Grand Rounds

SOMATISATION
Assessment and management

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"somatisation is the tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them"

Lipowski 1988

DEFINING CHARACTERISTICS

- Psychological distress manifested in the form of physical symptoms
- Symptoms are not associated with pathological organic abnormality
- The symptoms are attributed by patient and parents to organic illness
- Medical treatment is sought

SOMATISING- terms used

- "somatising"
- "psychosomatic"
- "medically unexplained symptoms"
- "functional"

OVERVIEW OF TALK

- Clinical vignettes
- Epidemiology
- Diagnostic categories
- Historical footnotes(psychiatry)
- Assessment
- Psychological models
- Management

"SALLY"

15 year old living with parents/yr 10 private girls school. Presented following "allergic rash" with dramatic chorea-like movement disorder. Admitted to RCH. Developed lower limb weakness and incontinence. Investigations normal.

Background: only child to professional and devout religious couple

high expectations

(medicine or law)

no sex before marriage

"ELIZABETH"

17 yr old living with mother and younger brother, yr 12 local high school.
Developed (R) arm and leg weakness, diagnosed as Moya Moya disease, required surgery.
Subsequently ongoing symptoms of headaches and episodes of (R) weakness. ?non-organic
Background: mother with MS
parents separated when 5yo("he cheated")
"father abandoned me"
took on role of caring for mother (sister lives with father)
sister the "golden girl", got high TER score
in year 7 sexually assaulted/ unresolved consequences
NOW: can't play sport/ missed school+++/can't travel/increasingly tied to mother/increasing sibling rivalry

"SAMANTHA"

- 15 yo girl living at home with mother and siblings. Admitted to RCH with Abdominal pain. Obese with fatty liver and biliary sludging.
- Mother reported to be busy, Samantha expected to care for siblings. Reported history of violence in past from father.
- Denies school issues/ denies any stress/won't go home until pain is fixed

"SIMON"

11yr old living with professional parents and younger brother, grade 5 private school.
Presented with vomiting/gastro illness followed by fatigue/headaches/nausea/loss of appetite and significant LOW/aches and pains. Admitted to RCH, nasogastric feeds/ rehab. Seen by staff as "resistant" and "playing up to mother" ?functional component
Background:
eldest of 2
"obsessive"/ "controlling"/"won't do anything unless he knows he can do it well"
recognised dyads in family- mo-Simon vs father-brother

"MARY"

16 yo girl living at home with parents and siblings (7th of 8) in rural Victoria, attempting yr 10 at local school. Admitted to RCH for Ix of unusual group of symptoms.
3-4/12 hx of hair loss (circular area of baldness)/ unusual bruises/ back abrasions/polydipsia, polyuria/ reported weight loss/aches and pains/epistaxis.
Past hx of "asthma"/knee dislocations.
Medical investigations normal.
Minimised stressors but hx of being bullied and of bullying
On examination: "la belle indifference"/ articulate and communicative/no explanation for symptoms

EPIDEMIOLOGY

- 24% of children/adolescents (2-17 yo) experience somatic complaints regularly
- 2% "somatisers" (regular health care utilisation- Campo et al)
- Overall, minimal research in in area of SD's in children/adolescents
- Increased risk of being classified as somatiser as get older(4 year follow up/Bremen), 52% remitted/48% same
- Conversion Disorders more likely to remit

CLINICAL SYNDROMES-DSM IV

- Somatisation Disorder
- Undifferentiated Somatoform Disorder
- Somatoform disorder NOS
- Conversion disorder
- Pain Disorder
- Hypochondriasis
- ?fibromyalgia/irritable bowel/chronic fatigue/complex regional pain syndrome (RSD)
- ?factitious disorders

PROBLEMS WITH CLASSIFICATION SYNDROMES

- Criteria established for adults
- No child/adolescent specific research base or developmentally diagnostic classification

DSM V
COMPLEX SOMATIC SYMPTOM DISORDER

- Somatic symptoms causing significant distress or dysfunction in which psychosocial factors may initiate, aggravate or maintain the symptoms
- High levels of > 1 of misattributions/excessive concern/preoccupation with symptoms
- Increased pattern of health care utilisation
- At least 6 months duration

PSYCHOLOGICAL MODEL OF CLASSIFICATION (AC)

- **"DISSOCIATIVE"**
  totally "unconscious"
  "primary gain" most important ("la belle indifference"), secondary gain out of conscious awareness
  "PHYSIOLOGICAL"
  sympathetic/parasympathetic pathways mediating avoidance of "stress" by inducing physical symptoms
- **"ABNORMAL ILLNESS BEHAVIOURS"**
  "unconscious" but element that is learned
  mixture of primary and secondary gain
- **"FACTITIOUS"**
  totally conscious
  either clear secondary gain or "Munchausen" (where emotional needs met by seeking medical care)

HISTORICAL NOTE

"Hysteria" Greek for uterus

Galen Epilepsy vs Hysteria

15th Century Guainerius "vapors from uterus"

18th Century Tissot et al hysterical convulsions

HISTORICAL NOTE

Freud first to use term "conversion" (1893) in "Studies in hysteria":

"For the sake of brevity, we adopt the term 'conversion' to designate the transformation of psychical excitement into chronic somatic symptoms, which is so characteristic of hysteria"

HISTORICAL NOTE

Charcot (neurologist) viewed hysteria as a "neurosis" which he saw as being "organic" with a hereditary basis

Janet (philosopher and neurologist)first to use the word "dissociative" in relation to hysteria- "a division among systems of ideas and functions that constitute the personality"

A defensive response a human being has that involves some form of distancing from or translation of the unbearable

HISTORICAL NOTE

2006 Science section New York Times
"Is Hysteria Real: Brain Images Say Yes"
fMRI SPECT images showing neuronal changes, abN in sensory and motor pathways directly corresponding to hysterical symptoms ("Brain")
"conversion reactions are fixed beliefs of somatic dysfunction arising from psychological distress that control cortical and subcortical pathways to produce patterns of loss or gain of function that are not organic in the conventional sense"
?if paralysis/seizure shown up in a scan, something thought to be "in your head" actually in your body

AETIOLOGY- BIOLOGICAL

- Gender
- Genetic differences in neurotransmitter levels and responses (Serotonin-neuroticism,anxiety; Catecholamin-O-Methyl transferase-pain sensitivity; Tryptophan hydroxylase-somatic anxiety)
- Temperament (behavioural inhibition, harm avoidance)

AETIOLOGY- PSYCHOLOGICAL

- Past trauma
- "alexithymia" not able to relate to psychological models of responses to difficulty
- "don't get stressed"/ avoid anxiety
- conscientiousness
- Poor coping/catastrophize
- Psychopathology such as anxiety/depression

AETIOLOGY-SOCIAL

- Parental behaviour (parents own presentations as "model"/ parents response to somatising/ possible role of the symptom-keeping parents together, distraction from conflict)
- Medical response
- Social response (stigma with "mental" disorder vs "medical disorder")

COMPLEX FAMILY AETIOLOGY

- ALSPAC (8,272 children from pregnancy to 6yo) Parental anxiety and maternal somatic symptoms significant risk factors for FAB
- All other studies retrospective- putative risk factors are somatisation of parents/ organic disease of significant other/psychopathology of close family member/dysfunctional family climate/trauma in family context/insecure attachment

TRIGGERS

- Physical illness
- Peer group problems
- Family dynamics
- Mismatch between academic ability/performance and internalised expectations

PRIMARY AND SECONDARY GAIN

- Primary gain is the avoidance of unpleasant and overwhelming affect (anxiety/anger/depression)
- Secondary gain is tangible and "rewarding" (avoidance of distressing environment, eg school/benefits of being ill/distraction from parental conflict)

EARLY RECOGNITION (diagnosis NOT just by exclusion)

- Not corresponding to organic syndrome
- Not following normal pathway of recovery
- Fluctuates depending on observer
- Pt describes lack of fluctuation/lack of response to treatment
- "Protesteth too much"vehement denial of possible psychological role/ of any stressors
- Past somatising
- Temperamental factors
- Possible secondary gains

ASSESSMENT TOOLS

- Postilnik et al (algorithm- 'sick,somatisers,well',limitations)
- Rask et al (medical record interview)

MEDICAL RECORD INTERVIEW

- Headache
- Syncope/collapse
- Dizziness
- Pain in limb
- Abdominal pain
- Constipation
- Functional diarrhoea

MEDICAL RECORD INTERVIEW

- "Organic" vs "Functional"
- More likely functional if:

not following defined physical illness (duration and severity)

personal or family history of somatising

social or family history of reinforcement

temporal relationship to psychosocial stressor

POSSIBLE SCREENING TOOL "MADISON"

- Multiple symptoms
- Authenticity (need to authenticate the symptom)
- Denial (of possible stressors)
- Interpersonal (variation of symptom with different observers)
- Singular presentation (not in keeping with known organic illness)
- Only you (can help)
- Nothing works

DIFFERENTIAL DIAGNOSIS

- Unrecognised physical illness
- Primary Anxiety or Mood Disorder
- Factitious disorder
- Psychological factors affecting medical condition

PRINCIPLES OF MANAGEMENT

- Treat symptoms seriously
- Investigate appropriately (= until confident that no organic aetiology + after diagnosis, no further Ix unless new symptoms or signs)
- Have "somatising" on list of differentials from beginning and discuss openly when appropriate (involve mental health early if seems recovery may be complicated)

PRINCIPLES OF MANAGEMENT (2)

- Give "positive" dx (eg "somatising illness")rather than "negative" dx (eg "nothing seriously wrong" or "caused by stress")
- Have model of explaining symptoms to patient and parents
- Give plenty of time to communication of diagnosis (be direct/ ready for resistance)
- Regular medical review and "laying of hands"
- Rehabilitation model

PRINCIPLES OF MANAGEMENT (3)

- Psychological treatment if open to possibility of psychological model and/or not getting better
- Manage "the dilemma"/ what is being avoided by the symptom (eg school avoidance/ anxiety secondary to academic performance/ family conflict)

POSSIBLE SOMATISING "MODEL"

- Everyone has different ways of dealing with stress. Some people don't feel "stress" but just "cope". Their minds and bodies have developed ways of avoiding stress/ sympathetic-parasympathetic pathways fire inappropriately to cause physical symptoms (eg diarrhoea when anxious)-end organ normal but symptom as real as if had disease
- These symptoms are protective of the mind-anxiety is a horrible symptom/happen automatically to avoid anxiety/unfortunately they often lead to loss of function
- Normal physical treatments of the symptom don't usually work effectively in somatising=> need to re-train body and mind to function appropriately despite symptom

ASSESSING APPROPRIATENESS OF PSYCHOLOGICAL INTERVENTION

- Are you someone who gets stressed?
- Are there stressful things happening in your life at the moment?
- Is it possible that your symptoms are made worse by stress?

(same for parents regarding their child)

PSYCHOLOGICAL INTERVENTION (THEORETICAL TAILORED)

- "DISSOCIATIVE" (more likely to be open to psychological intervention- ? interpretive/dynamic understanding of symptoms)
- "PHYSIOLOGICAL" (possibility of psychological intervention- ?CBT techniques, symptom relief)
- "ABNORMAL ILLNESS" (unlikely to take up psychological intervention, work with parents towards rehabilitation"
- "FACTITIOUS" (overt it, unlikely to take up psychological intervention)

FORMULATION AND MANAGEMENT OF "SALLY"

- Conversion symptoms only way of dealing with overwhelming distress associated with inability to meet internalised academic expectations and (as discovered over time) with repressed sexual desires
- Individual therapy addressing above issues
- Regular medical review and support
- Vocational/ School review and liaison
- Family meetings and psychoeducation

FORMULATION AND MANAGEMENT OF "ELIZABETH"

- Young woman who has compliantly looked after sick mother/ felt abandoned by father and had sister favoured over her/ been sexually assaulted and unable to appropriately have this addressed and then had serious medical condition. Overwhelmed with anger, but compliant, superficially "sweet" temperament=> conversion disorder
- Support and gradual sharing of formulation with her
- Addressing sexual assault both with her and with sister
- Special consideration regarding VCE result

FORMULATION AND MANAGEMENT OF "SIMON"

- Initial gastro illness in young boy who had obsessive fear of vomiting/ temperamental need for control=> controlled eating, sensitivity to anxiety(in turn caused by lack of control) with ongoing symptoms and then exacerbated by mother-son dynamic with need to control mother/ express anger at mother by resistance
- Single paediatrician (clear medical message of recovery)/ rehabilitation model with physiotherapy/ individual therapy (support and gradual disclosure of formulation) and mother-son work with recognition of dynamic and more functional ways of addressing each others anger at each other/ liaison with school and agreement that school avoidance not an option

FORMULATION AND MANAGEMENT OF "SAMANTHA"

- Unclear formulation, complex social background, number of primary and secondary gains from symptoms. Impossible to engage.
- Discussed diagnosis of "Somatising" and that no medical/organic aetiology to her symptoms. Discharged herself (with mothers consent)

FORMULATION AND MANAGEMENT OF "MARY"

Unclear formulation.

Diagnosis of factitious disorder.

Possibility openly discussed with her and with family (given "honorable" ways out-"unusual medical illness that has resolved/ "somatisation" or factitious disorder)

Discussion with GP. Need for single treating doctor/ psychological follow-up if ongoing symptoms

SUMMARY

- Somatisation should be a “positive” diagnosis (not one of exclusion)
- Early recognition is important
- Guiding principle of management should be rehabilitation (as a “positive” treatment) with added need to address what is being avoided
- Mental Health likely to have a role with assessment of severe end of spectrum/ treatment of targeted patients