

Somatoform Disorders

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Somatoform Disorders

- Somatization Disorder
- Undifferentiated Somatoform Disorder
- Pain Disorder

- Conversion Disorder

- Hypochondriasis
- Body Dysmorphic Disorder

- These are not factitious disorders!
 - Not intentional or feigned illness...not Munchausen's!

Views of Somatization Disorder MUS – Medically Unexplained Sx

- “Somatization”: process and disorder
- Polysymptomatic MUS, chronic, primarily affecting women
- Briquet’s syndrome:
 - 25 of 59 MUS in 9 of 10 symptom groups
- Somatization Disorder
 - DSM-III-R: 13 of 35 MUS
 - DSM-IV: 4 pain, 2 GI, 1 genitourinary/sexual and 1 pseudoneurologic

DSM-IV Somatization Disorder

- Many physical sx before age 30
 - Result in treatment or impairment
- Low Prevalence: 0.2%-2% women, <.2%men
- Criteria;
 - Pain (4): head, abdomen, back, joints...
 - GI (2): nausea, bloating, vomiting, diarrhea
 - Sexual (1): indifference, dysfunction, irregular menses
 - Pseudoneurological (1): balance, paralysis, trouble swallowing, lump in throat, urinary retention

Abridged Somatization

- **Problem:**
 - DSM Somatization Disorder is rare but MUS are common
- **“Polysymptomatic Somatoform Disorder”:**
 - 7 MUS over two years (Rief and Hiller 1999)
 - Psychological factors (faulty attribution, hyperattention)
- **“Abridged Somatization”** (Escobar 1989)
 - 4 MUS in men or 6 MUS in women from 40 Symptoms
 - 12% prevalence in United States ECA study
- **“Multisomatoform Disorder”** (Kroenke 1997)
 - 3 MUS from a 15 item checklist with a 2 year history
 - 8% of 1000 primary care pts met criteria

Medical Conditions that may manifest as Anxiety

- **Cardiac**
 - Angina, CHF, MI...
- **Endocrine**
 - Hyperadrenal, hyper- or hypothyroid...
- **Infectious/Immuno.**
 - Systemic lupus
 - Lyme disease
- **Hormonal tumors**
 - Carcinoid
 - Pheochromocytoma
- **Metabolic**
 - Hyponatremia, hypoglycemia
 - Hyperkalemia, hyperthermia
- **Neurologic**
 - Seizure disorders, esp Temp.
 - Akathisia, Vertigo...
- **Respiratory**
 - COPD, Asthma, PE...
- **Drugs**
 - Reserpine, INH, Caffeine, Dig toxicity, pseudoephedrine...

General Medical Symptoms in Patients with Panic Disorder referred to Primary Care

(Katon, Am J Med, 1984)

- **Neurologic** 44%
 - Headache (20%)
 - Dizziness (18%)
 - Syncope/pseudo-seizures (9%)
- **Cardiac** 39%
 - Chest pain (22%)
 - Tachycardia (25%)
- **Gastrointestinal** 33%
 - Epigastric pain with hx of peptic ulcer (15%)
 - Epigas. pain w/o ulcer (13%)
 - Diarrhea (13%)
- **Respiratory** 15%
 - Shortness of breath (13%)
 - Asthma (5%)
- **Alcoholism** 15%

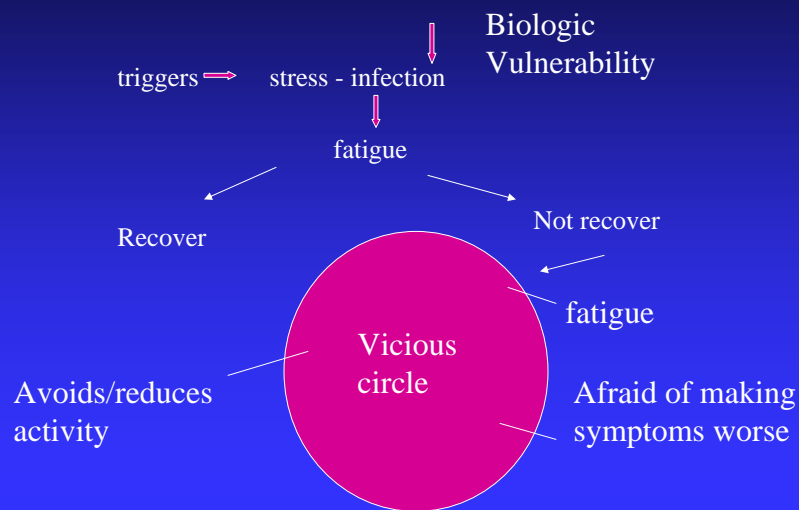
Functional Somatic Syndromes?

- Fibromyalgia
- Chronic Fatigue Syndrome
- Irritable Bowel Syndrome

- Are these somatoform disorders?
- These patients are often included in studies of somatization. Diagnostic misclassification?

Model of Chronic Fatigue Syndrome

(Chalder, 2002)



Conversion Disorder

- A. Motor or sensory sx suggest a neurologic or general medical problem ("pseudoneurologic")
- B. Psychological factors are key, as stressors precede onset of deficit/symptoms (a symbolic resolution that keeps psychological conflict out of conscious awareness)
- C. Sx are not intentional, as in Factitious Disorder or Malingering
- D. Cannot be fully explained by:
 - A. General medical condition or effects of substance
 - B. Culturally sanctioned behavior
- E. Causes significant distress or impairment
- F. Not limited to pain or sexual dysfunction

Common Conversion Symptoms

- Motor:
 - Impaired coordination or balance
 - Paralysis or localized weakness
 - Inability to speak
 - Difficulty swallowing or lump in throat
 - Tremors
 - Seizures or convulsions
- Sensory:
 - Loss of touch or pain sensation
 - Double-vision, blindness
 - Deafness, hallucinations

“The Grief that has no vent in
tears
Makes other organs weep.”

Maudsley

Clinical Features of Conversion

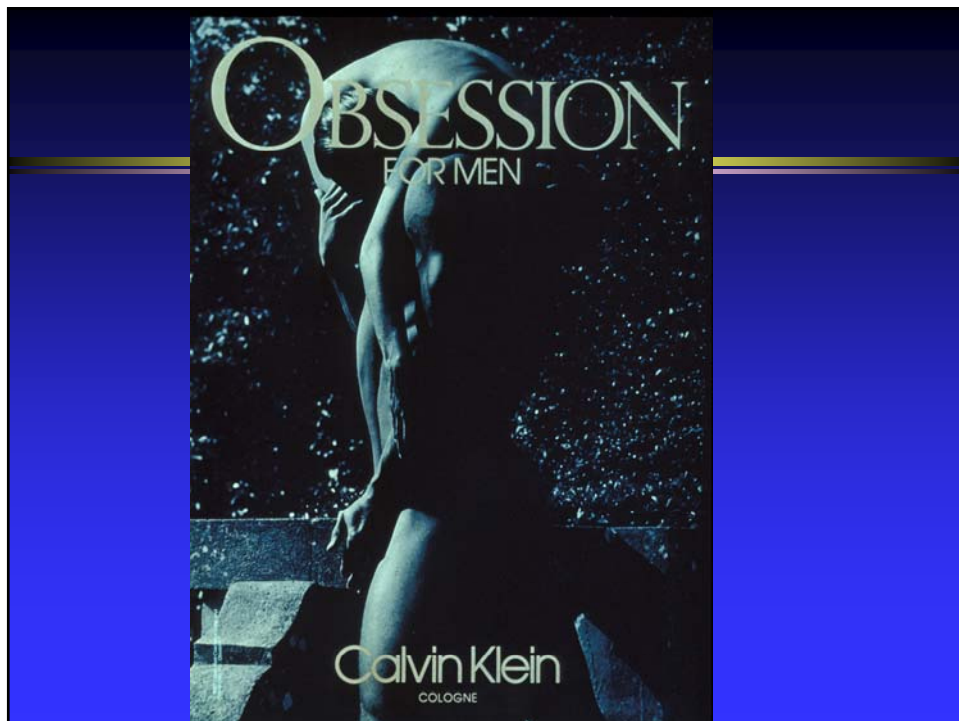
- Onset between age 10-35
- Onset is usually acute
- Symptoms are usually of short duration
- May present in dramatic fashion or with “la belle indifference”
- Prevalence varies widely from 0.1-3/10,000 general population....much higher in general neurology clinics

Clues to Conversion Symptoms

- Paralysis
 - No loss of muscle tone, inadvertent movement when dressing, intact reflexes
 - Arm moves when dropped on face
 - EMG is normal
- Difficulty swallowing equal with liquids & solids
- Seizure does not have paroxysmal activity on EEG
- “La belle indifference”.

Pain Disorder

- Pain
- Common (10-15% of adults in the U.S. in any given year have disability from back pain)
- Psychological factors have a role in onset, severity, exacerbation or maintenance of pain
- Common Medical:
 - Musculoskeletal (disc herniation, arthritis)
 - Neuropathies (diabetic, post-herpetic)
 - Malignancies



Body Dysmorphic Disorder

- A. Preoccupation with an imagined or slight defect in physical appearance
- B. Causes significant distress or impairment
- C. Classified as a somatoform disorder but its delusional variant is classified as a psychotic disorder (“delusional disorder, somatic subtype”)

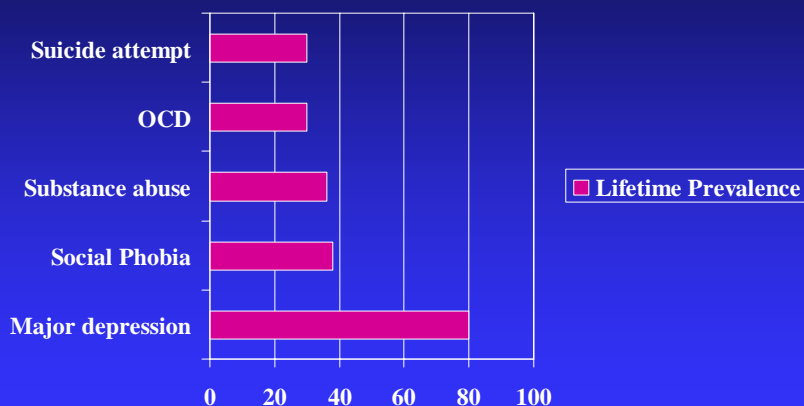
Clinical Features of BDD

- **Demographics:**
 - Mean age of onset 16 yrs, equal gender distribution, majority never married
- **Preoccupations:**
 - usually involve face or head
 - asymmetry concerns (“uneven buttocks”)
 - Focus on flaws 3-8 hrs/day
- **Compulsive Behaviors:**
 - Comparing, checking, grooming, camouflaging, reassurance seeking
- **Psychological impact**
 - Shame, defective, low self-esteem, rejection sensitive

Prevalence of Body Dysmorphic Disorder

- Common in certain clinical settings:
 - Dermatology: 12% screen + for BDD
 - Cosmetic surgery: 6%-15% BDD
- Relatively common with other disorders:
 - OCD: 8%-37% have BDD
 - Social Phobia: 11%-13% have BDD
 - Trichotillomania: 26% BDD
 - Atypical depression: 14-42%
- BDD is usually not recognized or diagnosed

Comorbidity in BDD



Insight in Body Dysmorphic Disorder

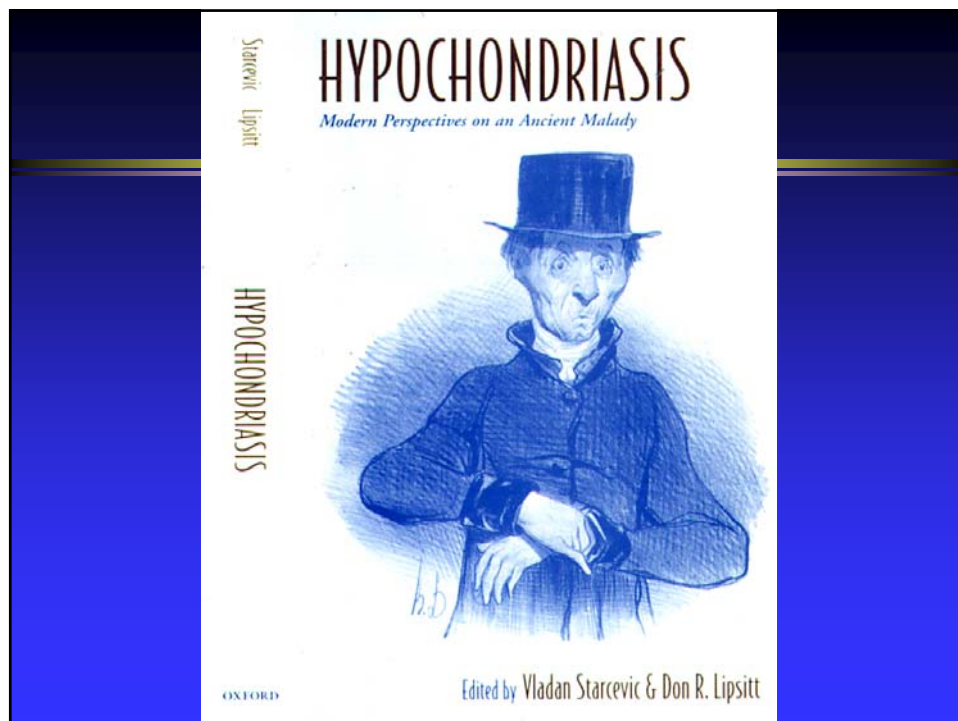
- Many are delusional about the “defect” for a significant period of time
- Many have ideas or delusions of reference
 - Example: “others are staring at my defect”
 - Referential thinking contributes to social isolation
- Insight shifts over time
- Delusional symptoms are reduced by SRIs alone but not by typical or atypical antipsychotics alone

Similarities between BDD and OCD

- Similarities include
 - Prominent obsessions & compulsive behaviors
 - Similar sex ratio, illness severity, course of illness, and comorbidity
 - Similar neurocognitive deficits (overfocus on irrelevant stimuli)
- Differences include
 - BDD: less likely to be married
 - BDD: poorer insight
 - BDD: More likely to have had suicidal ideation
 - BDD: May not respond as well to behavioral treatment (without a cognitive component). Sx more often accompanied by shame, humiliation, rejection sensitivity.

Controlled Pharmacologic Studies of BDD

- **Clomipramine vs Desipramine** (Hollander 1999)
 - 16 wk double-blind cross-over trial
 - CMI was superior to DMI
- **Fluoxetine vs Placebo** (Phillips 2002)
 - 12 wk double-blind trial
 - Fluoxetine more effective starting at wk 8
 - Responder rate of 53% (F) vs 18% (pl)
 - Response independent of severity, comorbidity
 - Delusional status did not decrease likelihood of response



5 Books for Hypochondriacs

by **drleathers**, Occasional Hypochondriac

E-mail this list to a friend!

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1. The Coming Plague : Newly Emerging Diseases in a World Out of Balance
by Laurie Garrett (Paperback - October 1995)
Average Customer Review: ★★★★★
Usually ships in 24 hours
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2. Virus Hunter : Thirty Years of Battling Hot Viruses Around the World
by Mark Olshaker, C. J. Peters(Contributor)
(Paperback - May 1998)
Average Customer Review: ★★★★★
Usually ships in 24 hours
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3. Sex : What You Don't Know Can Kill You
by Marion McIlhane(Contributor), Joe S., Jr.
McIlhane (Paperback - March 1997)
Average Customer Review: ★★★★★
Usually ships in 24 hours
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4. The Hot Zone
by Richard Preston (Paperback - August 1995)
Average Customer Review: ★★★★★
Usually ships in 24 hours

The Hypochondriac's Handbook

BUY FROM AMAZON.COM

by [Wendy Marston](#)

★★★★★ **The perfect gift for that special paranoiac in your life,**
November 26, 1998

Reviewer: **A reader**

This book is a wonderful way to torture anyone who has ever thought twice about touching that doorknob. Lots of fun and chilling information about the germs, microbes, and other agents of death that are everywhere around us, invading us insidiously, hastening disease. Do not read this book on the toilet, for example. Written with humor and a sly sadism, this is a user-friendly manual that, if studied and heeded, could add years to your life, provided you spend them in a plastic bubble. A perfect stocking-stuffer for anyone who thinks it's safe to shake hands--and for those who know that it isn't.

Hypochondriasis (DSM IV)

- Fear or belief that one has a serious disease based on bodily symptoms
- Persists despite medical reassurance
- Belief is not delusional nor restricted to concerns about appearance
- Causes distress or impairment
- Lasts at least 6 months
- Not better accounted for by GAD, OCD, Panic Major depression, another Somatoform dx.

Mad Cow Disease

- 24 Year old, well-educated, high functioning female, developed terrifying fear of having “mad cow disease” after hearing on TV that fatigue might be an early sx. Checked frequently for reassurance. Avoided any signs of beef.
- History:
 - Age 12: Fear of death started, focused on illnesses. Age 14, she saw a church play about the end of the world and became terrified of earthquakes or signs from God that the world was ending. Age 16: bruised coccyx....possible rectal cancer? Age 21: HIV fear. Age 23: Pain in arm/rib: Leukemia?...Bone cancer?...Heart problems?...Ovarian Ca?...Breast Ca?
- Treatment: Luvox 300 mg/day....very much improved

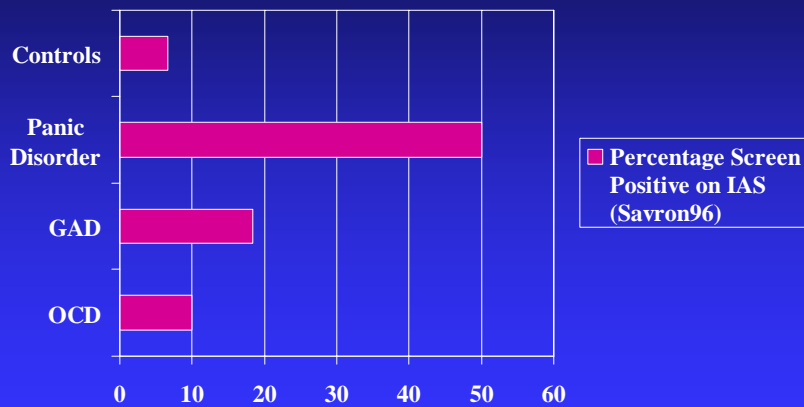
Hypochondriasis responsive to antibiotics: The Case of the retired man, Mr. Z

- Past Hx: A lifetime worrier, Mr. Z had hypochondria acutely 8 years earlier which responded well to ECT
- Current: Hypochondriasis re-emerged with retirement, but was unresponsive to ECT and to drug therapy.
- Current Sx: Fear of Cancer....or is it shingles doc?
 - 40 lb weight loss over 4 months
 - Bodily vibrations in the morning
 - Early morning awakening
 - Dry mouth
 - Itchiness all over his body
 - Legs are cold/warm in some areas
 - BP is normal -- “Does that mean I’m going into shock?”
 - Eye pressure
 - Tingling
 - Freq urination
 - Rib pains
 - Wrinkles on arm

The Case of Mr. Z (continued)

- Other symptoms:
 - paranoia, myalgias, testicular pain, fasciculations, lower back pain, shooting pains, vision change, headaches
- Tx: No response to fluvoxamine(300 mgs) x 8 weeks
- New onset bull’s eye rash....?Satelite Erythema Migrans?....Could Lyme Disease be present?
 - Lab #1: ELISA +, WB equivocal/negative
 - Lab #2: ELISA -, + WB (4-6 CDC IgG bands)
- Treatment: 4 mos. Oral Doxy 100 tid & 2 mos Biaxin
- Outcome: - no longer hypochondriacal
 - no longer complaining of physical symptoms

Hypochondriasis in Anxiety Disorders



Similarities between Hypochondria and OCD

- Similarities include
 - Prominent obsessions and compulsions
 - Pathologic doubt
 - Responsiveness to Serotonin Reuptake Inhibitors
- Differences include
 - Hyp: older age of onset (early 20s)
 - Hyp: female gender preference (3:1)
 - Hyp: unexplained somatic sx more common
 - Hyp: may have less insight about Irrationality of fears
 - Hyp: larger placebo response
 - Hyp: fear of **having an illness** (Hyp) vs fear of **getting an illness** (OCD). (In one study, hyp worried 4x more frequently about having an illness than about getting an illness).

Family Studies

- Hypochondriasis (Noyes et al, 1997)
 - 19 hyp & 72 relatives vs 24 non-hyp medical pts & 97 relatives
 - No Diff. in freq of hypochondria bet two groups of relatives. Only Somatization Disorder was more freq among the hypochondriasis relatives. Hyp relatives also had more hostility, antagonism, & dissatisfaction with medical care
- OCD Spectrum Disorders in OCD vs controls
 - 80 OCD & 343 relatives vs. 73 controls & 340 relatives
 - Hyp, BDD, and any eating disorder occurred more frequently in cases and first degree relatives

Are hypochondriacs physiologically more sensitive?

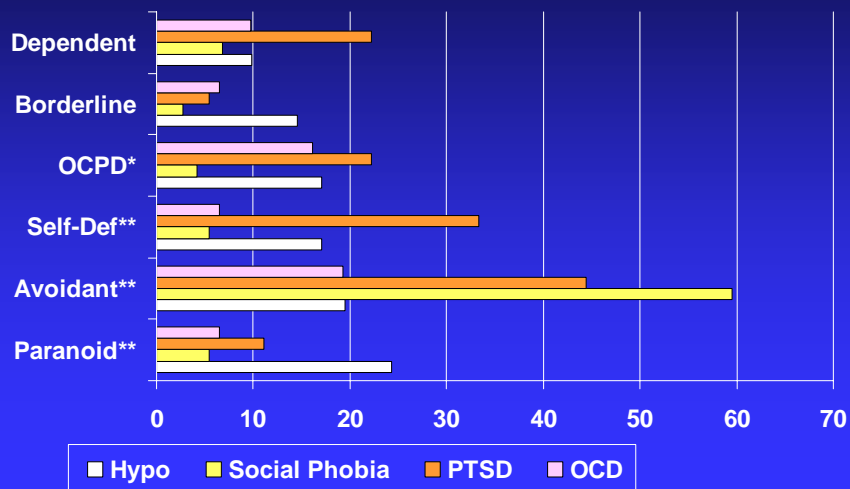
- High and Low hypochondriasis groups do not differ on sensitivity to pain based on heat pain thresholds (Lautenbacher et al, 1998 J Psychosomatic Research, n=28)
- Hypochondriacs are not better able to discriminate normal physiological cardiac sensations than non-hypochondriacs
- Hypochondriacs rate themselves as more sensitive to benign sensations but are not better able to discriminate two tactile bodily signals (Haenen, n=27 Hyp vs 27 healthy controls, 1997, PsychotherPsychosom)

Do patients with hypochondria have greater personality disorder comorbidity?

- Methods: SCID-II administered to patients entering Anxiety Disorder Treatment trials
- Results: Presence of DSM Per.Dis.

■ Hypochondriasis:	22/41	54%
■ Social Phobia:	45/74	61%
■ PTSD:	10/18	56%
■ OCD:	11/31	35%
- Conclusion: No significant difference in frequency of P.D. across diagnostic groups

Which Personality Disorders were significantly more frequent among patients with Hypochondriasis?



Natural Course of Hypochondria

- Barsky et al, Arch Gen Psychiatry 1998

- Methods:
 - Prospective Case-control study with a 4-5 yr FU of 120 Hyp and 133 non-hyp medical controls
- Results:
 - 36.5% no longer had DSM-III-R Hypochondriasis
 - Hyp sample has less hyp and somatiz than at base
 - Less disease conviction & somatiz at baseline were associated with loss of Hyp dx at follow-up
 - Sig more medical illness during FU interval occurred in those patients who were no longer Hyp

Typical Dysfunctional Thoughts (Salkovskis 1996)

“Bodily changes are usually a sign of disease.”

“Every symptom has to have an identifiable physical cause”

“If you don’t go to the doctor right away, then it will be too late”

“If I don’t worry about my health, then I could get sick.”

Cognitive-Behavioral Tx of Hypochondriasis

- Barsky et al, Br J Psychi 1996

- Methods:
 - Cog-Beh therapy or wait-list control
 - 32 pts, weekly sessions x 16 weeks
- Results:
 - Significantly greater improvement among the CBT treated patients
 - Improvement sustained over a 3 mon FU
- Question:
 - Is a wait-list an adequate control?

SRI Therapy of Hypochondriasis: Uncontrolled Series

- Imipramine (Wesner & Noyes, 1991)
 - 8 week trial, 10 pts with good insight, 150 mg/d:
100% moderate improvement
- Fluoxetine (Fallon 1993)
 - 12 week trial, 16 pts without Maj Depression, up to 80 mg/d: 71% much or very much improved
- Fluvoxamine (Fallon 2001)
 - 10 week trial, 18 pts, 2 wk placebo run-in, 300 mg/d:
73% of 11 pts who completed at least 6 wks improved
- Paroxetine (Oosterbaan et al, 2001)
 - 12 week trial, 11 pts entered, up to 60 mg/d: 88.9% of 9 completers were at least much improved (5 very much)

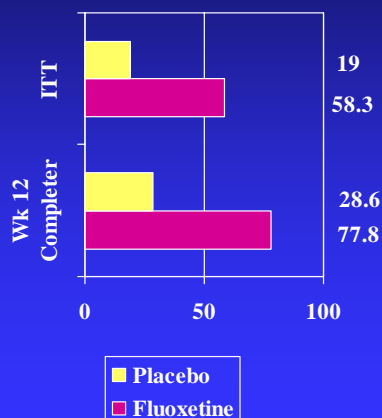
Controlled Fluoxetine Trial of HIC: Week 12 Primary Outcome Measure Results

CGI Responder rate
(much or very much improved)

- Fluoxetine significantly more effective than placebo in ITT and completer analyses
- Of Wk 12 Completers:
Very much improvement:
Fluox: 7/18 (38.9%)
Placebo: 1/14 (7.1%)

Sum: Fluoxetine is effective for Hypochondriasis, starting at week 8.

CGI Responder Rates



Was the presence of any Personality Disorder at baseline associated with a poor treatment response?

	CGI Responder rate	
With Personality Disorder	9/15	60%
Without Personality Dis.	9/14	64%

Therefore, the presence of at least one comorbid Personality Disorder was not associated with poor outcome.

What do you write in the Chart?

- A hospital chart that has the diagnosis “hypochondriasis” in it could be harmful for the patient in the future.
- A less problematic and more accurate term that would not result in automatic negative inferences by future health care providers would be “illness anxiety” or “heightened illness concern”.

Disorder	Fear / Focus	Risk
Body Dysmorphia	Bodily defect	Surgery
Somatization Disorder	Symptoms	Tests/meds/ surgery
Hypochondriasis	Disease	Tests/vague diagnoses
Somatoform Pain	Pain	Pain med dependence

