Somatic Symptom and Related Disorders

Somatic Symptom & Related Disorders

Core Concepts

Definition

- Disorders with **prominent somatic symptoms**
- Cause **distress + functional impairment**
- Not defined only by absence of disease
- Defined mainly by **excessive psychological response** to symptoms

DSM-5 Shift

- DSM-IV ? focused on “medically unexplained symptoms”
- DSM-5 ? focuses on psychological criteria:
    - Excessive thoughts
    - Excessive anxiety
    - Excessive health-related behaviors

Core Pathophysiology

Biopsychosocial model

- **Biological** ? altered brain-body processing
- **Psychological** ? misinterpretation of body sensations
- **Social** ? reinforcement of illness behavior by family/doctors

Historical Terms

TERM	EXPLANATION
Hysteria	Old term; historically linked to “wandering uterus” theory
Conversion disorder	Physical neurologic-like symptoms due to unconscious conflict
Somatization disorder	Multiple chronic physical complaints without adequate medical explanation

Key Contributors

- **Jean-Martin Charcot** ? studied hysteria using hypnosis
- **Pierre Janet** ? linked hysteria with dissociation
- **Sigmund Freud** ? proposed conversion of psychic conflict into physical symptom

Epidemiology

Somatic Symptom Disorder

- Exact DSM-5 prevalence unknown
- Older somatization disorder data:
    - USA ? 0.1%
    - Germany ? 0.8%
- Broader somatic symptom clusters ? more common

Illness Anxiety Disorder

- True prevalence unknown
- General medical clinic ? 4–6%
- General population ? up to 10% may worry about serious illness

Conversion Disorder

- General population ? <1%
- General hospital psychiatry referrals ? 5–14%
- Psychiatric OPD ? 5–25%
- More common in females
- Can occur in children

- Rare after 35 years

Factitious Disorder

- Around 1% of healthcare-seeking population
- Factitious disorder imposed on another ? <0.04% of reported child abuse cases

Etiology

Genetic Factors

- Familial link noted between:
    - Hysteria/Briquet syndrome in females
    - Antisocial personality disorder in male relatives
- Genetic + environmental factors may contribute

Biological Factors

- Functional neuroimaging may show altered brain activation
- No consistent biochemical marker

Psychological Factors

Somatic Symptom Disorder

- **Amplification of somatic sensation** ? normal body sensations feel intense/distressing
- Low threshold for discomfort
- Faulty cognitive schema ? normal symptoms interpreted as serious disease

Conversion Disorder

- **Behavioral theory** ? symptoms learned and reinforced
- **Psychoanalytic theory** ? unconscious conflict converted into physical symptom
- May be linked to trauma in some cases

Illness Anxiety Disorder

- Catastrophic thinking about health
- Mild symptoms interpreted as serious illness

Psychosocial Factors

- Somatic symptoms may act as a request for sick role
- **Sick role** ? patient receives care, attention, and relief from responsibilities
- Reinforcement by family, friends, or doctors may maintain symptoms
- Stressors may trigger worsening

Flowchart

Stress ? Emotional conflict ? Body symptom ? Attention/relief ? Reinforcement ? Chronic illness behavior

Somatic Symptom Disorder

Clinical Features

- One or more distressing somatic symptoms
- Excessive:
    - Thoughts about seriousness
    - Anxiety about health
    - Time and energy spent on symptoms
- May coexist with real medical illness
- Reassurance often fails
- Common symptoms:
    - GI
    - Neurologic
    - Musculoskeletal
- Associated with anxiety and depression

DSM-5 Diagnosis

- ?1 somatic symptom causing distress/disruption

- ?1 of:
    - Disproportionate thoughts
    - Persistent anxiety
    - Excessive time/energy
- Persistent state >6 months

DSM-5 vs ICD-10

FEATURE	DSM-5	ICD-10
Main focus	Psychological response	Unexplained physical symptoms
Duration	>6 months	?2 years
Medical explanation	Not essential	Absence of medical cause emphasized

Differential Diagnosis

DISORDER	KEY DIFFERENCE
Illness Anxiety Disorder	Fear of illness, symptoms minimal
Conversion Disorder	Neurologic-like symptoms
Body Dysmorphic Disorder	Concern about appearance
Depression/Anxiety	Mood or anxiety symptoms dominate
Panic Disorder	Episodic attacks

DISORDER	KEY DIFFERENCE
Delusional Disorder	Fixed false belief
Factitious Disorder	Intentional symptoms for sick role
Malingering	Intentional symptoms for external gain

Course and Prognosis

- Episodic course
- May last months to years
- 1/3 to 1/2 improve over time

Better prognosis

- Sudden onset
- High socioeconomic status
- Treatable anxiety/depression
- No personality disorder
- No childhood trauma
- No chronic physical illness

Treatment

CBT

- Most effective
- Corrects catastrophic thinking
- Improves coping
- Reduces avoidance
- Uses diary keeping, relaxation, gradual exposure

Pharmacotherapy

- Used only if comorbid depression, anxiety, psychosis, or pain

DRUG	DOSE
Amitriptyline	Start 10–25 mg HS; target 75–150 mg/day
Nortriptyline	Start 10–25 mg/day; target 50–100 mg/day
Fluoxetine	Start 10–20 mg/day; target 20–60 mg/day
Sertraline	Start 25–50 mg/day; target 100–200 mg/day
Duloxetine	Start 30 mg/day; target 60–120 mg/day

Consultation Letter Strategy

- Regular scheduled visits
- Avoid unnecessary investigations
- Validate symptoms
- Explore stress without saying symptoms are imaginary

Illness Anxiety Disorder

Clinical Features

- Preoccupation with having/acquiring serious illness
- Somatic symptoms absent or mild
- Excessive health anxiety
- Repeated reassurance does not help
- May show:
    - Body checking
    - Repeated doctor visits
    - Avoidance of hospitals/doctors

Subtypes

- **Care-seeking type** ? frequently visits doctors
- **Care-avoidant type** ? avoids doctors due to fear of diagnosis

Diagnosis

- Preoccupation with serious illness

- Minimal or absent symptoms
- High health anxiety
- Excessive health behavior or avoidance
- Duration ?6 months
- Not better explained by another disorder

Differential Diagnosis

DISORDER	KEY DIFFERENCE
Somatic Symptom Disorder	More physical symptoms
GAD	Worry is broad, not only health
OCD	Obsessions/compulsions not limited to illness
Depression	Low mood dominates
Delusional Disorder	Fixed unshakable belief
BDD	Appearance concern
Panic Disorder	Fear of immediate catastrophe

Treatment

- CBT ? best
- Psychoeducation

- Regular visits with one physician
- Avoid excessive testing
- SSRIs if comorbid anxiety/depression:
    - Fluoxetine
    - Paroxetine
    - Sertraline

Conversion Disorder

Functional Neurological Symptom Disorder

Clinical Features

- Neurologic symptoms incompatible with known neurologic disease
- Symptoms are not intentionally produced
- Common symptoms:
    - Paralysis
    - Tremor
    - Abnormal gait
    - Blindness

- Deafness
- Anesthesia
- Non-epileptic seizures

Important Terms

- **La belle indifférence** ? patient appears unusually calm despite serious symptom, e.g., paralysis or blindness
- **Functional symptom** ? symptom is real, but due to abnormal nervous system functioning, not structural damage
- **Non-epileptic seizure** ? seizure-like episode without epileptic EEG changes

Diagnosis

- ?1 altered motor or sensory symptom
- Clinical findings show incompatibility with neurological disease
- Not better explained by another disorder
- Causes distress/impairment

Key Signs

SIGN	EXPLANATION
Hoover’s sign	Test for functional leg weakness. When patient is asked to lift the weak leg, hip extension seems weak. But when asked to lift the opposite leg against resistance, involuntary extension power returns in the “weak” leg. This suggests functional weakness rather than true paralysis.

SIGN	EXPLANATION
Tremor entrainment test	Functional tremor changes rhythm to match voluntary tapping movement of another limb. Organic tremor usually does not entrain like this.
Non-anatomic sensory loss	Sensory loss does not follow known nerve/dermatome distribution, e.g., sharp midline splitting of sensation.
Give-way weakness	Sudden collapse of power during testing, inconsistent with true neurological weakness.

Differential Diagnosis

DISORDER	KEY DIFFERENCE
Neurologic disease	Objective organic findings present
Somatic Symptom Disorder	Multiple somatic symptoms, not mainly neurologic
Factitious Disorder	Intentional production
Malingering	Intentional + external gain
Psychotic Disorder	Bizarre beliefs/behavior
Dissociative Disorder	Memory/identity disturbance may dominate

Course and Prognosis

- Usually early adulthood
- Can occur in children
- Often acute onset

- May remit spontaneously

Good prognosis

- Acute onset
- Clear stressor
- Good premorbid function
- Short duration
- No comorbid psychiatric illness

Treatment

- Psychoeducation
- Explain as “functional brain disorder,” not faking
- Physiotherapy for motor symptoms
- CBT for thoughts, trauma, stress processing
- Treat anxiety, depression, PTSD
- Avoid unnecessary tests/procedures
- Multidisciplinary care:
    - Neurology
    - Psychiatry
    - Physiotherapy

Psychological Factors Affecting Other Medical Conditions

Definition

- Medical illness is present
- Psychological or behavioral factors worsen:
    - Course
    - Recovery
    - Treatment adherence
    - Health risk

Examples

- Asthma worsened by anxiety
- Diabetes poorly controlled due to denial/depression
- CAD worsened by hostility and chronic stress
- Hypertension worsened by anxiety
- Chronic pain worsened by catastrophizing
- Poor adherence due to depression or substance use

DSM-5 Diagnosis

- Medical condition present
- Psychological factor adversely affects the condition
- Not better explained by another mental disorder

Treatment

- Psychoeducation about brain-body relationship
- CBT
- Stress management
- Mindfulness
- Relaxation
- Treat comorbid depression/anxiety/substance use
- Integrated medical + psychiatric care

Factitious Disorder

Clinical Features

- Intentional falsification of symptoms
- Motivation ? to assume sick role

- No obvious external gain
- May include:
    - Fabricated history
    - Self-injury
    - Lab tampering
    - Medication misuse
    - Dramatic/inconsistent symptoms
    - Frequent hospital visits

Types

- **Factitious disorder imposed on self** ? patient produces/fakes symptoms in self
- **Factitious disorder imposed on another** ? caregiver produces/fakes illness in another person, often child; form of abuse

Diagnosis

- Falsification of signs/symptoms or induction of disease
- Presents self/another as ill
- Deception without external reward
- Not better explained by another mental disorder

Differential Diagnosis

DISORDER	KEY DIFFERENCE
Malingering	External gain present
Somatic Symptom Disorder	Symptoms not intentional
Conversion Disorder	Symptoms involuntary
Delusional Disorder	Belief is genuine, not deceptive
Borderline Personality Disorder	Attention-seeking may occur, but medical deception not essential
Substance Use Disorder	Drug-seeking may mimic symptom fabrication

Course and Prognosis

- Usually begins early adulthood
- Often after illness or hospitalization experience
- Chronic course
- Repeated hospitalizations
- High iatrogenic harm risk

Iatrogenic harm ? harm caused by medical tests/procedures/treatment.

Treatment

- Avoid direct accusation

- Empathic, non-punitive approach
- Build therapeutic alliance
- CBT
- Psychodynamic psychotherapy
- Family therapy
- Limit unnecessary procedures
- Coordinate care with primary physician
- Imposed on another ? legal/child protection intervention

Other Specified Somatic Symptom and Related Disorder

Definition

- Somatic symptoms cause distress/impairment
- Full criteria for a named disorder not met
- Clinician specifies the reason

Common Presentations

- **Pseudocyesis** ? false belief of pregnancy with signs like abdominal enlargement, amenorrhea, breast changes, but no actual pregnancy

- Brief somatic symptom disorder ? duration <6 months
- Brief illness anxiety disorder ? duration <6 months
- Illness anxiety disorder without excessive health behaviors

Unspecified Somatic Symptom and Related Disorder

Definition

- Somatic symptoms cause distress/impairment
- Criteria for specific disorder not fully met
- Clinician does not or cannot specify the reason

When Used

- Emergency setting
- Crisis setting
- Insufficient time/information
- Provisional diagnosis

Other Specified vs Unspecified

FEATURE	OTHER SPECIFIED	UNSPECIFIED

Reason given	Yes	No
Use	Subthreshold but clear pattern	Lack of sufficient information
Example	Brief illness anxiety disorder	Emergency case with unclear details

Master Treatment Flowchart

Somatic symptom / health anxiety / functional symptom
? Medical evaluation
? Rule out urgent organic disease
? Identify psychological + behavioral factors
? Explain mind-body model
? CBT + psychoeducation
? Regular follow-up with one physician
? Add drugs only for comorbid depression/anxiety/pain
? Avoid repeated unnecessary tests

Drug Treatment Summary

DRUG CLASS	EXAMPLES	USE
TCAs	Amitriptyline, Nortriptyline	Pain, insomnia, somatic symptoms
SSRIs	Fluoxetine, Sertraline, Paroxetine	Health anxiety, depression, anxiety
SNRIs	Duloxetine, Venlafaxine	Pain + depression/anxiety
Anticonvulsants	Gabapentin, Pregabalin	Neuropathic pain-like symptoms

Important Doses

DRUG	STARTING DOSE	TARGET DOSE
Amitriptyline	10–25 mg HS	75–150 mg/day

DRUG	STARTING DOSE	TARGET DOSE
Nortriptyline	10–25 mg/day	50–100 mg/day
Fluoxetine	10–20 mg/day	20–60 mg/day
Paroxetine	10–20 mg/day	20–50 mg/day
Sertraline	25–50 mg/day	100–200 mg/day
Duloxetine	30 mg/day	60–120 mg/day
Venlafaxine	37.5–75 mg/day	150–225 mg/day
Gabapentin	100–300 mg HS	900–1800 mg/day
Pregabalin	75 mg/day	150–300 mg/day

Exam Pearls

- DSM-5 focuses on **excessive psychological response**, not only medically unexplained symptoms.
- SSD ? physical symptoms are prominent.
- Illness anxiety disorder ? fear of illness is prominent, symptoms minimal.
- Conversion disorder ? neurologic symptom + incompatibility with neuroanatomy.
- Hoover’s sign is a classic sign of functional limb weakness.
- Factitious disorder ? intentional symptom production for sick role.
- Malingering ? intentional symptom production for external gain.
- CBT is the most important psychotherapy.
- Avoid over-investigation because it reinforces illness behavior.

- Regular scheduled follow-up with one physician is high-yield management.