Somatoform Pain Disorders

Jeffrey W. Janata, Ph.D.
University Hospitals Case Medical Center
Case Western Reserve University School of Medicine

Conflict of Interest and Financial Disclosure

Jeffrey W. Janata, PhD
Professor of Psychiatry, Anesthesiology
Case Western Reserve University School of Medicine

Chief, Division of Psychology
Director, Behavioral Medicine Program
University Hospitals Case Medical Center
Cleveland, Ohio

Jeffrey W. Janata - in the past year has received:
• Research support from the NIH (NIDDK)
• Consulting fees - none;
• Lecture honoraria from American Society of Interventional Pain Physicians.
Overview

• Definitions and Clinical Issues
• Current Diagnostic Approaches
• Explanations for Excessive Pain Behavior
• Implications and Future Directions

Summary

• “Real” vs. psychogenic pain distinction is outmoded and inaccurate
• Pain is always best understood in physical, emotional and behavioral terms
• Psychological aspects of pain greatly exceed those accounted for by the DSM somatoform categories
Summary

- DSM V defines disorders based more on psychological criteria
- In clinical practice, there remains a tendency to marginalize and pathologize normal pain behavior

Summary

- Reconceptualization is in order:
  - Research on inclusion criteria is lacking
  - Diagnoses need to be better operationalized
  - DSM V and ICD-10 taxonomies are more dissimilar
Chronic Pain Syndrome

Characteristics of Patients Referred for University Pain Center Management

• Minor to moderate pathophysiology
• Moderate to severe pain complaints and behaviors
• Disrupted and fluctuating activity levels
• Sleep disturbance
• Anxiety and depression
• Excessive medication use and/or surgeries
• Disruption in vocational, social, familial and recreational activities
How Do We Understand Pain?

- Shared conceptualization of pain by providers and patients alike
- Pain specialists are often confounded by pain behavior; how are primary care docs (who provide the majority of treatment) supposed to manage these patients?
- 4PCP data

The Sensory Model of Pain
Problems with the Sensory Model

- Pathology without symptoms
  - Low back pain
  - Knee pain
  - The gardening syndrome
- Symptoms without pathology
  - Pain behavior

Definition

- Pain Behavior
  - Cognitive, emotional, & behavioral reactions to perceived pain
- Examples
  - Grimacing, slow gait
  - Reporting intensity
  - Seeking medical care
  - Missing work
  - Asking for help from family & friends
Definitions

Physical vs. Non Physical Factors

Given the same insult in 100 people, there will be a wide range of reactions

• Stoicism or fearful-avoidant responding
• “Typical” responding
• Excessive illness behavior

Pain Behavior

• When our understanding of pain expanded to include pain behavior, psychologists took interest
• Wilbert Fordyce
Definitions

• Excessive Pain Behavior
  • Unnecessary
    • ED visit for non-cardiac chest pain
  • Excessive
    • weekly ED visits for non-cardiac chest pain
• Factitious
  • inauthentic illness behavior that is not motivated by the desire to maintain or restore health
  • using complaints of “flu-like symptoms” to skip Grand Rounds

The Sick Role

• Term coined by Talcot Parsons to describe a social role with culturally defined responsibilities and privileges
  • Sick role occupant is temporarily excused from most social responsibilities, and afforded an extra measure of kindness and forbearance
  • Legitimacy of the sick role is assumed
  • Sick role occupant is obliged to do whatever is necessary to resume normal activities
  • No cheating! No luxuriating in the sick role!
Medical and Psychiatric Approaches

- Medically Unexplained Symptoms (MUS)
  - Medical complaints that cannot be adequately explained by underlying pathology.
  - Also called “multiple unexplained symptoms” (MUS); “multiple unexplained physical symptoms” (MUPS); or “unexplained medical complaints” (UMC)

- Functional Somatic Syndromes
  - Clusters of symptoms with no reliable signs
    - Chronic Fatigue Syndrome
    - Fibromyalgia
    - Chronic Regional Pain Syndrome (Reflex Sympathetic Dystrophy)
Descartes Created an Artificial Distinction

• Mind-body dualism
  • Physician: I cannot explain pain complaint so:
    • I'll keep looking. I've got cool machines now.
    • Blame the patient for our failure: “The pain must be in his head.”
  • Psychologist:
    • It must be in his head but the motivation is unconscious
    • Since we don't know, let's address the patient's function

Traditional Psychiatric Approach

• Somatoform Disorders
  • DSM IV category
  • Illness behavior in the absence of adequate physical explanation
  • Presumed to be unconscious / unintentional
  • Specific Disorder
    • Conversion disorder
    • Somatization Disorder
    • Pain Disorder
Traditional Psychiatric Approach

- **Factitious Disorder**
  - Intentionally exaggerating, lying about, simulating or producing an illness for the purpose of assuming the sick role
  - Motivation is psychological
- **Malingering**
  - Same as FD except that the purpose of the behavior is to secure an external reward

Prevalence of Excessive Illness Behavior

- Generic MUS in Primary Care: 20-30%
- Chronic or multiple MUS, subclinical somatorm disorders: 10-15%
- Functional Somatic Syndromes: 0.2-5%
- Somatofom Disorders: 2-3%
- Factitious Disorder among inpatients: 0.5-1%
- Medically self-sabotaging behavior among primary care patients: 7%
A Survey of Physicians

• Prevalence:

- No objective evidence found to explain complaint: 13%
- 95% sure that there is nothing medically wrong with the patient: 7%
- Multiple or chronic MUS causing distress or dysfunction: 6%
- Diagnosed with a somatoform or factitious disorder: 3%

Drawbacks to the DSM III - IV Approach

• Small problems
  • There is little evidence to support the DSM categories
  • No one uses them
    • Medicare data
  • They are often used incorrectly
    • E.g. the bias to conversion

• Big problem
  • Segregation and marginalization of pain behavior
Drawbacks to the DSM III – IV Approach

• DSM requires proof of intentional faking to diagnose FD, malingering
• Proof means physical evidence, and this is not always or even infrequently available
• Reinforce the impression that presence of pain behavior negates physical causes

DSM V Approach

• Relatively sweeping revisions to Somatoform Disorders
• Hypochondriasis, other somatoform dxs replaced by:
  • Somatic Symptom Disorder
  • Illness Anxiety Disorder
Somatic Symptom Disorder

Criteria:

• One or more chronic somatic symptoms w/ excessive concern, preoccupation, fear
• Cause significant distress, dysfunction
• Lack of reassurance from freq. use of health care resources
• Often feel medical care is inadequate

Illness Anxiety Disorder

Criteria:

• Patients may or may not have a medical condition
• Heightened bodily sensations
• Intense anxiety that there may be an undiagnosed condition
• Devote excessive time and energy to health concerns
Illness Anxiety Disorder

- Not easily reassured
- Significant distress, life disruption

Relatively Unchanged in DSM V

**Conversion Disorder** (Functional Neurological Symptom Disorder)

- Altered voluntary motor or sensory function
- Incompatibility between symptom and recognized medical condition
- Causes distress
- No longer stipulates unconscious motivation
Relatively Unchanged in DSM V

Psych Factors Affecting Other Medical Conditions
• Behavioral factors adversely affect medical condition
  • Influence course of illness
  • Interfere with treatment
  • Add established health risks
  • Influence underlying pathophysiology

Factitious Disorder
• Falsification of signs, symptoms or intentional injury
• Presents to others as ill, impaired, injured
• Deceptive behavior not linked to obvious external rewards
• Not better explained…
Other Specified Somatic Symptom and Related Disorder

- Brief Somatic Symptom Disorder
- Brief Illness Anxiety Disorder
- Illness anxiety without excessive illness behavior
- Pseudocyesis

Removed Diagnoses

- Somatization Disorder
- Hypochondriasis
- Pain Disorder
- Undifferentiated Somatoform Disorder
Malingering

• Still a V Code
  • Condition that may be a focus of clinical attention
  • Intentional production of false or exaggerated physical or psychological sx.
  • Motivation is external reward

Alternative Explanations for Excessive Pain Behavior

• Pain behavior is the normal accompaniment to nociception
• Depression and anxiety are normal accompaniments to pain
  • 70% of pain patients have comorbid depressive diagnosis
  • Depressive symptoms are often expressed in physical terms
  • Pain catastrophizing is highly associated with disability and impairment
Alternative Explanations for Excessive Pain Behavior

Depression and anxiety are normal accompaniments to pain

- We overlook or pathologize emotional processing of pain
- Pain tolerance data when pain processed as sensory vs. emotional information
- Explosive growth in neuroscience understanding of normal pain processing

Alternative Explanations for Excessive Pain Behavior

- Our pain treatment itself can amplify pain
  - PRN administration of short-acting opiates
  - Opiate-induced hyperalgesia
  - Pursuit of treatment validates complaints
Alternative Explanations for Excessive Pain Behavior

• Our health care system can amplify pain
• Patients reporting pain are required to prove their pain when the implicit assumption is malingering
• Payment preference for procedures
• Third-party payors share the same sensory bias that characterizes providers and patients

Improvements

• DSM V abandons unexplained medical vs. explained medical distinction
• DSM V no longer emphasizes dualism
• Somatic Symptom Disorder and concurrent medical illness not mutually exclusive
Disappointments

• Psychological aspects of pain still exceed those accounted for by the DSM somatoform categories
• Positive psychological criteria still lacking
• Still not likely to be popular with patients, tendency to marginalize
• ICD 10 = DSM III

Concluding Remarks

• Revisions to DSM are in order:
  • Research on inclusion criteria is lacking
  • Diagnoses need to be better operationalized
  • DSM categories should be expanded to capture normalcy of emotional and behavioral aspects of chronic pain