

A. Case examples of somatic symptoms disorders

1. 42 year old WF EFM self refers to HU with multiple complaints over a several month period. Reports from community regarding problem relationships between her and others at post/children's school
 - Patient defers all blame for problems on others (difficult co-residents, unfai teachers, exploitive friends etc.)
 - HU nurse gradually alarmed at time and resources related to multiple medical appointments
 - Over time complaints increase in significance: malaria, toxic shock syndrome persistent diarrhea. Requests frequent specialist appointments in community cardiology, infectious disease etc

Key Clinical Signs

Multiple psychosocial stressors

- History of serious problems that are difficult to identify but impossible to ignore
- Once medications prescribed or diagnoses given; other physicians (especially psychiatrists) are unwilling to overrule specialists
- Treatment team feels helpless; unable to deny care on medico-legal grounds. Energy, time, and money taken away from other patients

B. Case example of illness anxiety

1. 40 yo MWM s/p CABG 12 years earlier, No prev MH treatment – but taking SSRI, Routinely monitors breathing and when he notes any change becomes concerned that he may be having a stroke or brain hemorrhage. Over time health concerns generalized: any unexpected. body sensation (esp in upper body) would lead to anxiety and seeking medical care. Describes chronic anxiety and worry from “the moment he awakes”; refuses to travel abroad because he does not trust care outside the UK
2. Key features
 - Disabling anxiety/fear prominent
 - Can be associated with previous illness or trauma
 - Reassurance generally not helpful; even negative radiological and laboratory studies explained to patient have minimal impact
 - Best approach is often supportive listening by primary care physician; frequently “concerns about physical symptoms become a major way of interacting

Case example on conversion

1. 33 yo SWF med evac'ed to London with abdominal pain, fainting spells, and urinary incontinence } Multiple specialty examinations WNL } Acute onset of various symptoms involving various organ systems } History of previous sexual assault: never reported } Work involves working with law enforcement in a developing country with poor vetting process for police officials

Key Clinical Signs

- Pseudo neurological symptoms (pain, LOC, incontinence)
- Young age
- History of unresolved traumas; new triggers?
- Resistant to mental health referral
- Striking lack of affect: "La belle indifference"
- Early life modeling of illness behavior

Case example on

1. 64 yo WF seen in consultation in ICU
2. Despite evidence of GI bleed is refusing endoscopy and other treatments; very fearful that she "is going to die"
3. Evaluation reveals husband died of pancreatic cancer and "this is how they found out"
4. Eventually agrees to procedure but is not reassured by positive outcome and continues to call and present with non specific GI symptoms as an outpatient for the next several months

Core features

- Clear medical illness present
- Psychological (anxiety/denial) and behavioral (refusing the procedure) creating significantly increased medical risk
- Focus needs to be on the underlying source of the behavior (often, but not always, fear)
- Separating out the psychological issue and dealing with that is the best approach – rather than getting into a power struggle over what the provider thinks is best from a medical standpoint.