

CASE REPORT

Somatic Symptom Disorder: Costly, Stressful for Patients and Providers, and Potentially Lethal

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Patients with somatization disorders have twice the annual medical care expenses and use twice as much outpatient and inpatient services as controls (1). They tend to be dissatisfied with their medical care when treatments fail and often “doctor shop.” It is difficult for patients to accept that psychosocial factors may contribute more than underlying pathophysiologic factors to the disorder given the severe and unrelenting nature of their symptoms. In fact, 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 (2).

Although treating the symptoms can be difficult, a good therapeutic alliance helps minimize excessive and unnecessary evaluation and ineffective treatments, reduces medical care utilization and costs, and improves patient satisfaction. Clinicians should help patients focus on functioning and coping, which can be achieved through cognitive-behavioral therapy (CBT) (3, 4). Antidepressants such as selective serotonin reuptake inhibitors have shown some efficacy, whereas opiates have not and should be avoided (5). There is a high rate of comorbidity with other psychiatric disorders, and treatment of these comorbid psychiatric conditions also appears to be helpful (6).

We present the case of an older woman with many of the hallmarks of somatic symptom disorder who resorted to a suicide attempt. The case displays the natural history of suicide in some individuals with somatic symptom disorder, which may help assist clinicians in recognizing warning signs and better treat patients.

CASE

“Mrs. M,” a 53-year-old married, unemployed, Orthodox Jewish woman with suspected bipolar II disorder and unspecified pain syndrome of the nose, was transferred to the psychiatry department from an outside hospital after a suicide attempt. For 3 years prior to her suicide attempt, the patient had been experiencing constant tearing and bilateral pain from the surface of her nose. She attributed her nose pain to “pinched nerves” secondary to teeth grinding in the setting of stress from her daughter’s divorce. Initial treatment for temporomandibular joint dysfunction successfully reduced jaw pain, but her nose pain persisted.

The patient sought evaluation by neurologists, neurosurgeons, and pain specialists. Treatment with opiates, as well as gabapentin and other neuropathic pain medications, failed to improve symptoms. Head imaging revealed a right sphenoid meningioma. However, neurosurgeons from outside and within the institution felt the lateralized meningioma could not adequately explain bilateral nose pain. An outside hospital suggested that the patient’s pain might be psychogenic, and thus she sought outpatient treatment with a private psychiatrist.

The patient’s husband and other family members reported that she became increasingly depressed as the pain continued. Her ability to function drastically declined, and she discontinued her once beloved athletic endeavors because she felt limited by pain. Instead, she remained in bed, rubbing her nose, preoccupied with the pain. She also had minimal appetite, low energy, reduced ability to concentrate, and intermittent passive suicidal ideation.

One week prior to her suicide attempt, the patient had bothersome thoughts, including a new attraction to her rabbi and the feeling she was being “punished for being evil.” She told her husband and saw her psychiatrist the following week. The psychiatrist reportedly told the patient that her thoughts were “foolish” and recommended ECT treatment, since the patient’s medication regimen seemed ineffective. After this psychiatric appointment, she parted from her husband and began the return trip home with her eldest daughter, at which point she jumped in front of an oncoming train. She reported that the attempt was impulsive and the result of “going crazy” after seeing a multitude of doctors, none of whom offered any effective treatment. She denied any recent manic symptoms, suggesting the attempt did not occur during a manic episode. The patient had no prior psychiatric hospitalizations or suicide attempts.

DISCUSSION

Like many with somatic symptom disorder, the above patient was an unemployed older woman with a stressful life event and concurrent psychiatric illness. She met DSM-5 criteria (see Table 1) for a distressing somatic symptom that she perseverated on and devoted excessive time to for more than 6 months. As is typical, she saw numerous doctors without finding a satisfactory treatment. She also demonstrated prevalent severe disability, as she gave up physical activities and felt unable to care for her children. As is common, she found it difficult to accept the psychosocial components of her illness, failing to consider that her unhappiness regarding her daughter’s

TABLE 1. Somatic Symptom Disorder: DSM-5 Versus DSM-IV^a

DSM-5 Diagnostic Criteria	DSM-IV 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: • Disproportionate and persistent thoughts about the seriousness of one's symptoms. • Persistently high level of anxiety about health or symptoms. • 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 than 6 months).	Many physical complaints. Beginning before age 30. Each of the following: • ≥Four pain symptoms • ≥Two gastrointestinal symptoms • ≥One sexual symptom • ≥One pseudoneurological symptom Symptoms cannot be fully explained by a known general medical condition or substance. Not intentionally feigned or produced.

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divorce may have contributed to her nose pain.

Furthermore, the case demonstrates that somatoform symptom disorders, particularly those that are painful, may be a risk factor for suicide. The relationship between somatic symptom disorders and suicide is unclear, given the high comorbidity of depressive disorders that are known to be strongly associated with suicide. One small study of 120 participants showed that somatization disorder is significantly associated with suicide attempt, even after controlling for comorbid depressive and personality disorders (7). Park et al. (8) found that a “medically unexplained pain symptom” specifically increased suicide risk even when co-occurring with another psychiatric illness. In another study of primary care patients, 37% of those with somatoform disorders endorsed any suicidality compared with 7% of those without somatoform disorders. Furthermore, at follow up, 28% of those with somatoform pain disorder endorsed active suicidal ideation. Eighteen percent of these patients had attempted suicide in the past, and 80%

of those who had attempted suicide did so within 6 months of the onset of symptoms. Those with suicidal ideation were more likely to perceive that symptoms caused profound negative effects on their life, would last a long time, and were out of their control (9).

Our patient in the above case had exhausted all non-psychiatric treatment options and made her suicide attempt only after she lost confidence in her last resort, a psychiatrist. She reported that a previous institute told her the pain was “in her head,” and notably she described the attempt as “impulsive” because she was going “crazy” from her pain. Clinicians should take care to avoid making patients feel as though they are responsible for their symptoms or that their pain is somehow less real than that attributable to an identifiable physiological cause. This patient's suicide attempt occurred directly after a visit to her psychiatrist in which the doctor-patient relationship was damaged by the doctor's use of the word “foolish,” which made the patient feel responsible for her unrelenting pain, as well as hopeless. This highlights the importance of thera-

peutic alliance in treating somatoform disorder, not only to avoid alienating patients, but also because poor interactions may make patients feel hopeless. Furthermore, the suicide attempt was made directly in front of the patient's eldest daughter, whose divorce may have contributed to the onset of the disorder, suggesting that stressors associated with a somatoform symptom disorder need to be actively identified and addressed in psychotherapy, such as CBT.

CONCLUSIONS

Unfortunately, psychiatrists are likely the last in the long line of doctors to see somatoform symptom disorder patients. Because of this, it is important that doctors in other disciplines, such as primary care and neurology, be aware of cases showing interaction between somatoform disorders, comorbid mental illness, and suicide. Although existing evidence supports the independent correlation between somatoform disorders and suicide, further research is needed to not only confirm these data, but also to further define the relationship so that improvements can be made in identification and treatment with the goal of reducing suicide and disability.

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KEY POINTS/CLINICAL PEARLS

- Somatic symptom disorder may be a risk factor for suicide; suicidal ideation is important to consider when treating these patients.
- Patients with somatic symptom disorder are prone to doctor shopping and will likely feel failed by medical professionals by the time they see a psychiatrist; therefore, a good doctor-patient relationship is essential.
- Pain may be real and very distressing, even if there is no physiological factor causing it; treatment may include addressing comorbid psychiatric conditions, cognitive-behavioral therapy, and selective serotonin reuptake inhibitors.

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