

# Somatoform disorders presenting with vertigo and balance disturbance - how to identify and manage them



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# Case

- 32 Male unmarried, puberphonia, political worker
- Difficulty in balancing – front back, while walking standing
- CSA, Bullying, cannabis, alcohol, proxyvon, abstinent since 2 years
- Hypertension, hypothyroid, PPBS 79 mg/dl
- Distressed, death wishes, no obvious features of depression, anxiety
- No obvious stressors
- Involuntary jerky movements,
- Referred to Speech pathology, audiology, neurology, physician
- Escitalopram, clonazepam, propranolol

# SOMATIZING PATIENTS IN ENT HAVE

- **Chronic headache**
- **Vertigo, giddiness**
- **Tinnitus**
- **Aphasia**
- **Hearing loss**

# Common case scenarios :

## Chronic Headache

- Vague description of headache, generally all over the head and face, involving neck and shoulder area
- Coexisting other bodily pain of knee and lower back
- General BSO functioning not effected or restricted
- Normal CT Brain, CT Paranasal sinuses, lateral X Ray neck and MRI
- Neuro and Ophthalmology consultations are normal
  
- Suspicion of Tension headache, psychosomatic illnesses, Hypochondriasis

# Common case scenarios: Vertigo

- Episodic and atypical (No associated nystagmus, body posture change related or with associated headache and vomiting)
- Normal MRI brain and CT brain and neck
- Neurological consultation is normal
- No associated comorbidities like chronic diabetes and hypertension
- Suspicion of hypochondriasis, psychosomatic or dissociative illnesses

# Common case scenarios : Tinnitus

- Sudden onset with no relatable cause (Ear trauma, barotrauma, exposure to sudden loud noise)
- Musical in nature or whispering sounds
- Normal Pure Tone Audiogram ruling out sensorineural deafness
- Normal Tympanometry ruling out middle ear fluid or negative pressure
- Masking devices and medicines ineffective
- Suspicion of auditory hallucinations, psychosis

# Common case scenarios : Aphasia

- Non congenital
- Occurs after a personal event that lead to grief or loss of loved one
- Able to make Aaa and ooo sounds but not able to speak
- Able to cough and no history of aspiration
- On video laryngoscopy bilateral vocal cords are mobile and functioning
- Ultrasound neck, CT brain and neck and MRI brain are normal
- Suspicion of dissociative disorder or psychosis [catatonia]

# Common case scenarios : Hearing loss

- Non congenital
- Sudden in onset with out associated viral URTI or trauma
- Pure Tone Audiogram is normal
- ABR (Auditory brainstem responses) and OAE (Otoacoistic emissions) are normal
- CT Brain, MRI Brain are normal
- History of onset with a personal event or grief of a loved one
- Suspicion of dissociative hearing loss or psychosis

# General pointers for referral to PSY

1. Cases where all causes of diagnosis are ruled out through clinical, radiological and pathological investigations and poor or limited response to medical line of treatment for over 6 months
2. Vague or atypical history or clinical presentation that worsens at time of stress
3. Long medical history with lots of consultations and repeat investigations
4. Long consultation periods requiring excessive reassurance, clarification of doubts & queries that are often repetitive and redundant. Patients reaching out over phone multiple times
5. Predominantly anxious and concerned. Family members indicate or suggest psychiatric evaluation

# **Somatoform symptoms & Medically Unexplained Symptoms**

# Somatisation phenomenon

- Physical symptoms
  - For which there are negative evidence
    - no 'demonstrable organic' findings
  - Positive evidence
    - they are linked to psychological factors

# What are we talking about?

- Patients presenting with
  - Physical symptoms
    - No obvious organic cause
  - In addition, identifiable
    - Psychological }  
• Emotional } Factors  
• Behavioural }  
• Psychiatric }
  - Unidentifiable
    - Spiritual factors

# Medically Unexplained Symptoms

- Medically implies ? Psychologically, social, psychiatric, or investigations
- Temporary category till explanation found !
- Un understood hence unexplained → mysterious
- Impact on patient, families, health professionals
- Multifactorial and multi dimensional like most psychiatric diagnosis / categories
- There are many explanations often

# Medically unexplained symptoms

- Professionals do not like this term
  - Implies they don't know what's wrong
  - And can't be bothered to find out or too bothered to do numerous investigations
  - Patients have numerous records and thick files
  - No identifiable pathology – feel frustrated and cheated
  - Anger towards patients, for testing their knowledge and patience

# Reasons for confusion

- Clinicians afraid of getting it wrong
  - Aware of limitations of ‘tests’
  - Difficult to be certain
- Afraid of litigation
  - Or upsetting the patient
- Uncomfortable in broaching issues
  - For which they are poorly trained
- Reluctant to open “a can or worms” or ‘getting the lid off’
  - Which they do not have time to deal with

# Iatrogenic causes

- Medicalisation of patient's symptoms
  - Over-investigation
  - Inappropriate treatment
    - Especially by more junior doctors
  - Failure to provide clear explanation for symptoms
    - Increasing uncertainty and anxiety
  - Failure to recognise and treat emotional factors

# Difficulties in Managing Somatoform vertigo

- **Should they be treated ? To treat or not to treat**
- **Who should treat ?**
- **How to treat ?**
  
- **What and how to communicate ?**
- **Should we provide information, if so how much, when, how ...?**

- **How much to investigate ? Problems with under investigating, over investigations.**
- **Should medicate or not ?**
- **How much to medicate ? &**
- **With what drugs ?**
- **How long to treat ?**
- **How to prevent doctor shopping ?**
- **When to refer ?**
- **How to improve compliance ?**
- **What should be the goal of management?**

# Diagnostic Issues

- **Functional Somatising Disorder**
- **Physical disease with insufficient evidence of pathology**
- **Co-existing Physical disease & Psychiatric disorder**
- **Idiopathic disorder**

# Characteristics of Somatisers

- **Somatic focusing**
- **Somatic preoccupation**
- **Somatic interpretation – misinterpretation**
- **Somatic amplification & exaggeration**
- **Sick role**
- **Neuroticism**
- **Alexithymia**

# Recognition of somatisation is important

- **To avoid unnecessary tests**
- **To avoid inappropriate treatment**
- **To prevent encouragement & reinforcement of abnormal behaviours**

**Vulnerability factors**

- Current subthreshold organic disease
- (Epi-)genetic profiles
- Prior organic disease
- Adverse childhood experiences
- Precedent life stressors
- Cultural beliefs

Sensory input

Expectation

**Triggering factors**

Acute illness, accidents

Perception of bodily distress

Current life stressors

**Maintaining/ aggravating factors**

Sequelae of prior inappropriate treatment

Avoidance and deconditioning

Cognitive and emotional factors (anxiety, depression, illness conviction)

Health care experiences  
Operant conditioning ("secondary gain")

Sensory input

Expectation

Chronic, disabling bodily distress

# Other names & terms

- Hysterical or HYS
- Psychogenic
- ‘Supratentorial’
- All in the head
- Faking or feigning or deliberately doing
- Malingering
- Factitious
- Out of proportion
- There’s nothing

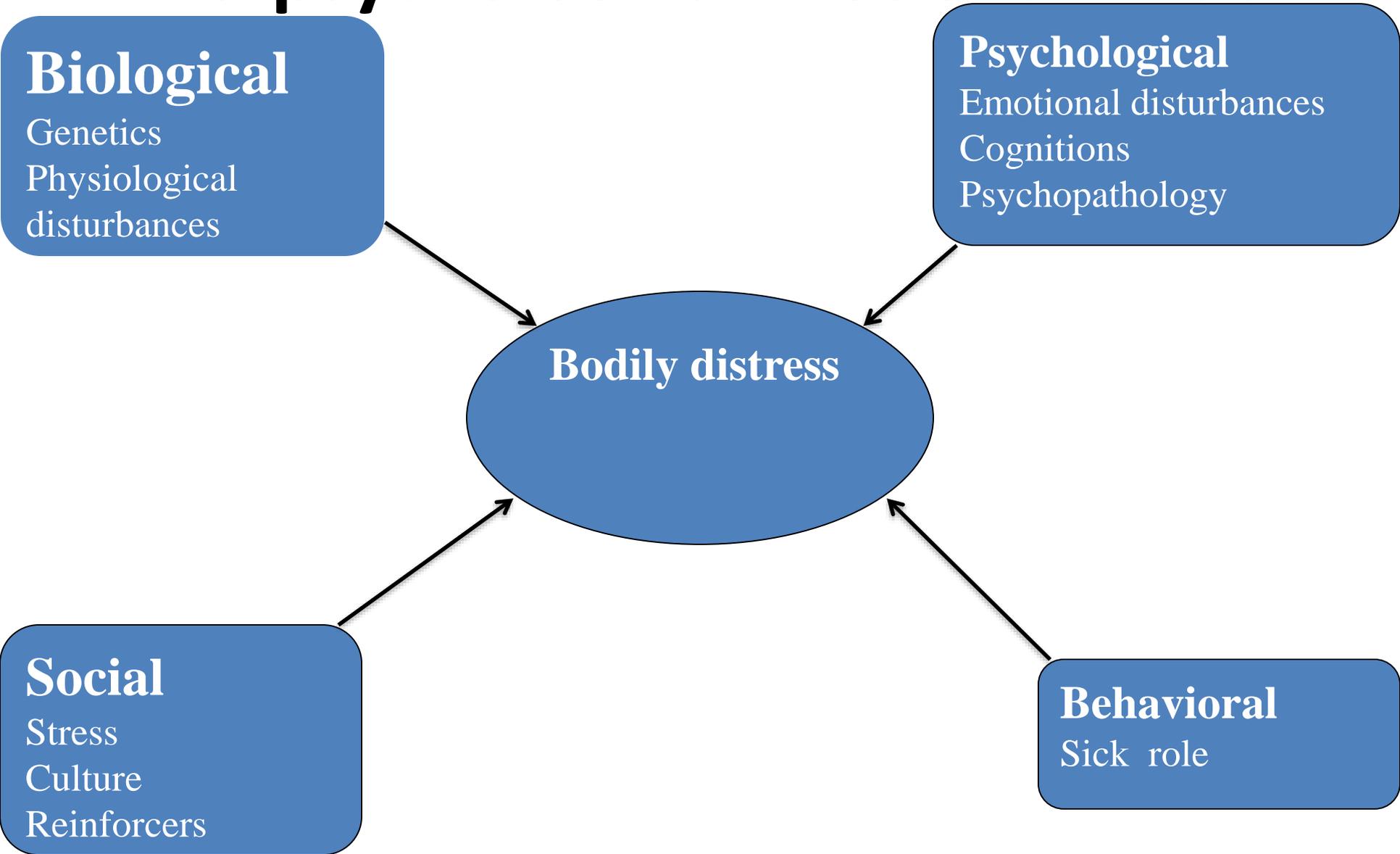
# Alternative terms

- Idiopathic disorders
- Anonymous disorders
- Bodily symptom of unknown origin
  
- Functional somatic symptoms

# Somatoform disorder

- **ICD-10 : (F-45)**
  - Somatization disorder
  - Undifferentiated somatoform disorder
  - Hypochondriacal disorder
  - Somatoform autonomic dysfunction
  - Persistent somatoform pain disorder
  - Other somatoform disorders
  - Somatoform disorder, *unspecified*
- There are other disorders with prominent somatic presentations

# Bio-psycho-social model of MUS



# Clinical Multiaxial classification

- Multiaxial classification

**Bodily symptom e.g., giddiness or vertigo**

with or w.o. Depression / anxiety

with or w.o. antecedent stress or life event

with or w.o. somatic focus/preoccupation etc

with or w.o. attribution/misattribution

with or w.o. coexisting medical disorder .....

# ICD 11: Bodily distress disorder

- Bodily distress disorders include presence of persistent bodily symptoms that are distressing to the individual with excessive attention towards the symptoms.
- The symptoms are not alleviated by clinical examination or investigations and associated with significant impairment in functioning.
- (1) Mild Bodily Distress Disorder
- (2) Moderate Bodily Distress Disorder, and
- (3) Severe Bodily Distress Disorder.

Severity is assessed in terms of the degree of distress or preoccupation with bodily symptoms, persistence of the disorder, as well as the degree of impairment and healthcare seeking behaviour.

	<b>DSM 5</b>	<b>ICD 11</b>
<b>Name</b>	<b>Somatic symptom disorder</b>	<b>Bodily Distress Disorders</b>
<b>Diagnostic criteria</b>	<b>One or more distressing symptoms With excessive thoughts, feelings, behaviours Health seeking</b>	<b>One or more distressing symptoms Excessive attention on the symptoms Not alleviated by reassurance after clinical examination/investigations.</b>
<b>Specifier</b>	<b>Pain Duration</b>	<b>None</b>
<b>Sub categories of somatoform disorders</b>	<b>Removed</b>	<b>Removed</b>
<b>Hypochondriasis</b>	<b>Renamed as Illness anxiety disorder and is included under SSD</b>	<b>Moved to OCD and related disorders</b>
<b>Severity</b>	<b>Mild Moderate and Severe Based on the number of symptoms under Criterion B</b>	<b>Mild Moderate and Severe Based on the preoccupation duration and impact on functioning</b>

# Somatiform Giddiness & Dizziness

- Common symptom in Anxiety, Depression
- Anxiety and Depression can be comorbid in [patients with Vertigo/ Giddiness/Dizziness
- Challenging to delineate the two
- Poor response to treatment, co morbid anxiety and Depression, phobia of losing balance- manifest as Illness behaviours

# Giddiness as a symptom in somatoform disorders

- Giddiness as a symptom has been included in majority of the scales for somatoform disorders
- Scale for Assessment of Somatic Symptoms
- Patient Health Questionnaire
- Swartz Somatization Index
- Bradford Somatic Inventory

# Giddiness & Dizziness as MUS

- In a study on 301 subjects with chronic non organic pain as presenting symptoms, Dizziness (moderate to severe intensity) was found in 24 subjects
- Of the 24, 16 were women; mean age 36.23 $\pm$  7.5
- The most common Psychosomatic Diagnosis were
  - Health Anxiety (17)
  - Disease Phobia (6)
  - Alexithymia (8)

# Psychiatric Diagnosis (ICD-10)

- Somatoform Disorders (12)
- Pain disorders (7)
- Anxiety and Depression (5)

Other bodily symptoms along with giddiness, in numbers

- 0            5
- 1            9
- 2            6
- 3            4
- 4            2

# Other physical symptoms

- Headache 18
- Palpitations 9
- Pain in limbs 9
- Weakness of body 20
- Lack of sleep 24
- Poor appetite 22

# Illness Behaviors and Dizziness

- Illness Behaviors measured by Illness Behavior questionnaire (IBQ) on patients with giddiness versus all somatisers

- Mean scores of on subscales of IBQ

• Health concerns	7.29 <sub>±</sub> 4.23	6.49 <sub>±</sub> 3.67*
• Affective inhibition	2.46 <sub>±</sub> 1.93	2.64 <sub>±</sub> 1.80
• Affective distress	5.79 <sub>±</sub> 3.68	5.11 <sub>±</sub> 3.33
• Bodily distress	11.38 <sub>±</sub> 3.21	11.34 <sub>±</sub> 3.15

# **GENERAL MANAGEMENT STRATEGIES:**

- 1. Evaluation**
- 2. LISTEN**
- 3. Physical Examination**
- 4. Acknowledge symptoms; Clarify it does not mean 'malingering'**
- 5. Relevant & Rational Investigations**
- 6. Feedback**

# **GENERAL MANAGEMENT STRATEGIES:**

- 7. Elicit concerns**
- 8. Emotional / Psychological factors;  
Give idea about psychological  
nature**
- 9. Symptom reduction**
- 10. Rehabilitation : Focus on coping &  
care instead of cure & to maintain  
the best possible QUALITY OF LIFE**

# Avoid the following

- “I can’t find anything wrong with you”
- “There’s nothing abnormal to find”
  - They will simply go elsewhere to find a better doctor who can find out what’s wrong
- Indicate what is wrong
  - Both physically and psychologically
    - Make sure they understand that this is an entirely normal and very common response to their condition
  - Beware of ‘stigma’ of psychiatric diagnosis

# Difficulties in Managing Somatisers

- **Should they be treated ?**
  - Should be managed
- **Who should treat ?**
  - Their own doctor or specialist, family physician, psychiatrist, preferably one person
- **How to treat ?**
  - Multi modal, need based management

# Difficulties in Managing Somatisers

- **What and how to communicate ?**
  - Listening, exploring concerns & coping
- **Should we provide information, if so how much, when, how ...?**
  - Yes, if asked for, in bits and pieces, check understanding and feelings.
- **How much to investigate ?**
  - Relevant and necessary investigations and discuss results, if asked for.
  - Discuss investigations demanded by the patient or family.

# Difficulties in Managing Somatisers

- **Should medicate or not ?**
  - If necessary.
- **How much to medicate ?**
  - Seek patients view point
- **With what drugs ?**
  - As needed, antidepressants, anti anxiety medications, Vitamins & drugs for medical problem

# Difficulties in Managing Somatisers

- **How long to treat ?**
  - Usually short duration.
- **How to prevent doctor shopping ?**
  - By appropriate communication.
- **When to refer to psychiatrist?**
  - Before chronicity sets in.
- **How to improve compliance ?**
  - By information and education

# Management of somatoform giddiness

- Empathic relationship with the patient
- Assessment of severity of the symptoms and other symptoms
- Assess Distress and impairment
- Experiences related to health care to elicit illness behaviours
- Assess comorbid anxiety and depression
- Consider anxiolytics and antidepressants, if need be; be aware of side effects of psychotropics
- Psychological & behavioural interventions

# How to refer to a mental health professional

- Discuss the need for referral with the patient
- Discuss the possibility of psychosocial factors, in maintaining and perpetuating the symptoms
- Discuss the goal of treatment is to remove symptoms and improve functioning
- Discuss the mind body relationships

# **In Conclusion :**

- **Medically unexplained giddiness symptoms are complex & common problem**
- **Invariably, these indicate a 'cry for help'**
- **Need to be understood, handled with care & caution**
- **Naming an illness in itself is a therapeutic act. The patient's anxiety decreases as naming shows that the doctor understands what the matter is.**
- **Try to achieve symptom relief and good QOL**
- **Try to prevent chronicity & doctor shopping**

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