

SOMATIC SYMPTOMS AND RELATED DISORDERS



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OBJECTIVES

1. Compare and contrast the etiologies and basic symptoms of somatic system disorders.
2. Differentiate the significant differences between the bulk o the somatic symptom and related disorders and factitious disorder.
3. Understand how this would affect your thought process while giving nursing care.
4. Identify factors that can make it difficult to identify somatic symptom disorders.

Definitions

SOMATIZATION

- To **somatize** is the process of experiencing and communicating psychological distress through physical symptoms.
- The symptoms may or may not have a medical basis that can be identified.
- A key identifying feature is the patient's disproportionate and excessive distressful reaction to the physical symptoms, which causes life impairment.
- This is an unconscious process in most cases, with the exception of factitious disorder.



What Exactly Are Somatic Symptom Disorders?

- **Somatic symptom disorder** and related disorders (formerly called somatoform disorders) are an umbrella group of disorders characterized by the presence of one or more physical symptoms accompanied by **abnormal thoughts, feelings, and behavioral reactions** in response to these symptoms, often in the absence of known physical findings or medical illnesses that would explain them.
- These symptoms are associated with extreme distress and/or dysfunction contributing to life impairment.
- The emphasis is not only on the presence of physical symptoms but also on the way an individual presents and interprets the symptoms in a persistent and excessive manner.

- Often, people with somatic symptom disorders are associated with increased health care use, functional impairment, dissatisfaction with and changing providers, psychiatric comorbidity, and failure to respond to standard treatment.
- Individuals with somatic symptom disorders are often seen in medical clinics and not psychiatric settings because the distressing symptoms present as primarily physical in nature.
- Actual diagnosed medical issues and somatic syndrome disorders can be present concurrently, which can make it difficult to diagnose.

MUPS: Medically Unexplained Physical Symptoms

- Broader Term that encompasses Somatoform disorders
- Defined as “complaints of physical symptoms or signs for which there is no adequate objective pathophysiologic evidence to explain the distress”¹
- Secondary MUPS: Patients with primary psychiatric disorder experienced as a physical symptom (e.g., Major Depression and Vegetative Symptoms)

Assignment read and prepare submission on the medically unexplained Syndrome

- irritable Bowel
- Chronic Pelvic Pain
- Fibromyalgia
- Non-Cardiac Chest Pain
- Non-Epileptic Seizures
- Respiratory Hyperventilation Syndrome
- Chronic Fatigue Syndrome

How Common?

- Difficult to measure; heterogeneous group of disorders; PCPs have different levels of receptivity
- Meta-analysis (7) cohorts: Prevalence Rates
 - 11-21% in younger adults
 - 10-20% in middle aged
 - 1.5 -13% in older age
- MUS show wider ranges – but still lower after age 65.

Why would anyone want to be sick?

Sorry I spent all day
Googling how to kill
my boss and get
away with it.



your  cards
someecards.com

Factors that influence illness behavior:

- Genuine organic pathology
- Modulation of symptoms by co-morbid depression or anxiety
- Process of perception and symptoms interpretation
- Reactions of others (family, friends, etc)
- Iatrogenic processes
- Insurance, compensation, and disability systems

1. SOMATIC SYMPTOM DISORDER

- People with somatic symptom disorders are extremely and persistently preoccupied with and distressed by their perceived health issues.
- They may demand unnecessary tests, and may be noncompliant with provider recommendations.
- Individuals with this disorder experience significant life impairment as a result of their symptoms, preoccupation, and high anxiety.
- They tend to incur large health care costs, with the person usually failing to respond to standard treatment.

- When patients do not obtain an answer from a physician concerning their physical distress, they may become frustrated and visit several medical facilities seeking relief (referred to as “doctor shopping”).
- Unfortunately, these individuals often undergo unnecessary surgeries, invasive diagnostic procedures, and drug trials, all of which can be life-threatening.
- This situation can also be frustrating for the medical professionals involved because of the inability to find causes and the high emotionality of the patients.
- It is important to remember that in most somatic symptom disorders, with the exception of factitious disorders, these symptoms are not intentional or under the conscious control of the patient.

PREVALENCE AND COMORBIDITY

- Prevalence rates of somatic symptom disorders in the general population are about 4%.
- It is estimated, however, that 30% of patients seen by their primary care providers present with unexplained symptoms, and 30% of these patients are diagnosed with no serious medical basis for their symptoms.
- No differences in the rates of somatic syndrome disorders were found across cultures, although the unique expression of the disorder may vary.

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- Differentiating somatic symptom disorders from physical disorders and identifying co-occurring/**comorbid medical or psychiatric conditions** are significant issues for the primary care provider.
 - Research shows that half of all frequent users of medical care have psychological problems.
 - Psychiatric disorders are frequently present in people who have unexplained medical complaints, including **depressive disorders** and **anxiety disorders** in approximately 50% of patients (Burton et al., 2011).

ETHIOLOGY-THEORY

Genetic Factors:

- Several factors may contribute to the development of somatic symptom disorders.
- These include genetic vulnerabilities such as low tolerance to pain, early trauma, learning disorders (such as attention during illness or failure to learn emotional coping methods), and societal recognition of physical problems while devaluing psychological distress (APA, 2013)

- School stressors are a common environmental actor in the development and continuation of these symptoms (Hart et al., 2011).
- There is no direct evidence of a genetic etiology or any one *specific* somatic symptom disorder.
- However, data do support a genetic theory that somatic symptom disorder tends to occur in families, presenting in 10% to 20% of first-degree relatives with somatization disorder (Spratt, 2014).
- Rates may also be higher in monozygotic twins (Ask et al., 2016) and in women (Kurlansik & Ma ei, 2016).
- Twin studies looking at the construct of “health anxiety” support somatic symptom disorders as being moderately heritable (Ask et al., 2016).

Environmental Factors

- Antecedents of somatization may include living around a family member with an illness, receiving attention or an illness, or having an overprotective parenting style, childhood expectation of perfection, or history of divorce, maltreatment, or trauma (Kurlansik & Ma ei, 2016).
- This may reflect a learned process where experiencing illness in the environment or the self can lead to a heightened focus on symptoms (Ibeziako & Bujoreanu, 2011).

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- In addition, children may not have the ability or training to express distress verbally, which can plant the seeds of somatic behavior.
 - This pattern of focus can carry over into adulthood and be reinforced over time.
 - Before pubescence the rates of somatizing are equal between boys and girls with the rate in females being higher after this time (Spratt, 2014).

Psychological Theory

- Somatizing behavior may be understood as being driven by a maladaptive and anxious attachment style.
- The behavior is fostered by real or perceived rejection from significant others and is geared toward attempts to elicit care or nurturing.
- Difficulty with expressing distress verbally is thought to underlie the expression through physical symptoms (Spratt, 2014).
- Positive and negative responses from parents or role models can lead to reinforcement and operant conditioning of somatic and illness behaviors (Spratt, 2014).

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- There are both positive and negative rewards associated with somatizing behaviors and assuming the sick role.
 - Positive reinforces include lessened expectations at work or home, time off from work or school, disability payments, and justification of life conflicts.
 - At the same time there is a loss of career, status, and independence (Lubkin & Larson, 2013).

Interpersonal Model

- There is growing evidence that childhood adversity is linked to adult somatic symptom disorder.
- Children raised in homes where there is a high degree of parental somatization may model somatization.
- Early physical or sexual abuse may be associated with increased risk of somatization or **functional neurological disorder (conversion disorder)** later in life, in addition to other psychiatric disorders (Koelen et al., 2014).
- Exposure to illness in parents or other family members during development can result in learned behaviors (Spratt, 2014).

CLINICAL PICTURE

- When a patient presents with severe preoccupation with and distress surrounding unexplained physical symptoms that cannot be explained by a medical disorder, substance use, or another mental disorder, then a somatic disorder may be diagnosed.
- In addition, factitious disorder or the behavior of malingering should be considered.
- Because anxiety disorders and mood disorders often present with physical symptoms, these disorders must be ruled out (Yates, 2010).
- Therefore, both a medical and a psychological workup are used to diagnosis these disorders.

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 behaviors 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 more than 6 months).

Specify if

With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if

Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

Mild: Only of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

ILLNESS ANXIETY DISORDER (Hypochondriasis)

- According to the DSM-5 (APA, 2013), individuals with Illness Anxiety Disorder are preoccupied with having or eventually developing a serious illness.
- Individuals with this disorder may or may not present with somatic symptoms, and if they do, the symptoms are usually mild.
- What they do exhibit is a high level of anxiety and alarm about their health lasting at least 6 months, and may either excessively check for problems or avoid medical care.
- It is important to consider other possible diagnoses such as anxiety disorders.

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- The preoccupation with health leads to an encompassing anxiety that severely impairs functioning.
 - They are more alarmed by the potential implications of any disorder than with the disorder itself, and are alarmed with any new bodily sensations.
 - Patients can misinterpret normal physical sensations such as sweating, abdominal cramping, or awareness of heartbeat as indicative of disease (Dimsdale, 2015).

Conversion Disorder (Functional Neurobiological Symptom Disorder)

- According to the DSM-5 (APA, 2013), this disorder presents with one or more symptoms of impaired motor or sensory function.
- Findings are incompatible with or an exaggeration of recognized neurological conditions and are not better explained by another mental or medical disorder.
- The deficit causes significant distress to the patient and impaired social or occupational functioning.
- Symptoms are further specified as including weakness or paralysis, abnormal movement, swallowing or speech difficulties, seizures or attacks, sensory loss or anesthesia, or symptoms involving the senses (blindness or loss of smell).

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- The symptoms are not voluntarily controlled or created.
 - Patients may be highly distressed or show a lack of emotional concern known as **la belle indifférence** (Braun et al., 2010).
 - Episodes are typically brief but may become chronic.
 - Some symptoms such as tremor may disappear when the patient is distracted (Dimsdale, 2015).

Conversion disorders

- Neurologic Deficit - Sensory or Motor
- Acute Onset in Response to Stressor
- Psychologically Unsophisticated
- Generally Dramatic (Pseudoseizures)
- Can Co-exist with True Morbidity
- Poor Prognosis if not Resolved Quickly

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- The long-held view of conversion disorders is based on psychoanalytic theory.
 - Now competing theories dispute a purely psychological origin.
 - Functional brain imaging studies are pointing to the understanding of conversion disorders as symptoms related to the brain as well as encompassing the mind-body perspective of disease.
 - A number of studies in people with stress-related disorders have found there is of ten smaller hippocampal volume in the brain, lending scientific support to the notion that conversion disorders are not purely psychological in nature (Stone et al., 2010).

- Conversion disorders are among the most common of the somatic symptom disorders; they are more prevalent in women, in the elderly, and among lower educated and rural populations.
- Comorbidities include childhood abuse, depression, anxiety, and personality disorders (Black & Andreasen, 2014).
- It is estimated that one fourth of patients admitted to neurological units have conversion symptoms.
- The course of the disorder is related to its acuity.
- If symptoms have been present for more than 6 months, the remission rate is about 50%.

Factitious Disorder Imposed on Self (Formerly Munchausen Syndrome)

- According to the DSM-5 (APA, 2013), factitious disorder imposed on self refers to the deliberate fabrication of symptoms or self-injury, without obvious external reward or gain.
- The patient identifies himself/herself in a deceptive manner to others as sick or impaired.
- This disorder is further specified as a single episode or recurrent.

Factitious Disorder Imposed on Another

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- The individual presents another individual (victim) to others as ill, impaired, or injured.
- The deceptive behavior is evident even in the absence of obvious external rewards.
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
Note: The perpetrator, not the victim, receives the diagnosis.
- Specify
 - Single episode
 - Recurrent episodes

Psychogenic Seizures

- One of the only psychogenic syndromes that can actually be proven/disproven (split screen EEG)
- Myth: Many (30-60%) of patients with pseudoseizures also have epilepsy
- Reality: only 9-13% do¹
- Significant correlation of childhood trauma (all domains)²

Differential Diagnosis

- SSD Vs FD : In SSD there may be excessive attention and treatment seeking for the perceived medical concerns but there is no evidence that the individual is behaving deceptively.
- Malingering Vs FD: in malingering there is a intentional reporting of the symptoms for personal gain (e.g. Money, time off work etc.) but in factitious disorder requires the absence of obvious reward.
- Conversion disorder Vs FD: CD is characterized by neurologic symptoms that cannot be explained by medical evaluation. FD is distinguished from CD by the evidence of deceptive falsification of symptoms.
- Borderline personality Disorder Vs FD: in BPD a deliberate physical self harm can occur in association with other mental disorders but in factitious disorder the induction of injury occur in association with deception or to show others that the person is sick.

Psychological Factors Affecting Other Medical Conditions

- There is a medical condition present
- Co-morbid psychological or behavioral factors adversely impact the medical condition and lead to increased risk of suffering, death, or disability
- Should be a clear connection between the mental health issue and the increase in morbidity of the medical problem
- Typical examples:
 - Anxiety exacerbating asthma
 - Denial of need for treatment of acute chest pain (really any condition!)
 - Diabetic patient mis-using insulin to lose weight

Body Dysmorphic Disorder

- Preoccupation with an imagined defect in appearance
- Repetitive Behaviors (mirror checking, excessive grooming, skin picking) or Mental Acts (comparing appearance to others)
- Significant distress, e.g., limiting face to face contact with others, frequent consultations for surgery etc.
- Belief in defect borders on delusional; must not be confused with Anorexia Nervosa despite some shared characteristics

Other Specified Somatic Symptom and Related Disorder

- In other specified somatic symptom and related disorders, the symptoms are of somatic symptom and related disorders that causes clinical significant distress or impairment in social or occupational areas of functioning but do not meet the full criteria for any of the disorder in the somatic symptom and related disorders.

E.g. A person has the symptoms of a somatic symptom disorder but the duration of the symptom is less than 6 months then it should be counted in other specified somatic symptom and related disorder.

- Brief somatic symptom disorder, brief illness anxiety disorder, illness anxiety disorder without excessive health – related behaviour
- Pseudocyesis: a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.

Unspecified Somatic Symptom and Related Disorder

- This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the
- somatic symptom and related disorders diagnostic class.



Treatment Options

All patients with complaints should be properly assessed
for any possible organic etiology

Treatment Options: Core Principles

- Never say “it’s all in your head” – always respect the patient’s complaint
- Regular routine visits with the medical physician are important
- Avoid excessive lab tests and procedures
- Try to shift attention away from the physical complaints and to the current life issues
- Symptoms are not “either” physical or psychological – they are both

Treatment Options: Conversion Disorder

- Early identification crucial
- The longer the patient lives with the symptom and the sick role the harder it will be to treat
- Best approach is a benign intervention that allows the patient to “save face” and give up the symptom

Treatment Options: Somatoform Disorder

- Supportive listening
- Regular visits with physician
- Antidepressants have been shown to be helpful; especially noradrenergic (TCAs and SNRIs) and pregabalin (Lyrica)
- Recent studies have shown promise with Cognitive Behavioral Therapy

Treatment Options: Factitious Disorder

- Very difficult to treat; patients wary of psychiatrists and will not comply with referrals
- Significant co-morbidity with Borderline Personality Disorder
- Key is to develop relationship and dialog that isolates physical symptoms
- Some authors have observed that Factitious Disorder symptoms will wax and wane over time in response to stress and are not always chronically worsening.

Good Prognostic Factors

- Younger age
- Ability to grasp and discuss abstract concepts
- Access to multi-disciplinary providers (primary care physician, pain specialist, physical therapy etc)
- Previous high level of functioning

Poor Prognostic Factors

- Chronicity
- Disordered family and interpersonal relationships
- Financial gain as a result of illness
- Successful use of illness as a solution in the family
- Concrete thinking

Questions ???

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