ECHO Idaho: Behavioral Health in Primary Care

Somatic Symptom and Related Disorders
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The speaker has no significant financial conflicts of interest to disclose.
Learning Objectives

• Define Somatic Symptom Disorder based on updated DSM-5 criteria
• Learn to identify Somatic Symptom Disorder in patients, avoid pitfalls
• Learn tools to manage and treat condition
• Overview and review of psychogenic nonepileptic seizures
Epidemiology

• 5-7% of general population
• 20-25% of those with acute somatic symptoms develop a chronic somatic illness
• 10:1 female to male ratio
• Can develop in childhood, adolescence or adulthood
Etiology

- Heightened awareness of sensations and tendency to attribute them to medical illness
- Risk factors: Abuse, neglect, trauma, history of alcohol and substance abuse
- Association with personality disorders
Diagnostic considerations

• Risk of overtesting, overtreatment—significant potential for harm

• Problem of significant patient concern about physical symptoms, strong conviction that these are not related to psychiatric illness

• Must be persistent (greater than 6 months)—applies to state of being somatic, but not necessarily the specific symptom—as symptoms evolve, pattern may be missed
DSM-5 changes

• Change from somatoform to somatic symptom disorder and other related disorders
• Encompasses: Conversion disorder, Factitious disorder, illness anxiety disorder (hypochondriasis)
DSM-5 criteria for Somatic Symptom Disorder

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

B. Excessive thoughts, feelings, behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
   1) **Disproportionate and persistent thoughts about the seriousness of one's symptoms.**
   2) **Persistently high level of anxiety about health or symptoms.**
   3) **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 - **more than 6 months**.

Specify if predominant pain, persistent and **mild, moderate or severe**

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Screening

- Patient Health Questionnaire-15
- Somatic symptom scale-8

- Able to identify the somatic symptom burden, but also must meet diagnostic criteria and evaluate for depression and anxiety overlap
Management—CARE MD

• Approach targeted to primary care, but needs a team to execute
• C—Consultation—psychiatry/behavioral health
• A—Assessment—evaluate for comorbid psych and medical illness
• R—Regular visits—short interval follow-up, do not rely on symptom based visits, attempt to mitigate ER visits, large volume of calls
CARE MD continued

• E—Empathy—validate experience of symptoms. Spend time listening to experience.

• M—Medical-psychiatric interface—avoid phrases such as “there is nothing medically wrong with you.” Emphasize mind-body connection

• D—Do No Harm—Minimize unnecessary testing, medication, intervention and referral
Specific therapies

- CBT
- Mindfulness-based therapy
- Pharmacotherapy—amitriptyline, Prozac, St. John’s Wort (Not Wellbutrin, MAO-Is, antiepileptics and antipsychotics)
Key Points

• Significant risk of overtreatment—worth diagnosing and naming even if there is overlap with other disorders

• Use screening tools—Patient Health Questionnaire-15 and Somatic Symptom Scale-8 in conjunction with full evaluation of medical and psychiatric comorbidities to identify burden

• Use the CARE MD model for management

• Use evidence based therapies to guide treatment
Psychogenic nonepileptic seizures

- **Involuntary** episodes of movement, sensation, or behaviors (e.g., vocalizations, crying, other expressions of emotion) that do not result from abnormal cortical discharges
- Psychogenic when these are a result of psychological distress
- Can mimic tonic-clonic, absence, simple or complex partial seizures
- Identification can limit significant iatrogenic harm
Diagnosis

• Differentiate from other types of nonepileptic seizures (arrhythmias, syncopal episodes, complex migraines, TIAs, etc.)
• Inpatient video EEG is the preferred test
• Many features suggest diagnosis, but the no single feature or group is diagnostic
• Thorough history, focused physical, vEEG monitoring, once confirmed—Create list of triggers, perpetuating factors, predisposing factors to target therapy
Diagnosis to treatment

• Low threshold to refer for evaluation—average time to diagnosis over 7 years
• Significant risk of harm from overmedication, undertreatment of triggers
• As with other somatic disorders, patient and healthcare team understanding is critical for appropriate treatment
• Significant role for behavioral approaches, psychotherapy, treatment of underlying depression and anxiety
References

• Tadesse, R. (2015) Identifying and treating somatic symptom disorder in the primary care setting. [Powerpoint slides]. Retrieved from https://www.ohsu.edu/...echo/.../Project-Echo-didactic-on-Somatic-Symptom-Disorder...
• Additional references and resources available upon request!