, psychiatric

3. What it is, not what it’s not.
   • Somatic symptom burden
   • Illness anxiety
   • Specific functional disorders

4. Treat the untreatable.
   • Education – patients, families, clinicians
   • Psychological therapies – CBT and Mindfulness-based CT
   • Carefully selected use of medications (illness anxiety & pain)