Somatic Symptom and Related Disorders

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Psychosomatic Medicine

Psychosomatic medicine has been a specific area of concern within the field of psychiatry for more than 50 years. The term psychosomatic is derived from the Greek words psyche (soul) and soma (body). The term literally refers to how the mind affects the body. The practice of psychosomatic medicine has evolved considerably since its early clinical origins and has come to focus on psychiatric illnesses that occur in the setting of physical health care. Psychiatric morbidity is very common in patients with medical conditions, with a prevalence ranging from 20 to 67 percent, depending on the illness . Psychiatric morbidity has serious effects on medically ill patients and is often a risk factor for their medical conditions.

Psychosomatic Medicine

It is well established that depression is both a risk factor and a poor prognostic indicator in coronary artery disease. Psychiatric illness worsens cardiac morbidity and mortality in patients with a history of myocardial infarction, diminishes glycemic control in patients with diabetes, and decreases return to functioning in patients experiencing a stroke. Depressive and anxiety disorders compound the disability associated with stroke .

Psychological Factors Affecting Other Medical Conditions

- Patients have one or more clinically significant psychologic or behavior factors (stress, anxiety)that adversely affect an existing medical disorder (eg, diabetes mellitus, heart disease, asthma) or symptom (eg, pain). These factors may increase the risk of suffering, death, or disability; aggravate an underlying medical condition; or result in hospitalization or emergency department visit

- **Examples** include anxiety worsening asthma, denial of need for treatment for acute chest pain, and manipulating insulin doses in order to lose weight..

Psychological Factors Affecting Other Medical Conditions

- **<u>Psychologic or behavior factors that can adversely affect a medical disorder include</u>**
  - Denial of the significance or severity of symptoms
  - Poor adherence to prescribed testing and treatment
- **<u>Epidemiology</u>**

Prevalence and gender differences are unclear.

Can occur across the life span.

DSM-5 criteria of **Psychological Factors Affecting Other Medical Conditions**

A. A medical symptom or condition (other than a mental disorder) is present.

B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:

1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
3. The factors constitute additional well-established health risks for the individual.
4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.

C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

Psychological Factors Affecting Other Medical Conditions

- **TREATMENT**

- Treatment includes education and frequent contact with a primary care physician.

- SSRIs and/or psychotherapy (especially CBT) should be used to treat underlying anxiety or depression

Somatic symptoms and related disorders

- A group of disorders that share a common feature which is: the prominence of somatic symptoms associated with significant distress and impairment in social, occupational, or other areas of functioning.

Somatic Symptom and Related Disorders

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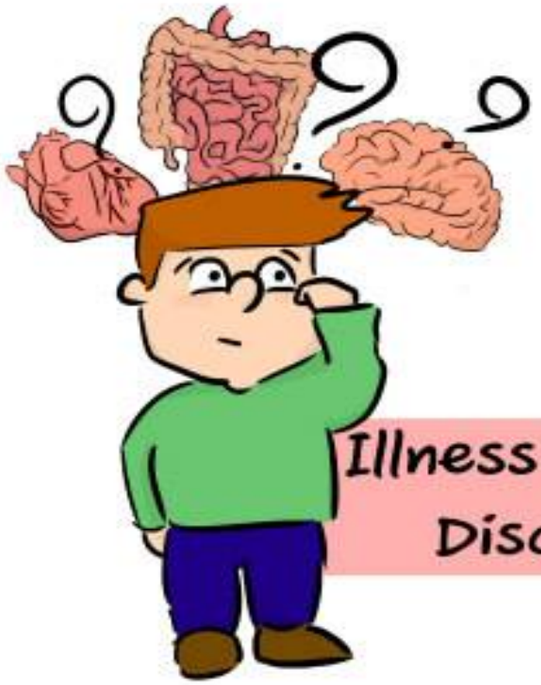

Illness Anxiety Disorder

Somatic Symptom Disorders

Conversion Disorder

(Functional Neurological Symptom Disorder)

Factitious Disorder

Other Specified Somatic Symptom and Related Disorder

Unspecified Somatic Symptom and Related Disorder

Psychological Factors Affecting Other Medical Conditions

- Ms. Thomas is a 31-year-old woman who was referred to a psychiatrist by her gynecologist after undergoing multiple exploratory surgeries for abdominal pain and gynecologic concerns with no definitive findings. The patient reports that she has had extensive medical problems dating back to adolescence. She reports periods of extreme abdominal pain, vomiting, diarrhea, and possible food intolerances. The obstetrician is her fourth provider because "my other doctors were not able to help me." Ms. Thomas reports fear that her current physician will also fail to relieve her distress. She was reluctant to see a psychiatrist and did so only after her obstetrician agreed to follow her after her psychiatric appointment. Ms. Thomas states that her problems worsened in college, which was the first time she underwent surgery. it took her 5½ years to graduate from college. She reports recently feeling very lonely and isolated Additionally, she is concerned that she might lose her job due to the number of days she has missed from work due to her abdominal pain, fatigue, and weakness.

- ***What is her diagnosis? ?***

Somatic symptom disorder

Somatic symptom disorder, also known as hypochondriasis, is characterized by 6 or more months of a general and nondelusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms. This preoccupation causes significant distress and impairment in one's life; it is not accounted for by another psychiatric or medical disorder;

.

Somatic symptom disorder

The DSM-5 diagnosis of somatic symptom disorder replaces the previous DSM-IV and DSM-IV-TR diagnoses of somatization disorder and undifferentiated somatoform disorder.

Somatic symptom disorder is defined by the **presence of somatic symptoms** (as pain , nausea ,dizziness and fainting) , as in the older classifications. Patients with somatic symptom disorder present with at least one (and often multiple) physical symptoms. They frequently seek treatment from many doctors, often resulting in extensive lab work, diagnostic procedures, hospitalizations, and/or surgeries.

Somatic symptom disorder

- the DSM-5 criteria for somatic symptom disorder do **not require that the symptoms be medically unexplained**, **nor are specific numbers or types of symptoms needed to meet the diagnosis.** Rather, the additional core feature of this diagnosis is presence of **abnormal thoughts, feelings, and behaviors associated with the somatic symptoms.**

- **DSM-5 Diagnostic Criteria for Somatic Symptom Disorder**

- A. one or more somatic symptoms that are distressing or result in significant disruption of daily life
- B. excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
  1. disproportionate and persistent thoughts about the seriousness of one's symptoms
  2. persistently high level of anxiety about health or symptoms
  3. 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 >6 mo)
  - **specify: with predominant pain**(previously pain disorder)for those whose somatic symptom is primarily pain

- patients have physical symptoms and believe these symptoms represent the manifestation of a serious illness

- persistent belief despite negative medical investigations and may develop different symptoms over time

SOMATIC SYMPTOM DISORDER (aka SOMATIZATION or SOMATOFORM DISORDER)

PHYSICAL SYMPTOMS NOT EXPLAINED by PHYSICAL/MENTAL DISORDER

OFTEN CAN'T BE SCIENTIFICALLY PROVEN

I'M NOT FAKING!

* DIFFERENT than FAKING for ATTENTION

EPIDEMIOLOGY

In general medical clinic populations, the reported 6-month prevalence of this disorder is 4 to 6 percent, but it may be as high as 15 percent. Men and women are equally affected by this disorder. Although the onset of symptoms can occur at any age, the disorder most commonly appears in persons 20 to 30 years of age.

- More common in **blacks** than among whites.
- Social position, education level, gender and marital status do not appear affected.
- This disorder's complaints reportedly occur in about **3% of medical students** usually in the first 2 years.

Etiology

- Persons with this disorder augment and amplify their somatic sensations; they have low thresholds for, and low tolerance of physical discomfort.
- Somatic symptom disorder is sometimes a variant form of other mental disorders.
- **80 percent of patients with this disorder may have coexisting depressive or anxiety disorders**.
- This disorder is also viewed as a defense against guilt, a sense of innate badness, an expression of low self-esteem, and a sign of excessive self-concern.

Course and prognosis

- **Episodic**, lasts from months to years and separated by equally long quiescent periods.
- Symptoms may periodically improve and then worsen under stress.
- **Good prognosis is associated with :**

✓ **High socioeconomic status**
✓ **Treatment responsive depression or anxiety**
✓ **Sudden onset of symptoms**
✓ **Absence of personality disorder**
✓ **Absence of related non-psychotic medical condition.**

Course and prognosis

- ✓ the most frequent and important complications:
  - Repeated surgical operations
  - Drug dependence
  - Suicidal attempts
  - Marital separation or divorce
- ✓ There is no evidence of excess mortality

Treatment

- Psychotherapy:
- Patients with somatic symptom disorder usually resist psychiatric treatment, although some accept this treatment if it takes place in a medical setting and focuses on stress reduction and education in coping with chronic illness.
- **Group psychotherapy** often benefits such patients, in part because it provides the social support and social interaction that seem to reduce their anxiety.
- Other forms of psychotherapy, such as individual insight – oriented psychotherapy, behavior therapy, cognitive therapy, and hypnosis may be useful.

Treatment

- **Frequent, regularly scheduled examinations** help to reassure patients that physicians are not abandoning them and their complaints are taken seriously.
- Invasive diagnostic and therapeutic procedures should only be undertaken, however, when evidence calls for them. When possible, the clinician should refrain from treating equivocal or incidental physical examination findings.
- Pharmacology alleviates somatic symptom disorder only when a patient has an underlying drug responsive condition, such as an anxiety disorder or depressive disorder.

A 44-year-old woman presents to her primary care doctor with multiple complaints, including weakness in her lower extremities, bloating,headaches, intermittent loss of appetite, and back pain. A careful review of symptoms reveals many other vague symptoms. Her complaints date back to adolescence and she has seen many doctors. Thorough workups, including an exploratory laparotomy, have failed to uncover any clear, anatomic, or physiologic cause.

Illness Anxiety Disorder

Illness Anxiety Disorder

Illness anxiety disorder is a new diagnosis in the fifth edition of Diagnostic and Statistical Manual of Mental Disorders(DSM-5) that applies to those persons who are preoccupied with being sick or with developing a disease of some kind. It is a variant of somatic symptom disorder (hypochondriasis) described in Section 13.2. As stated in DSM-5: Most individuals with hypochondriasis are now classified as having somatic symptom disorder; however, in a minority of cases, the diagnosis of illness anxiety disorder applies instead. In describing the differential diagnosis between the two, **according to DSM-5, somatic symptom disorder is diagnosed when somatic symptoms are present, whereas in illness anxiety disorder, there are few or no somatic symptoms and persons are "primarily concerned with the idea they are ill."**

Illness Anxiety Disorder

- Two predominant types of illness anxiety disorder are recognized in DSM-5:
  - Care-seeking type (in which medical care is frequently used)
  - Care-avoidant type (in which medical care is rarely accessed)

- **DSM-5 Diagnostic Criteria for Illness Anxiety Disorder**

A. Preoccupation with having or acquiring a serious illness.

B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.

C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.

D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).

- **DSM-5 Diagnostic Criteria for Illness Anxiety Disorder**

E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.

F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether:
Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

Illness Anxiety Disorder

- Patients with illness anxiety disorder are most commonly encountered in medical settings but may go to psychiatrists for treatment of anxiety.

- These patients' excessive concerns about undiagnosed disease are unlikely to be alleviated by medical reassurance or negative diagnostic tests.

Epidemiology

- The prevalence of this disorder is unknown aside from using data that relate to hypochondriasis, which gives a prevalence of 4 to 6 percent in a general medical clinic population. In other surveys, up to 15 percent of persons in the general population worry about becoming sick and incapacitated as a result. One might expect the disorder to be diagnosed more frequently in older rather than younger persons.

- Male to female ratio 1:1

Prognosis

- **Chronic but episodic**—symptoms may wax and wane periodically.
- **Better prognostic factors include fewer somatic symptoms, shorter duration of illness.**

Treatment

- A recommended treatment approach is consistent treatment, generally by the same primary physician, with supportive, regularly scheduled office visits not focused on the evaluation of symptoms.
- Because illness anxiety disorder shares many features with other anxiety disorders, it can be expected that **SSRI pharmacotherapy** may have some utility

Conversion Disorder (Functional Neurological Symptom Disorder)

Conversion Disorder (Functional Neurological Symptom Disorder)

- The essential feature is the presence of **symptoms of altered motor or sensory function that** (as evidenced by clinical findings) are incompatible with any recognized neurological or medical condition and not better explained by another medical or mental disorder.
- The DSM-5 criteria for conversion disorder explicitly require neurological examination findings that are inconsistent with known neurological disease.

DSM-5 Diagnostic Criteria forConversion Disorder (Functional Neurological Symptom Disorder)

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder. or substance use .

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Conversion Disorder (Functional Neurological Symptom Disorder)

- The most common conversion disorder symptoms are :

paralysis, blindness, mutism sensory complaints (paresthesia), seizures, globus sensation (globus hystericus or sensation of lump in throat).

Epidemiology

- Reported rates of conversion disorder vary from 11of 100,000 to 300 of 100,000 in general population samples.

- The ratio of women to men among adult patients is at least 2 to 1 and as much as 10 to 1 among children, an even higher predominance is seen in girls

- Onset at any age, but more often in adolescence or early adulthood

Conversion Disorder (Functional Neurological Symptom Disorder)

- Onset of conversion disorder is generally acute, but it may be characterized by gradually increasing symptomatology.
- **The onset** of conversion disorder is generally from **late childhood to early adulthood** and is rare before 10 years of age or after 35 years of age

- The typical course of individual conversion symptoms is generally short; **half to nearly all patients show a disappearance of symptoms by the time of hospital discharge.**
- However, 20%–25% will relapse within 1 year.

Conversion Disorder (Functional Neurological Symptom Disorder)

Factors traditionally associated with good prognosis:

- Acute onset.
- Presence of clearly identifiable stress at the time of onset.
- Short interval between onset and institution of treatment.
- Good intelligence.

Conversion Disorder (Functional Neurological Symptom Disorder)

- Conversion disorder may be most commonly associated with **dependent, antisocial, and histrionic personality disorders.**
- Depressive and anxiety disorder symptoms often accompany the symptoms of conversion disorder, and affected patients are **at risk for suicide**

Conversion Disorder (Functional Neurological Symptom Disorder)

- La Belle Indifference is a condition in which the person is unconcerned with symptoms caused by a conversion disorder; that is, the patient seems to be unconcerned about what appears to be a major impairment.

- The presence or absence of la belle indifférence is not pathognomonic of conversion disorder, but it is often associated with the condition.

Treatment

- Resolution of the conversion disorder symptom is usually spontaneous, although it is probably facilitated by insight oriented supportive or behavior therapy.

- The most important feature of the therapy is a relationship with a caring and confident therapist.

- Telling such patients that their symptoms are imaginary often makes them worse.

Mr. J is a 28 year old single man who worked in a factory. He was fired from his job recently. He was brought to the ER by his father complaining of vision loss while sitting in the back seat on the way home from a family gathering. There was no history of trauma . On exam , the pt was cooperative and his attitude was unconcerned about his blindness. Pupillary, occulomotor and general sensorimotor examinations were normal. Investigations came back normal also. What is the diagnosis?

Malingering

Malingering is the **fabricating of symptoms of mental or physical disorders for a variety of reasons such as financial compensation , avoiding school , work or military service , obtaining drugs , or as a mitigating factor for sentencing in criminal cases . It is not medical diagnosis . And it is more common in males.**

Malingering is typically conceptualized as being distinct from other forms of excessive illness behavior such as somatization disorder and factitious disorder.

Malingering

PRESENTATION

- Patients usually present with multiple vague complaints that do not conform to a known medical condition.
- They often have a long medical history with many hospital stays.
- They are generally uncooperative and refuse to accept a good prognosis even after extensive medical evaluation.
- Their symptoms improve once their desired objective is obtained

Factitious Disorder (Münchhausen syndrome)

Factitious Disorder

- A mental illness where an individual fabricates or exaggerate a physical or psychological symptoms to play the role of sick.

- **Not for : Money, time off from work or to take some medications as malingering**

- These symptoms can be fake or induced, like taking some medication to induce vomiting.

Factitious Disorder

- The essential feature is the **falsification of medical or psychological signs and symptoms in oneself or others that are associated with the identified deception.**

- Individuals with factitious disorder can also seek treatment for **themselves or another** following induction of injury or disease.

- The diagnosis requires demonstrating that the individual is taking surreptitious actions to misrepresent, simulate, or cause signs or symptoms of illness or injury in the **absence of obvious external rewards.**

Factitious Disorder

- **DIAGNOSIS AND DSM-5 CRITERIA**

- **Falsification of physical or psychological signs or symptoms**, or induction of injury or disease, associated with identified deception.

- The deceptive behavior is evident even in the **absence of obvious external rewards (such as in malingering).**

- Individual can present him/herself, or another individual as ill ,impaired or injured (as in factitious disorder imposed on another).

- Behavior is **not better explained by another mental disorder**, such as delusional disorder or another psychotic disorder.

- Commonly feigned symptoms:

❖ Psychiatric—hallucinations, depression

❖ Medical—fever (by heating the thermometer), infection, hypoglycemia, abdominal pain, seizures and hematuria .

Factitious Disorder

Factitious Disorder by Proxy

- In this diagnosis, a person intentionally produces physical signs or symptoms in **another person** who is under the first person's care, hence the DSM-5 diagnosis of "Factitious Disorder Imposed on Another."

- One apparent purpose of the behavior is for the caretaker to indirectly assume the sick role; another is to be relieved of the care taking role by having the child hospitalized.

- The most common case of factitious disorder by proxy involves a **mother who deceives medical personnel into believing that her child is ill.**

- **Treatment** : **separation**

Factitious Disorder

- Prevalence: 0.8 to 1%

- Patients diagnosed with factitious disorders with physical signs and symptoms are mostly women, who outnumber men 3 to 1 .They are usually 20 to 40 years of age with a history of employment or education in nursing or a health care occupation.

- Associated with personality disorders.

- Many patients have a history of illness and hospitalization, as well as childhood physical or sexual abuse.

Clues that Should Trigger Suspicion of Factitious Disorder

- **Unusual, dramatic presentation of symptoms that defy conventional medical or psychiatric understanding.**
- **Symptoms do not respond appropriately to usual treatment or medications.**
- **Emergence of new, unusual symptoms when other symptoms resolve.**
- **Eagerness to undergo procedures or testing or to recount symptoms.**

Clues that Should Trigger Suspicion of Factitious Disorder

- **Reluctance to give access to collateral sources of information (i. e., refusing to sign releases of information or to give contact information for family and friends).**

- **Extensive medical history or evidence of multiple surgeries.**

- **Multiple drug allergies.**

- **Medical profession.**

- **Few visitors.**

- **Ability to forecast unusual progression of symptoms or unusual response to treatment.**

You are treating a 48-year-old married female on the inpatient medical unit for pyelonephritis; she has responded well to appropriate antibiotic therapy and has been afebrile for the last 24 hours. You inform her of likely discharge if she continues to improve. The next morning, however, she complains of feeling feverish and achy, and having dysuria again. The nursing staff reports that she has a sudden fever of 103°F. You treat the fever with acetaminophen and perform a physical examination, order chest x-rays, draw blood, and order a urinalysis with culture. While you are awaiting these results, the nurse informs you that she witnessed the patient dipping her thermometer into a hot cup of tea before her temperature was taken.

Which of the following diagnoses most likely accounts for this woman's behavior?

(A) Factitious disorder
(B) Functional neurological symptom disorder
(C) Illness anxiety disorder
(D) Malingering
(E) Somatic symptom disorder

Table 7. Differential of Somatic Symptom and Related Disorders

	Somatic Symptom Disorder	Illness Anxiety Disorder	Conversion Disorder	Factitious Disorder	Malingering
Somatic Symptoms	Present	Mild or absent	Neurologic, voluntary motor or sensory	Psychological or physical	Psychological or physical
Symptoms Produced	Unconsciously	Unconsciously	Unconsciously	Consciously	Consciously
Physical Findings	Absent	Absent	Incompatible	Possible, attempts to falsify	Possible, attempts to falsify

Review of Distinguishing Features

- ▪▪ **Somatic symptom disorders:** Patients *believe* they are ill and do not intentionally produce or feign symptoms.

- ▪▪ **Factitious disorder:** Patients intentionally produce symptoms of a psychological or physical illness because of a desire to assume the *sick role,* not for external rewards.

- ▪▪ **Malingering:** Patients intentionally produce or feign symptoms for *external rewards*.

The End