Management of Patients with Somatoform Disorder and Abnormal Illness Behaviour

DR TONY MANDER
CONSULTANT PSYCHIATRIST
A useful series of definitions has been provided by Singh (1998), an Australian professor of Psychiatry, based in Melbourne. They are not all recognised by DSM-IV.

**Somatisation:** The tendency to experience, conceptualise and communicate mental states and distress as physical symptoms or altered bodily function.

- **Somatoform disorder:** The presence of physical symptoms that suggest but which are not fully explained by a general medical condition, the direct effects of drugs or another mental disorder. The symptoms must cause clinically significant distress, or impairment in social, occupational or other areas of functioning. In contrast to factitious disorders and malingering, the physical symptoms are not intentional.

- **Somatisation disorder:** A rare and extreme version of somatoform disorder where the patient over many years seeks medical attention for many physical symptoms with no evidence of organ pathology. The diagnosis of the disorder requires the presence of 14 of 37 potential symptoms for women and 12 for men (Box 3).
Somatisation syndrome: A partial version of somatoform disorder, in which the patient has fewer symptoms (four for men, six for women).

Hypochondriasis: A preoccupation with fears of having, or the idea that one has, a serious disease. The preoccupation must last at least six months, persist despite appropriate medical evaluation and reassurance and cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Factitious disorder: The intentional production of false or grossly exaggerated symptoms for reasons that are not obvious. It is presumed that there is a psychic need to assume the sick role and to receive care. Patients often present their history with flair or gross exaggeration (pseudologia fantastica), and receive multiple hospitalisations (Munchausen's syndrome). When there are external incentives for the behaviour (e.g., financial gain), malingering should be diagnosed.
Neurasthenia: "Tired nerves" or "nervous exhaustion", now defined as complaints of increased fatigue after mental effort, or bodily weakness after minimal physical effort, combined with unpleasant physical symptoms (dizziness, headaches), worry, irritability and sleep disturbance. The modern neurasthenic will more likely be diagnosed with chronic fatigue syndrome, depression or anxiety.

Sick role: When disease occurs in a previously well individual, that person is granted certain privileges (exemption from work and other responsibilities and the offer of care by family and significant others), but at the same time is expected to accede to certain obligations (to seek appropriate help and to accept the treatment offered in order to get well as soon as possible). Some people seek the privileges of the sick role without accepting the obligations; whether this is malingering or chronic somatisation disorder depends on the degree of conscious voluntary control the person has over their illness behaviour.
Illness behaviour: The way an individual in the "sick role" perceives, evaluates and acts upon symptoms. There is considerable variation in this behaviour. One person may be stoical, another dramatic. One may communicate distress verbally, another physically.

Abnormal illness behaviour: Inappropriate or maladaptive attempts to be granted the benefits of the sick role without meeting the necessary obligations.
KEY ISSUES

- The management of somatoform disorders is a confusing and difficult area.

- There are many iatrogenic complications, including unnecessary and repetitive investigations and surgery, drug dependence and “doctor shopping”.

- Somatisation is a worldwide phenomenon and a common presentation of psychological distress.
There are three main groups of patients:

- those with high levels of somatic symptoms,
- those with illness fear,
- and those with somatic presentations of other psychiatric illness.
**Management** is straightforward for the acute cases and consists of trying to get the patient to accept a link between the psychosocial conflicts and the symptoms.

**Management** is very difficult for chronic cases, where care, not cure, is the goal, as is an attempt to limit harm to the patient and limit the cost to the health system.
MANAGING CHRONIC SOMATISATION DISORDER 1

- Identify psychosocial cues. The patient may not volunteer these, so skilful interviewing is required.

- Conduct a thorough physical examination and provide unambiguous information about findings.

- See the patient regularly for review, not in response to the patient’s psychosomatic crises. Consultations during the times of “good health” may provide an opportunity to change attitudes that have been reinforcing illness.
MANAGEMENT 2

- Set the agenda – specify what the doctor will and won’t do. With some patients it is important to be very clear that certain physical therapies will not be offered.

- Set limits for investigation by specifying what will and will not be ordered and why.

- Ensure appropriate use of specialist referrals, and specify why a referral is being requested.
Avoid spurious diagnoses and do not treat what the patient does not have. The doctor may feel pressed to invent exotic conditions to explain the patient’s behaviour and symptoms, but this will not lead to a cure.

Avoid a dualistic model. Many of these patients prefer to insist that the mind has no impact on the body. The doctor must try to show them that mind and body are linked.

Provide an explanatory model of symptom processes (eg how stress leads to unnoticed muscular tension, which can lead to pain; how anxiety can lead to hyperventilation, producing tingling in the fingers).
MANAGEMENT 4

- Decide who should manage the psychosocial problems (i.e., GP or other specialist) because it is best for one doctor to integrate management.

- Organise joint assessments with other specialists if they are to be involved.

- Refuse to enter debate as to whether the condition is organic or functional.

- Be consistent and offer care.
The somatoform disorders of the new millennium are not very different from those of the 1920s. Now, as then, pain and fatigue tend to be the commonest complaints. There are two significant differences. Sufferers today are more “tuned in” to their bodies and more sensitive to the signals their bodies give off. They are also more ready to attribute symptoms to an organic disease. This increase in illness attribution stems from weakening of medical authority, a strengthening of individual patient rights, and increasingly the capacity of the media to spread information about new and exotic conditions. One possibility is that these new patterns may result from an increase in isolation of individuals and a disaffiliation from family life. The emphasis on self actualisation and personal growth may have many personal connotations in Western Society but one consequence may be an increasing focus on the “bodily self” and an increasing tendency to be intolerant of imperfections and dis-ease.

<table>
<thead>
<tr>
<th>CLAIMANT:</th>
<th>MR E C</th>
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<tbody>
<tr>
<td>DATE OF BIRTH:</td>
<td>7 FEBRUARY 1973</td>
</tr>
<tr>
<td>DATE OF ASSESSMENT:</td>
<td>13 JUNE 2011</td>
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EVENT

- He had a minor traffic accident in a car park. He describes being “in shock” but nevertheless was able to exchange particulars with the driver of the other vehicle. He had the onset of physical symptoms that afternoon.

- He subsequently exaggerates the level of damage to his car in the police report.
Shows decompression marks to the number plate backing panel.
Slight paint fracturing to top edge of bumper (right side)
CRASH INVESTIGATION

Crash investigator states

- “C claimed that the whole bumper had been pushed back and pointed out that the line of the top edge of the bumper cover beneath both headlights did not follow the line of the headlights evenly. On close inspection I noted that there was a very slight variation of the bumper line. Again I was not convinced that this was crash related”.

- The investigator also inspected a new Mazda 3 finding that the distortion at the top edge of the bumper was present on a new vehicle. The investigator concludes

- “from my examination of C’s vehicle it was obvious that the contact between the vehicles was very minor. I have difficulty in accepting that he could have received the injuries he is alleging. The comments from the Australia Wide Investigator who obtained his statement that he kept meticulous records of the time lost due to his alleged injury strongly suggests that he intends to incorporate a loss of earnings component to his claims accepted”.
Symptoms from motor vehicle accident

** Feeling tired and not as productive
** Neck pain on both sides, range in movement is really bad in cold weather
Neck and shoulder on the left side was extremely painful and I could hardly move it
** Sharp pain in the back of the head
* Forgetting things
* Ringing in the ears
** Extremely bad headaches in the front, side and back of the head which causes nausea, light headedness and dizziness
Feinted twice and felt like I had a little fit the first time
* Twitching underneath the right eye and left eye
** Tingly and numb feeling like pins and needles on the tongue, lips and around the lip area, and sometimes a funny sort of taste
** Funny feeling like a light touch around the face and ears and other random areas around the body - Burning sensation from the MRI increased this allot
Funny feeling in the throat going downwards
* Pain in the shoulders and upper back
* Pins and needles in the upper back and lower back
Some pain in the ribs and in the middle of the back
** Pain in the elbows, arms, hands and fingers on the right side
Pain in the left arm and left chest area
** Pins and needles in the hands and fingers on both sides causing the fingers and fingertips to become dry and cracked and making the fingertips painful
Severe spasm from left arm downward
** Pins and needles from left arm downward and feels shaky
** Hands feel a little shaky
** Twitching in the thumb and fingers on both sides
** Opening and closing the right hand is more difficult and tighter with similar symptoms in the left hand and the fingers are painful
** Pain in the lower back on both sides
** Pain in the groin area, hip area and stomach area
** Pain in the left knee area
** Pins and needles in the feet on both sides and more so with the left foot and more so with some toes causing the toes to become dry and making the toes painful
* Pain in right foot and a cramp type of feeling in both the left and right foot
** Pins and needles from the left leg downward and feels shaky and unstable

** Funny feeling running up the left leg and right leg like a light touch, also on the left stomach and right stomach area and other random areas around the body - Burning sensation from the MRI increased this alot

** Random sharp pain around the body

** Pins and needles are present even in a state of rest and increases in severity as the symptoms get worse

** Sitting, driving, working on the computer, writing and using mouse makes the symptoms worse

** Standing, bending over, kneeling, squatting, lifting or carrying things makes the symptoms worse

** Cold weather makes the symptoms worse

** Some disrupted sleep

** Whilst working as a Chartered Accountant, feel very tired at the end of a 7.5 hour work day and not as productive. Used to work at least a 9 hour day as a Chartered Accountant

** Have to get up and move around every 20 to 30 minutes

** Working longer hours as a Chartered Accountant or as a magician and illusionist makes the symptoms worse

Work as a Magician & Illusionist is in addition to the work as a Chartered Accountant. At least an additional one hour of work a day on the weekdays and at least an additional two hours of work a day on the weekends.

Had 41 bookings for the year ended 30 June 2007 (Before the motor vehicle accident and working as both a Chartered Accountant and a Magician & Illusionist)

Had 18 bookings for the year ended 30 June 2008 (After the motor vehicle accident and working as both a Chartered Accountant and a Magician & Illusionist)

Had 21 bookings for the year ended 30 June 2009 (After the motor vehicle accident and working as both a Chartered Accountant and a Magician & Illusionist)

Had 14 bookings for the year ended 30 June 2010 (After the motor vehicle accident and working as both a Chartered Accountant and a Magician & Illusionist)

Had 17 bookings for the period ended 31 May 2011 (After the motor vehicle accident and working only as a Magician & Illusionist)

Have been seeing the physiotherapist twice a week since the accident for approximately seven months, then once a week for approximately five months, then once every two weeks, then once every three weeks, then once every month and on an as needs basis.

Have had approximately 58 days off work since the accident.
The accident was minor

The claimant has subsequently had extensive physical symptoms for which no organic basis can be found. No direct psychiatric symptoms are admitted to, nor were there signs of such on examination today.

In the absence of organic findings, Dr N has appended a psychiatric diagnosis of somatoform disorder are met. This is in accord with DSM-IV criteria.

Both the claimant and psychiatrist ignore the possible relevance of 12 months unemployment. While it is true the symptoms started before this it is counterintuitive to accept the claimants view this is not a stressor.
PAST HISTORY

- Meticulous but denies OCD. Rang the next day to discuss his case further.
- Malaysian origin and describes no difficulties in his childhood.
- Oldest of three children.
- Warwick Senior High School and completed Year 12.
- Bachelor of Commerce and studied to become a Chartered Accountant.
- A single man who continues to live with his parents.
- Previous claim with similar characteristics took 12 years to settle for $8,000.
- Made redundant from GESB mid 2010.
- Police report exaggerates damage to vehicle.
Dr R noted that he presented with **generalised musculoskeletal pain**

Dr JR could “find no objective clinical evidence of him having a musculoskeletal or neurological impairment that could be reasonable attributed to his motor vehicle incident which I would regard as trivial and one that has no significant trauma potential”. “I do not attribute his current symptoms to his motor vehicle accident” and goes on “this is a hypochondriacal clinical presentation”.

Dr K in his report of 8 March 2011 states “it did appear to me that your client had become **somewhat preoccupied with his symptoms** and he has in this regard given a systematic and meticulous attention to the recording of his symptoms - which I would venture to suggest may prove to reinforce these symptoms”.
Dr N records no signs of mental illness on Mental State Examination.

Dr N concludes “I do believe that this man was traumatised to some extent by the motor vehicle accident of 7 July 2007 in a car park at Warwick Shopping Centre”.

“If and only if the physical symptoms that this man currently reports cannot be explained by the underlying physical and physiological abnormalities thought to be attributed to the accident, and given the widespread nature of the physical symptoms which he reports he has, then it is a possibility that following the accident in 2007, he did develop a somatoform disorder, with the onset following the accident, and following the initial soft tissue injury of more widespread physical pains and neurological-type symptoms etc, etc.”

He dismisses depression or anxiety as likely diagnoses.
CONCLUSION 1

- When physicians and surgeons cannot find an organic reason for an individual’s claims of symptoms it may be appropriate to consider a psychiatric evaluation. Care with terms used is likely to assist the claims manager and overall assessment of the case.

- It is important that any psychiatric diagnosis is made on the basis of positive evidence (which is not the same as lack of evidence to support an organic diagnosis).

- Psychiatric examination of this man was also normal.
CONCLUSION 2

- Is there a role for common sense when assessing any claimant.

  - I find it inconceivable that the impact was even at the level of 15 kms per hour as he claims. It would seem that nothing more than a minor touch occurred.

  - Could such an incident be responsible for causing a psychiatric illness in a person of ‘normal’ constitution

  - Is the exaggerated damage report relevant.

  - What do we make of the previous claim

  - Is he unwilling to admit pre-existing personality traits that might make this presentation more understandable.