Managing Injured Workers With Somatic Symptom Disorder

Psychosocial Factors Behind Symptom Magnification in Chronic Pain

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OUTCOMES

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Today's Speakers

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Learning Objectives

At the end of this session participants will be able to:

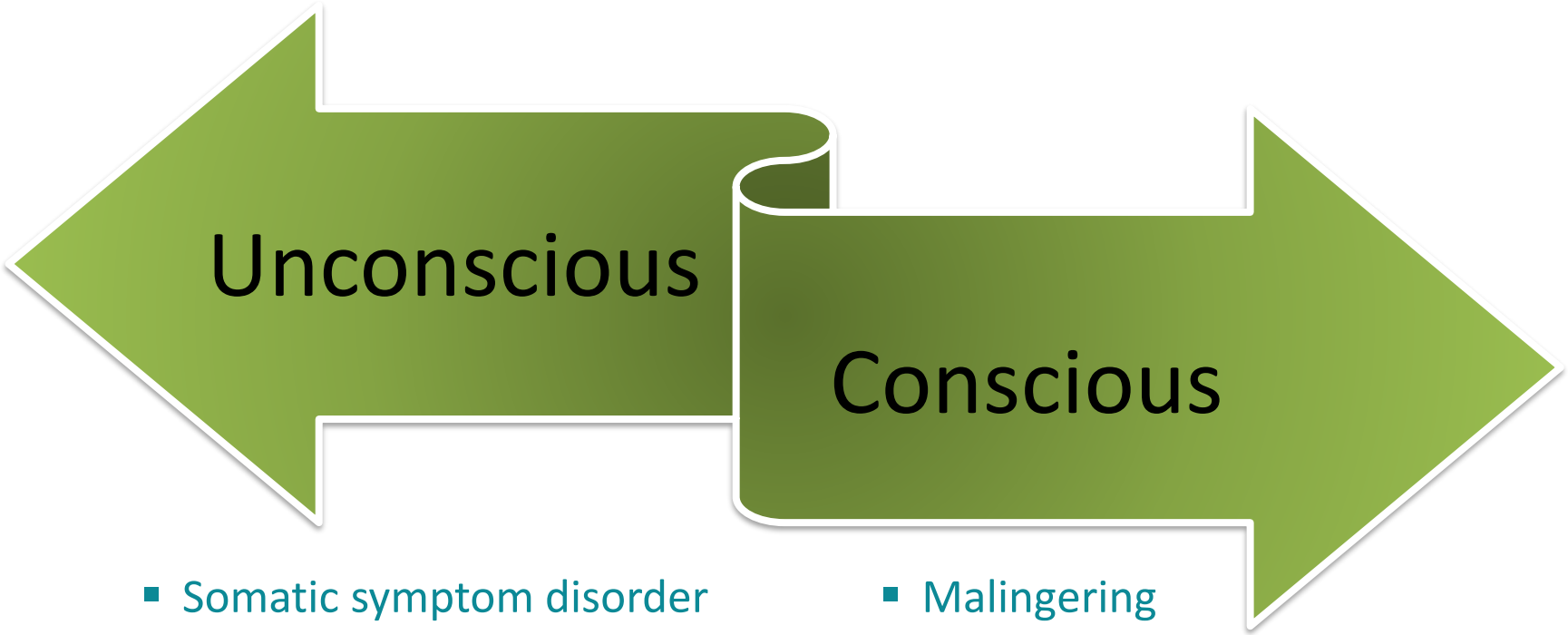
- Define the key characteristics of Somatic Symptom Disorder
- Differentiate Somatic Symptom Disorder from malingering and factitious disorder
- Describe potential problems in managing injured workers with this condition
- Identify strategies to minimize risks and increase the likelihood of a positive outcome in patients with this condition

Symptom Magnification

- Reports or displays excessive symptoms
- Out of proportion to findings
- Conscious or unconscious
- Helps sufferer to feel in control
- Can be self-destructive
- Can lead to extensive and/or prolonged treatment without benefit

Symptom Magnification

DSM V



- Somatic symptom disorder
- Illness anxiety disorder
- Conversion disorder

- Malingering
- Factitious disorder

Somatic Symptom Disorder

Diagnostic criteria:

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:

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 (typically more that 6 months).

Somatic Symptom Disorder

Diagnostic criteria:

- ***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, market 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).

Source: Reprinted with permission from the America Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC American Psychiatric Association; 2013:311

Disproportionately Elevated Rates of Medical Care Utilization

- 5-7% of general population
- Estimated $256 billion dollars in health care costs linked to effects of somatization yearly*
- Disproportionately elevated rates of outpatient visits, hospitalizations, total health care cost
- Tend to “doctor shop,” consult multiple physicians for the same problem
- Use emergency services, and tend to not to keep scheduled appointments
- Remain un-reassured after receiving normal medical evaluation results
- Tend to be dissatisfied with their medical care; does not alleviate their symptoms
- Remain distressed, disabled
- Convinced that they are physically ill, deny any psychosocial influences
- Resist psychiatric referral

Source:*https://russcrane.byu.edu/Documents/MFT%20and%20Health%20Care%20Research/2012%20CoFT%20Somatoform%20Disorder.pdf

Impact of Somatic Symptom Disorder

Impact of Somatic Symptom Disorder

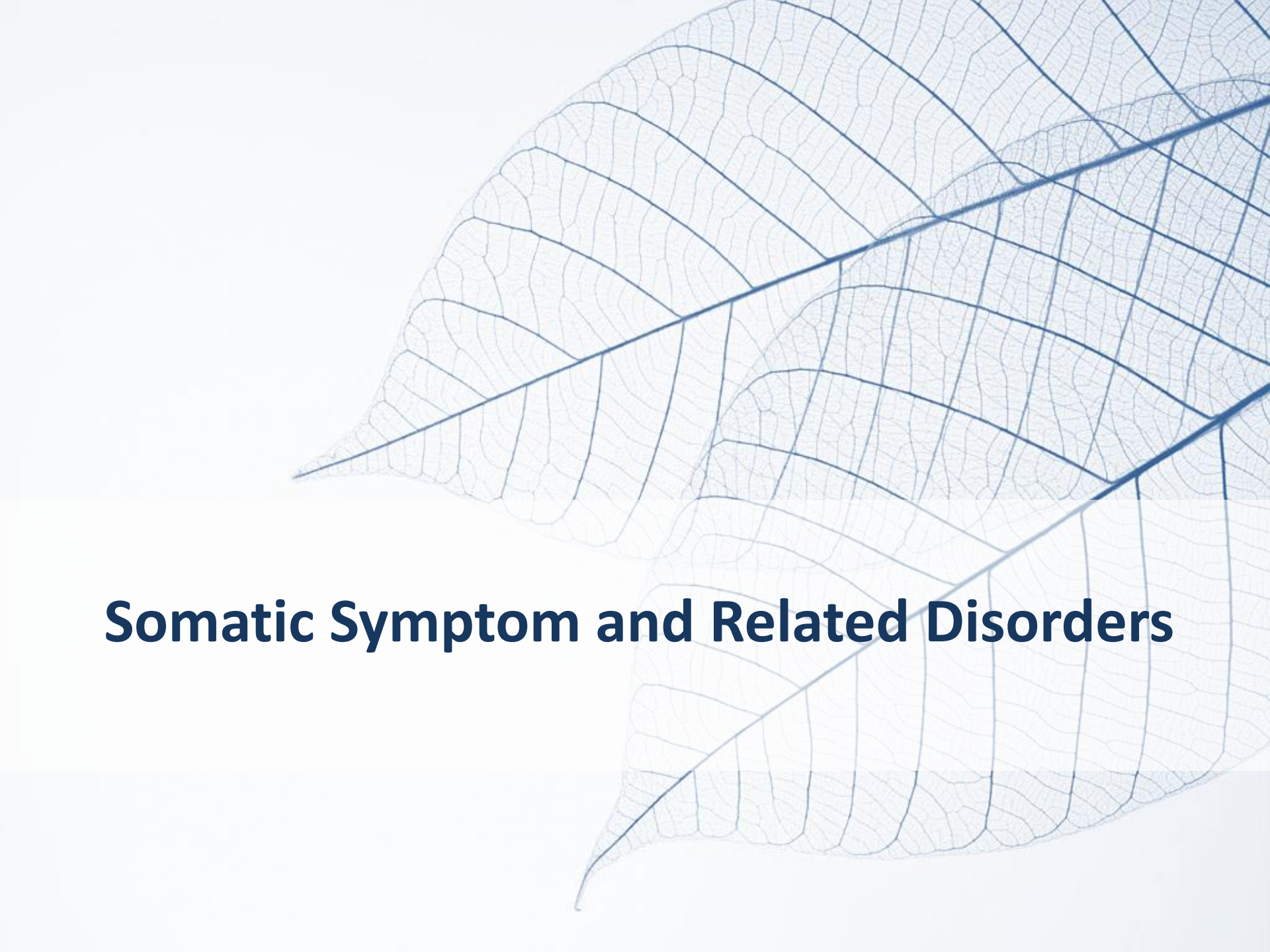
Somatoform disorders are associated with significant disability that is equal to or greater than that associated with major medical disorders such as chronic obstructive pulmonary disease and congestive heart failure.

Somatic Symptom Disorders: Clinical Case Study

45-year-old male with history of work injury

Diagnosis: Chronic Pain Syndrome, L4-S1 fusion X 2, failed back syndrome, SIJ syndrome

- Opiate dependence
- Multiple interventions including failed back fusions, dorsal column stimulator, injections
- Functional restoration program, deep brain stimulation for depression, CBT, biofeedback, acupuncture, PT
- Nothing helped, continued to have intractable pain complaints and new symptoms
- Multiple surgical evaluations for lumbosacral "pseudoarthrosis"



Somatic Symptom and Related Disorders

Different Name, Same Problem

Diagnostic and Statistical Manual of Mental Disorders, 5th ed.

Previously known as somatoform disorders

now called somatic symptom and related disorders

The main feature of this disorder is a patient's concern with physical symptoms that he or she attributes to a non-psychiatric disease.

Source: Somatic Symptom Disorder; STUART L. KURLANSIK, PhD, and MARIO S. MAFFEI, MD
Virtua Family Medicine Residency Program, Voorhees, New Jersey

Somatic Symptom and Related Disorders

DSM V Classification

Somatic Symptom Disorder

(Replaces Somatization DSO, Undifferentiated somatoform DSO, and Pain DSO)

Somatic symptoms that are very distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings and behaviors regarding those symptoms

Illness Anxiety Disorder

(Replaces Hypochondriasis)

Persistent and heightened bodily sensations associated with intense anxiety about the possibility of an undiagnosed illness accompanied by excessive thoughts, time, & energy spent researching or seeking treatment

Conversion Disorder

One or more neurological complaints such as pseudo-seizures, paralysis, tremors, blindness that are **not** under voluntary control

Patients with these disorders are not deliberately feigning illness. Their symptoms arise from unconscious reactions to a variety of internal and external stressors.

Somatic Symptom Disorder Defined

- Psychological distress is communicated as one or more physical symptoms
- Physical symptoms persist in the absence of physical disease
- Persistent distress related to the symptoms can inhibit ability to function
- Patient may be subjected to unnecessary testing and procedures

Challenge: Improve Function and Outcomes

Somatic symptom disorder may be no less debilitating than physical disorders.[1]

Patients experiencing somatization whose physicians incorrectly think they may have a biologic disorder can experience harm from unnecessary testing and treatment.[2]

Some physicians find patients with somatic symptom disorder frustrating, and may describe them in derogatory terms. They may consider physical disorders genuine, while essentially accusing somaticizing patients of manufacturing their symptoms.[3]

Source: 1) Harris AM, Orav EJ, Bates DW, Barsky AJ. Somatization increases disability independent of comorbidity. *J Gen Intern Med*. 2009;24(2):155-161. 2) Murray AM, Toussaint A, Althaus A, Löwe B. Barriers to the diagnosis of somatoform disorders in primary care: protocol for a systematic review of the current status. *Syst Rev*. 2013;2:99. 3) Rask MT, Andersen RS, Bro F, Fink P, Rosendal M. Towards a clinically useful diagnosis for mild-to-moderate conditions of medically unexplained symptoms in general practice: a mixed methods study. *BMC Fam Pract,* 2014;15:118.

A Person With Somatic Symptom Disorder Is Not Faking His Symptoms.

The pain and other problems are real. They may be caused by a medical problem.

Often, no physical cause can be found.

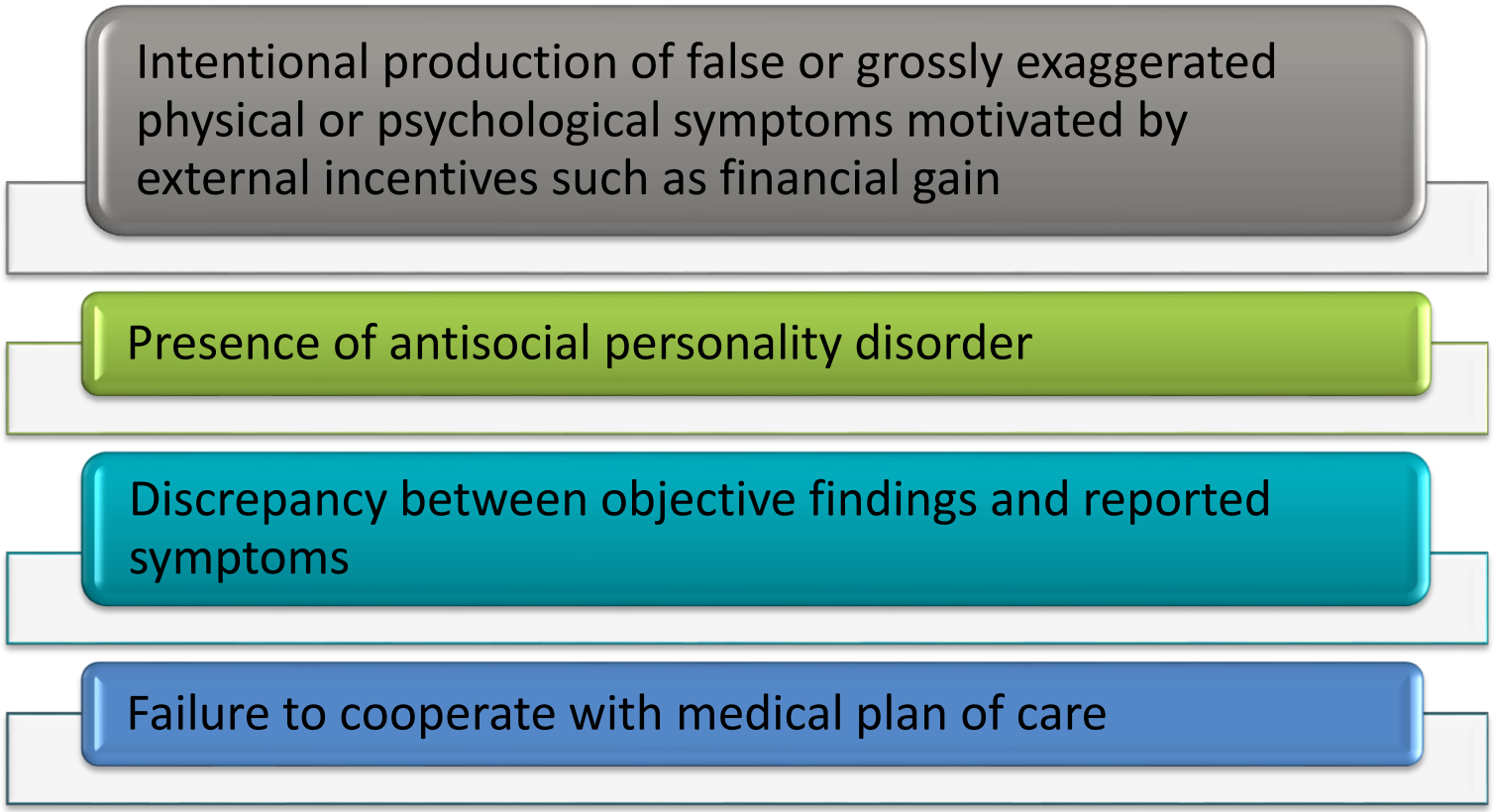
It's the extreme reaction and behaviors about the symptoms that are the main problem.

Source: NIH National Library of Medicine Medline Plus

Comparison: Malingering and Factitious Disorders Defined

These conditions are the result of **intentional** and conscious simulation, exaggeration, or self-induction of illness for an identifiable secondary gain.

Malingering



Factitious Disorder

Falsification of physical or psychological signs or symptoms, or induction of injury or disease associated with identified deception in the absence of obvious external rewards when the behavior is not explained by another mental disorder

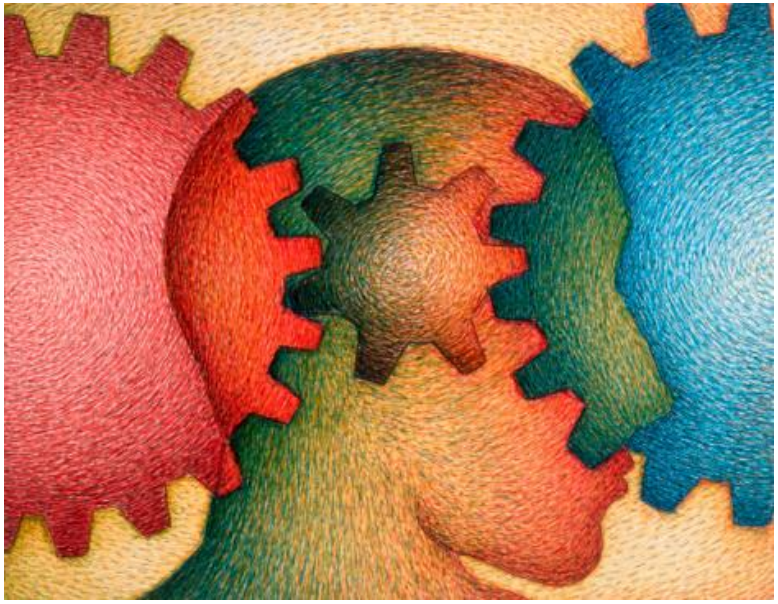
Individual presents to others as ill, impaired, injured, and takes the sick role

Diagnosis and Management Require a Systematic Biopsychosocial Approach

Why Apply the Biopsychosocial Rather Than Biomedical Approach?

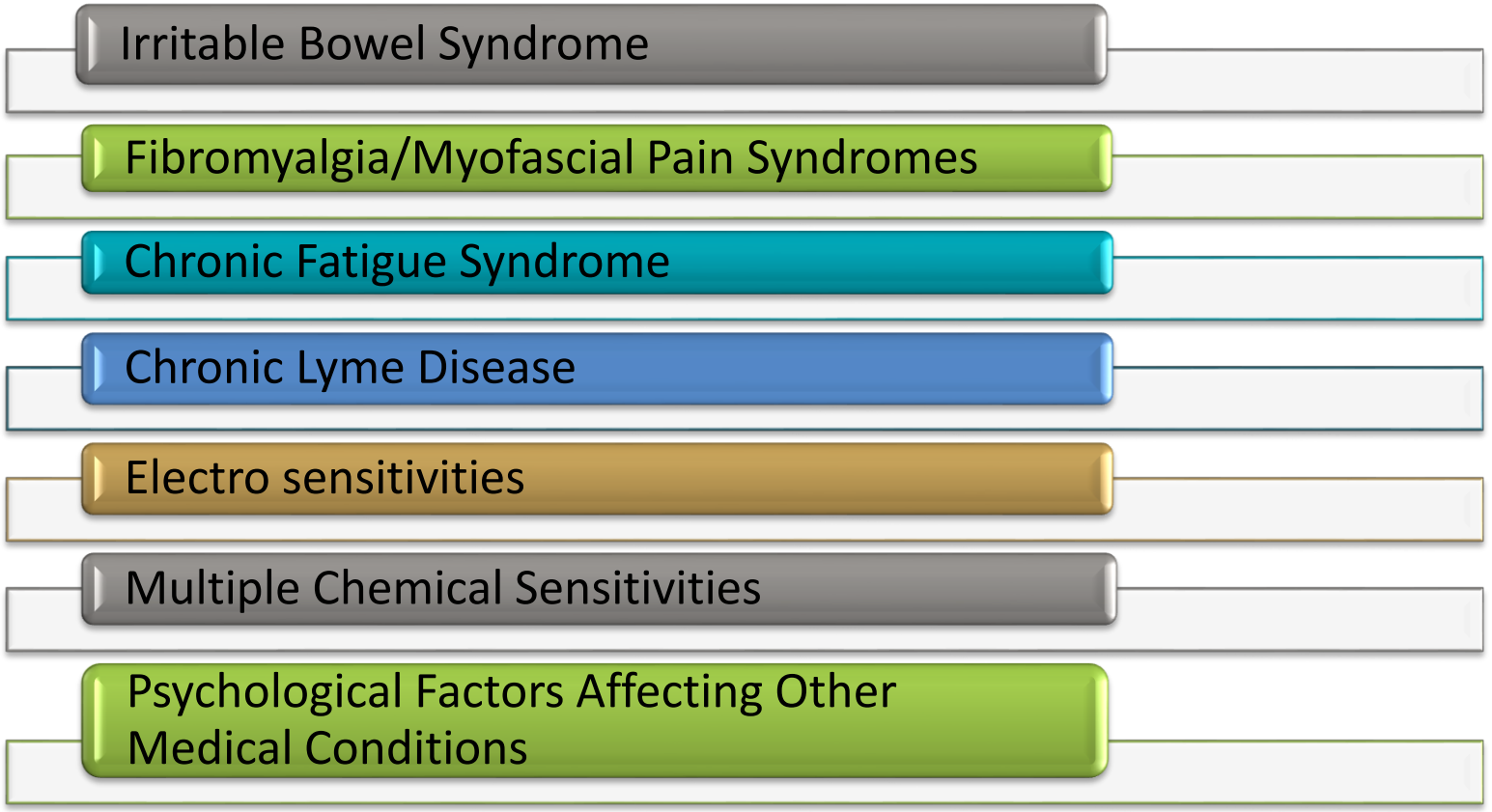
Traditional biomedical model is dualistic

Tries to explain the symptoms as **either** part of a medical disease **or** leaves them unexplained and blames the patient for them



Functional Somatic Syndromes

Somatic symptom disorders are a key factor in at least 26 percent of patients with:



Source: Massachusetts General Hospital Comprehensive Clinical Psychiatry (2nd Edition) printed in 2016. Chapter 24 pp.255-264

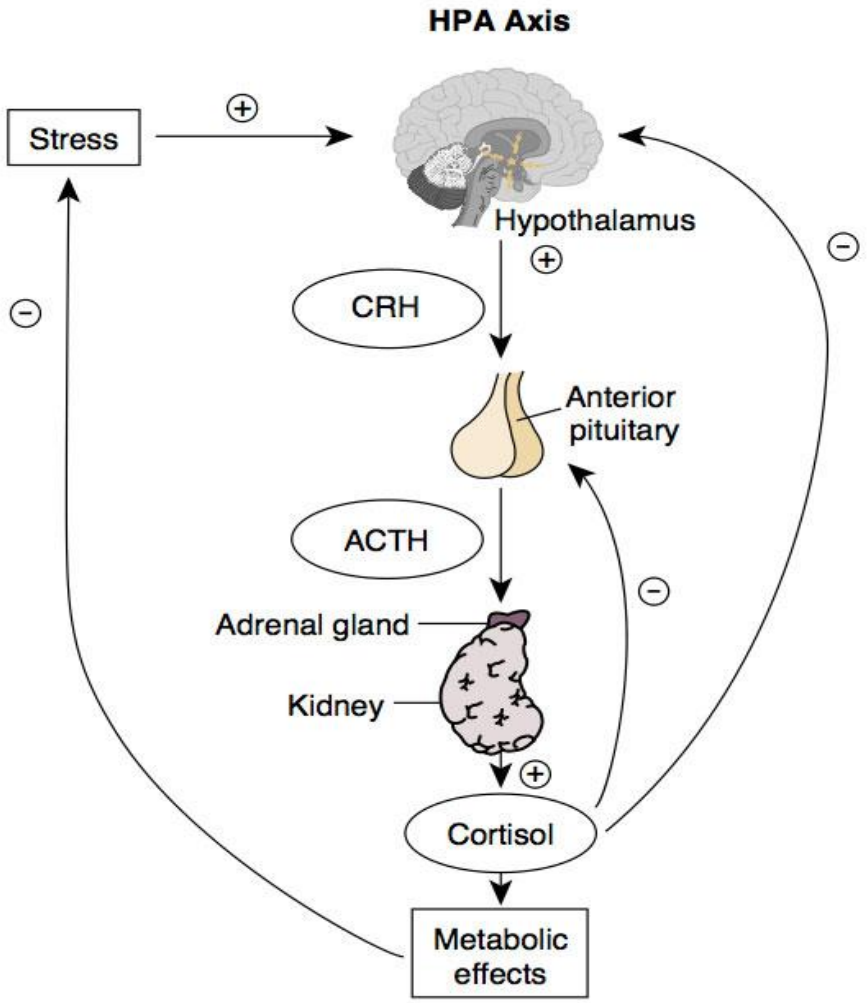
Mind Body Connection: Autonomic Nervous System, Stress Responses

Psychosocial Issues Can Cause Physiological Symptoms

Increased anxiety and stress can lead to dysfunction in the hypothalamic-pituitary-adrenal axis and the autonomic nervous system

Chronic HPA dysfunction and the ACE Study demonstrate impact of childhood experiences on adult illness including hypertension, diabetes, auto-immune disorders, and chronic pain

Restless leg syndrome, myofascial pain, fear, anger, agitation, irritability

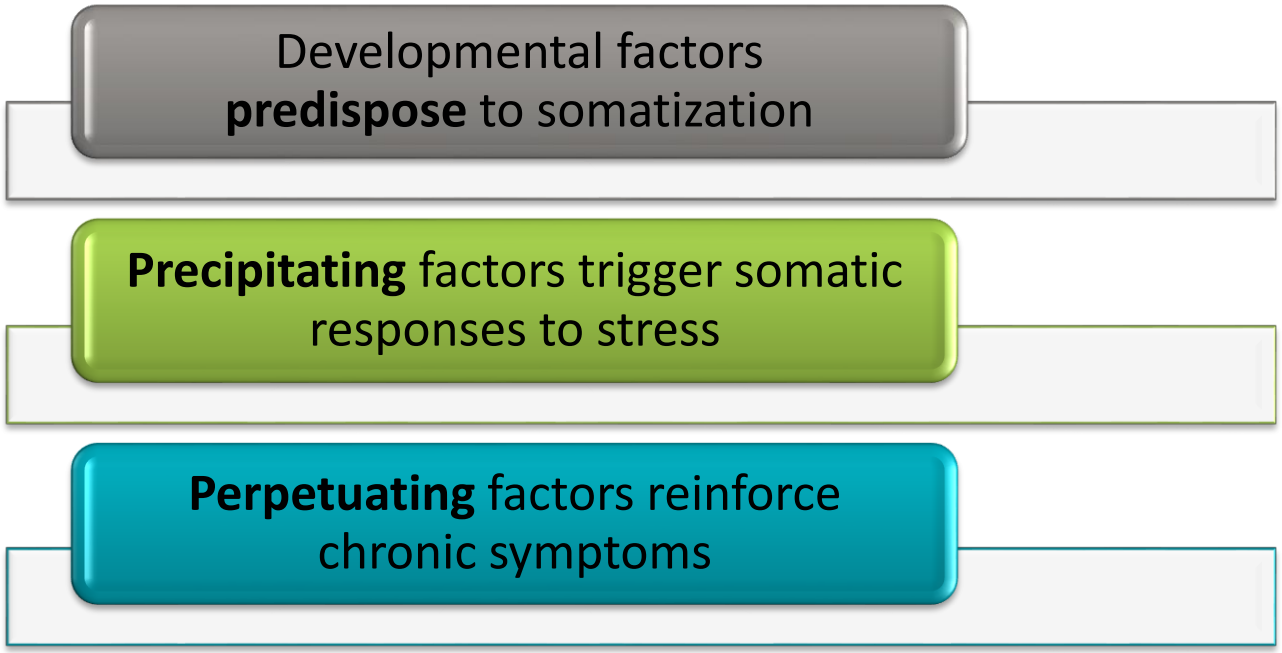


Autonomic Nervous System and Stress Responses

Sensitization of the body can lead to diminished pain threshold as well as cognitive sensitization

Perceived severity of symptoms along with desperation or fear that doctors won't take them seriously can often lead to intentional and unintentional exaggeration of acute distress

Psychosocial Factors and Somatic Symptom Disorders



Predisposing Factors

- Chronic illnesses during childhood or presence of family members with a chronic illness
- Childhood adversity
- Poor coping ability
- Comorbid medical conditions
- Psychiatric illness

More Predisposing Factors

Somatic Symptom Disorders are often associated with anxiety and depression

Combination of physiology, personality traits, life experiences, beliefs about health and illness, the degree to which people experience bodily sensations, and the ways a patient interfaces with the medical establishment all affect the severity and persistence of somatic symptoms

Precipitating Factors

Stressors or elements of a patient's life that have a chronological relationship with the onset of symptoms or precipitate a crisis.

Include:

- Medical illness
- Psychiatric disorder
- Loss or changes in important relationships
- Change in employment or financial status
- Traumatic events for the individual or community, and changes in social support

Perpetuating Factors

- Environmental and behavioral factors that maintain the current difficulties and reinforce chronic somatization
- Medical illness
- Maladaptive coping strategies
- Lack of social support, social isolation
- Illness-maintenance systems such as negative health habits and disability payments
- Opiate medication dependence
- Legal issues related to the symptoms
- Ongoing financial problems

More Perpetuating Factors

Sick Role Privileges

- Blamelessness for products of sickness
- Relief from duties incompatible with the sickness
- Entitlement to care including nurturing from people in the patient's life

The sick role provides relief and care for those feeling unworthy, overwhelmed, or unloved.

Mr. LL had factors that predisposed, precipitated and perpetuated SSD

45-year-old male with history of work injury

Diagnosis: Chronic Pain Syndrome, L4-S1 fusion X 2, failed back syndrome, SIJ syndrome

- Nothing helped, continued to have intractable pain complaints and new symptoms

- Evaluated by forensic psychiatrist
  - **Predisposition:** Significant developmental traumas including early abandonment, adolescence truancy, gang membership
  - **Precipitation:** Pain symptoms spike when there is a perceived fear of abandonment
  - **Perpetuate:** Mixed personality disorder with antisocial, borderline, histrionic, and dependent traits

Treatment Challenges: Patients

Patients with Somatic Symptom Disorder and chronic pain have a high affinity for medications and are reluctant to discontinue them even when there are no benefits.

Patients resist the psychosocial label, which can lead to rupture in therapeutic relationship.

Patients can feel demoralized and alone when they feel they're at fault or not believed.

Treatment Challenges: Doctor

Physicians are often unaware of what drives the symptoms

Often respond with medical tests and medical interventions

Patients with somatic complaints, especially injured workers, often have higher morbidity associated with repeated diagnostic testing, medications, and procedures than from an undiagnosed physical disease

More Treatment Challenges: Doctor

The diagnosis is a combination of clinical assessment based on how the patient responds to treatment interventions for their working diagnosis, plus psychological assessment and testing

Many physicians just don't understand the significance of Somatic Symptom Disorder

Many will initiate treatment based on a working diagnosis

Over time, when symptoms don't improve, or else as one set of symptoms improve, others start to pop up, SSD diagnosis becomes more evident

Some will choose a more timid diagnoses, such as psychological factors impacting medical treatment or else vague references to anxiety and depression

Somatic Symptom Disorder Management Strategy

Systematic Approach to Somatic Symptom Disorder

CARE MD Approach to Somatic Symptom Disorder

Component	Description
Consultation (cognitive behavior therapy)	Consult and collaborate with mental health professionals
Assessment	Evaluate for other medical and psychosocial diseases
Regular visits	Schedule short-interval follow-up to stop overuse of medical care (e.g., inappropriate emergency department visits, excessive calls) and avoid the need for symptoms to get an appointment; stress coping rather than cure
Empathy	Spend most of the time listening to patient and acknowledge that what he or she is feeling is real
Medical psychosocial interface	Emphasize the mind-body connection; avoid comments such as “there is nothing medically wrong with you”
Do no harm	Limit diagnostic testing and referrals to subspecialists; reassure the patient that serious medical diseases have been ruled out

Source: Adapted from McCarron RM. Somatization in the primary care setting. *Psychiatry Times.* 2006;23(6):32-34.

Cognitive Behavioral Approach

They believe they are ill

Cognitive reframing of injured worker's symptoms and disability

Education on how to de-escalate symptom focus

Encourage self efficacy:

- Diet, exercise, supplements, heating pads, and elastic bandages
- Mindfulness, biofeedback

➢ Tip: Time-limited and outcome-focused

Assessment

Avoid labelling a non-medical component to the patient's symptoms.

Clarify the extent of biomedical vs. psychosocial factors

- Review past history for functional somatic syndromes, psychiatric diagnoses, alcohol, or substance use
- Somatic symptoms screening tools
- Pay attention to any evidence of fear, paranoia, or secondary gain issues

Consider additional psychometric assessment

➢ Tip: Provide MD comprehensive records or summary of all diagnostics and treatments and results

Regular Visits

Carefully selected primary physician

Visits should be frequent enough to reassure injured worker

Pay careful attention during the initial interview to somatic beliefs

- How the patient describes or focuses on symptoms
- How the body diagram is completed
- How pain is rated on the BPI questionnaire

Redirect, reinforce self-care and CBT approach

➢ Tip: Find a doctor who is comfortable with managing symptoms using the biopsychosocial model without needless diagnostics and medical interventions.

How to Support Treating Physicians in Tailoring a Treatment Plan

Require objective outcome measures for all treatments to document impact or lack thereof

If Somatic Symptom Disorder is diagnosed:

- Treatment should be the least interventional possible
- Medications should be used for as short a period as possible

In the long term, medical schools must educate students and residents about psychosocial factors before they get hooked into the procedure-oriented biomedical model.

Empathy

Non-judgmental care, multi-disciplinary treatment under a single gatekeeper

Minimize the patient's need to legitimize symptoms

Emphasize what condition the patient doesn't have

Validate distress while avoiding unwarranted diagnostic labels

Deflect debates over symptom etiology

- Tip: Listen, don't challenge the patient directly. Reassure. Use UR in an objective manner.

Medical/Psychosocial Interface

5 Classes of Medications + CBT and Mindfulness-Based Therapy

1. TCAs
2. SSRIs
3. SNRIs
4. Atypical Antipsychotics
5. Herbal Medications

➢ Tip: Psych meds don't always indicate psychiatric claim.

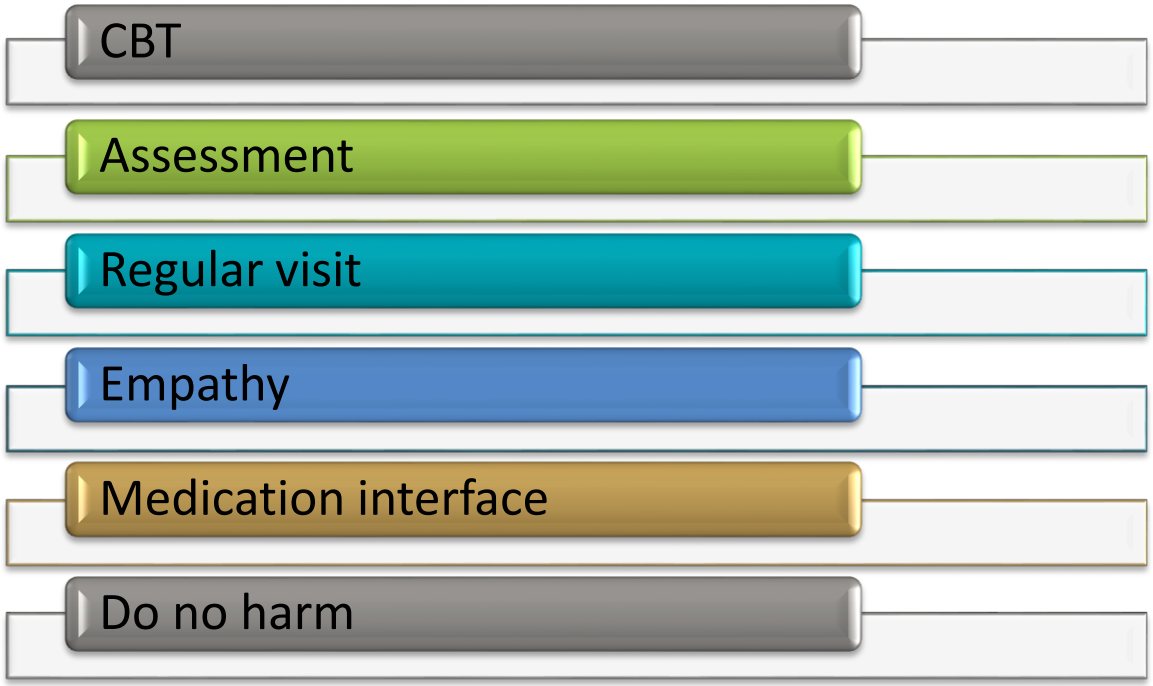
Do No Harm

- Avoid unnecessary diagnostic tests to prevent overly aggressive medical and surgical interventions
- Be empathetic and acknowledge validity of suffering
- Do not miss a real medical problem

Clinical Case Study: How Did Mr. LL Do?

45-year-old male with history of work injury

Diagnosis: Chronic Pain Syndrome, L4-S1 fusion X 2, failed back syndrome, SIJ syndrome



Somatic Symptom Disorder: Summary

- Somatic Symptom Disorder is an unconscious magnification of unexplained symptoms
- Malingering and factitious disorder are conscious symptom magnifications
- Physician often perpetuate the problem by over-diagnosing and treating
- Management strategies include the CARE MD approach

Management Summary

Restore function and make target symptoms more manageable

Symptom magnification is common and costly

Not always intentional

A biopsychosocial approach is needed with emphasis on replacing fixation on symptoms with empathetic acknowledgement and self management

- Tip: What is needed most are empathy, consistency, objectivity, reinforcement, patience.

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- Tip: If your work computer has blocked Survey Monkey, access the link via your home computer.

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