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Somatic Symptom & Related Disorders

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Somatic Symptom & Related Disorders

- Introduction
- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
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- Other Specified SS&RD
- Unspecified SS&RD

Somatic Symptom & Related Disorders – Introduction

- Prominence of somatic sx, assoc with distress + impairment
  - No longer emphasis on medically unexplained symptoms
  - Can accompany diagnosed medical disorders
- Somatic symptoms in anxiety + depressive disorders
  - Higher severity, functional impairment, refractoriness
  - May be so severe as to consider delusional disorder
- Factors
  - Genetic + biological vulnerability
  - Early traumatic experiences, learning, cultural/social norms
  - May be expression of personal suffering

Somatic Symptom Disorder

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Somatic Symptom Disorder – Diagnostic Criteria

A. **1+ somatic sx**, distressing or disruptive in daily life

B. Excessive thoughts/feelings/behav related to somatic sx (1+/3):
   1. **Disproportionate + persistent** thoughts about sx seriousness
   2. Persistent **high level of anxiety** about health/sx
   3. **Excessive time + energy** devoted to health/sx concerns

C. State of being symptomatic **>6 months** (may be different sx)

Somatic Symptom Disorder – Diagnostic Specifier

- *Specify if:*
  - **With predominant pain:** (previously pain disorder)

- *Specify if:*
  - **Persistent:** severe symptoms, marked impairment, long duration (>6 mo)

- *Specify current severity:*
  - **Mild:** only 1/3 of Criterion B
  - **Moderate:** 2+ of Criterion B
  - **Severe:** 2+ of Criterion B + multiple somatic complaints (or 1 very severe)

Somatic Symptom Disorder – Diagnostic Features

- Typically multiple, current, somatic symptoms
  - If only one severe symptom → **PAIN most common**
  - Specific vs non-specific sx, may represent normal bodily sensations
    - Generally does not signify serious disease
  - **Suffering is authentic** → regardless if medically explained

- May be assoc with another medical condition
  - Not mutually exclusively, and **frequently occur together**
  - Uncomplicated MI → disability from SSD (not MI sequelae)

- Excessive thoughts/feelings/behaviors related to symptom
  - May be an existing medical condition or at risk of developing one
  - High levels of worry → sx are **unduly threatening**, harmful, troublesome
  - Think the worst about their health, **even if evidence to contrary**

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Somatic Symptom Disorder – Diagnostic Features

- <u>If severe SSD</u> → health concerns may assume central role in life
  - Become feature of identity, dominate interpersonal relationships
  - Distress focused on **somatic sx + significance**
    - Some may describe distress in relation to other aspects of their lives
    - Other many deny any other sources of distress
  - **Health-related quality of life impaired,** physically + mentally
    - Can lead to **invalidism**

- <u>Often high level of medical care utilization</u>
  - Rarely alleviates concerns → may seek multiple doctors for same concern
  - Often seem **unresponsive to medical interventions**
    - New interventions may just exacerbate presenting sx
  - May be **unusually sensitive to medication SE**
  - May feel their **medical ax/tx is inadequate**

Somatic Symptom Disorder – Associated Features

- Cognitive features
  - Attention focused on somatic sx
  - Attribution of **normal bodily sensations** to physical illness (catastrophic)
  - **Worry** about illness
  - Fear that physical activity may **damage body**

- Behavioral features → most pronounced in severe, persistent SSD
  - Repeated **body checking** for abnormalities
  - Repeated **seeking of medical help** + reassurance
  - **Avoidance** of physical activity

Somatic Symptom Disorder – Associated Features

- Seeking medical help
  - Frequent requests, for different somatic sx → **cannot redirect**
  - Reassurance from doctors **short-lived or felt not taken seriously**
  - Typically present to **general medical services** (vs mental health)

- **Increased SUICIDE risk**
  - SSD assoc with depressive disorder
  - Unclear if there is an independent suicide risk

Somatic Symptom Disorder – Prevalence

- Prevalence = UNKNOWN (new to DSM5)
  - Estimate **5-7%** in general adult population
    - Higher than somatization disorder (<1%)
    - Lower than undifferentiated somatoform disorder (19%)
  - Higher in **FEMALES**

Somatic Symptom Disorder – Development & Course

- Older adults
  - Somatic sx + **concurrent medical illness COMMON**
  - May be underdiagnosed
    - Sx considered normal aging, worry is "understandable"
  - Concurrent depressive disorder is **COMMON if multiple somatic sx**

- Children
  - Most common sx = **abdo pain, headache, fatigue, nausea**
  - **SINGLE prominent sx MORE common** in children (vs adults)
  - Rarely worry about "illness" prior to adolescence
  - **Parents' response to sx** → may determine level of assoc distress
    - Parents may determine sx interpretation, time off school, seeking help

Somatic Symptom Disorder – Risk & Prognostic Factors

- Temperamental
  - Neuroticism (negative affectivity), comorbid anxiety or depression
- Environmental
  - **Lower education, lower SES**, recent stressful life events
- Course modifiers
  - **More persistent somatic symptoms**
    - **FEMALE, older**, less education, lower SES, unemployed
    - Hx sexual abuse, childhood adversity
    - Concurrent chronic physical illness
    - Psychiatric disorder (depression, PDD, anxiety, panic)
    - Social stress, reinforcing social factors **(illness benefits)**
  - **Cognitive factors** → sensitization to pain, heightened attention to bodily sensations, attribution of bodily sx to possible medical illness

Somatic Symptom Disorder – Culture-Related Issues

- "Culture-bound syndromes" → somatic sx often prominent
  - Similar patterns of commonly reported sx, impairment, tx seeking
  - Similar relationship between somatic sx + **illness worry**
    - Illness worry → greater impairment, more tx seeking
  - Similar relationship between somatic sx + **depression**

- Differences in somatic sx among cultures + ethnic groups
  - "idioms of distress" → "burnout", "gas", burning in the head

- Varying explanatory models
  - Family, work, environmental stresses; general medical illness
  - Suppression of anger + resentment
  - Culture specific phenomena (semen loss)

- Differences in seeking treatment

Somatic Symptom Disorder – Functional Consequences

- Marked impairment of health status
  - Likely >2 standard deviations below population norms

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Somatic Symptom Disorder – Differential Diagnosis

- If somatic sx consistent with AMD → dx AMD (not SSD)
  - If full criteria for SSD + AMD met → can dx both

- Other medical conditions
  - IBS, fibromyalgia → not sufficient to dx SSD
- Panic disorder → acute episodes of somatic sx + anxiety about health
- GAD → worry about multiple themes
- Depressive disorders → somatic sx common, but low mood/anhedonia
- Illness anxiety disorder → minimal somatic sx
- Conversion disorder → loss of function
- Delusional disorder, somatic subtype → greater intensity
- Body dysmorphic disorder → perceived defect in appearance
- OCD → more intrusive, compulsions

Somatic Symptom Disorder – Comorbidity

- <u>High rates of comorbidity</u>
  - Medical disorders → more impairment than physical illness alone
  - Anxiety disorders
  - Depressive disorder

Illness Anxiety Disorder

Illness Anxiety Disorder – Diagnostic Criteria

A. **Preoccupation with having/acquiring** serious illness

B. **Clearly excessive** preoccupation, or mild/no somatic sx

C. **High level of anxiety** about health, easily alarmed

D. Excessive health-related **behaviors** or maladaptive **avoidance**

E. Duration **>6 months** (specific illness may change)

F. Not better explained by AMD
   - SSD, panic disorder, GAD, BDD, OCD, delusional disorder somatic type

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Illness Anxiety Disorder – Diagnostic Specifiers

- *Specify whether:*
  - **Care-seeking type**
  - **Care-avoidant type**

Illness Anxiety Disorder – Diagnostic Features

- Previous hypochondriasis → most SSD, some IAD

- Somatic sx not present or just mild
  - Thorough evaluation fails to find explanatory serious medical condition
  - Distress primarily **about meaning or cause of complaint** (not sx itself)
  - Concern may be derived from **non-pathological physical sign**
    - Often normal physiological, benign/self-limited
    - Not generally indicative of disease

- Preoccupation clearly excessive/disproportionate to severity

- Significant anxiety about health/disease
  - Easily alarmed → someone else falling ill, health-related news story
  - Does not respond to medical reassurance, negative test, benign course
  - Physician attempts to reassure or relieve sx → may heighten anxiety

Illness Anxiety Disorder – Diagnostic Features

- Illness concerns assume prominent place in life
  - Affect daily activities → may result in invalidism
  - May become central feature of identity + self-image
  - Frequent topic of social discourse
  - Characteristic response to stressful life events

- Maladaptive behaviors
  - Examine self repeatedly
  - Research excessively
  - Repeatedly seek reassurance
  - Can be frustrating for othera
  - Maladaptive avoidance of situations that may jeopardize health

Illness Anxiety Disorder – Associated Features

- Encountered more frequently in medical health settings
  - Extensive, but **unsatisfactory** medical care
    - Unhelpful, not being taken seriously
    - May be justified concerns, but physicians dismissive/frustrated/hostile
  - Some may be too anxious to seek medical attention

- Higher rates of MEDICAL utilization (not mental health)
  - Consult multiple doctors about same problem
  - Repeated negative diagnostic tests
  - **Paradoxical exacerbation** of anxiety
  - **Iatrogenic complications** from diagnostic tests, procedures

Illness Anxiety Disorder – Prevalence

- Prevalence based on **hypochondriasis** (DSM-III/IV)
  - 1-2 year prevalence = **1 – 10%**
  - 6-12 month prevalence rates = **3 – 8%** (ambulatory medical)

- **Similar in males & females**

Illness Anxiety Disorder – Development & Course

- Onset → **early + middle adulthood**
  - **Increases with age** (rare in children)
  - Older adults → focus on memory loss
  - Thought to be **chronic + relapsing**

Illness Anxiety Disorder – Risk & Prognostic Factors

- Environmental
  - Predisposing: **childhood abuse**, **serious childhood illness**
  - Precipitants: **major life stress**, or **serious threat to health**

- Course modifiers
  - **50% have transient form of IAD**
    - Less psychiatric comorbidity
    - More medical comorbidity
    - Less severe IAD

Illness Anxiety Disorder – Functional Consequences

- Health concerns
  - Interpersonal relationships, family life, occupational performance
  - Role impairment, physical function, health-related quality of life

Illness Anxiety Disorder – Differential Diagnosis

- Other (underlying) medical conditions
  - Presence does not rule out IAD → ?proportionate, ?transient
- Adjustment disorders
  - Health-related anxiety → normal response to serious illness
    - Clearly related to medical condition, **time-limited**
    - If severe enough → adjustment disorder
    - If sufficient duration, severity, distress → IAD
- Somatic symptom disorder → sig somatic sx present
- Anxiety disorders → GAD, panic disorder (IAD may have PAs)
- Obsessive-compulsive & related disorders
  - IAD → focus on having a disease
  - OCD → fears of getting a disease in future
  - BDD → physical appearance
- Major depressive disorder → not IAD if exclusively during MDD
- Psychotic disorders → IAD not delusional, plausible
  - True somatic delusions → generally more bizarre

Illness Anxiety Disorder – Comorbidity

- Hypochondriasis co-occurs with
  - Anxiety disorder (esp GAD, panic disorder, OCD)
  - Depressive disorders

- 66% have 1+ comorbid major mental disorder
  - If IAD → incr risk for **SSD, personality disorder**

Conversion Disorder
(Functional Neurological Symptom Disorder)

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Conversion Disorder – Diagnostic Criteria

A. **Altered voluntary motor/sensory function**, 1+ sx
B. **Incompatibility** with recognized neuro/medical conditions

C. Not better explained by AMC/AMD
D. Significant distress or impairment

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Conversion Disorder – Diagnostic Specifiers

- *Specify symptom type:*
  - **With weakness or paralysis**
  - **With abnormal movement** (tremor, dystonia, myoclonus, gait)
  - **With swallowing symptoms**
  - **With speech symptoms** (dysphonia, slurred speech)
  - **With attacks or seizures**
  - **With anesthesia or sensory loss**
  - **With special sensory symptoms** (visual, olfactory, auditory)
  - **With mixed symptoms**

- *Specify if:*
  - **Acute episode:** <6 months
  - **Persistent:** ≥6 months

- *Specify if:*
  - **With psychological stressor** (specify stressor)
  - **Without psychological stressor**

Conversion Disorder – Diagnostic Features

- **"Functional"** → abnormal CNS functioning
- **"Psychogenic"** → assumed etiology

- 1+ symptoms, various types
  - Motor: weakness, paralysis, abnormal movements, gait, limb posturing
  - Sensory: altered/reduced/absent skins sensation, vision, hearing
  - Psychogenic/non-epileptic seizures
  - Episodes of unresponsiveness (like syncope/coma)
  - Speech: dysphonia, aphonia, dysarthria, globus

Conversion Disorder – Diagnostic Features

- REQUIRES that sx **not** explained by neurological disease
  - Needs clear evidence of **incompatibility** (not just bizarre)
  - **Internal consistency on exam**

  - **Hoover's sign:**
    - If affects hip flexion
      - Place hand under unaffected ankle, ask to raise affected leg
      - Normally, will feel unaffected ankle push down
      - If no pressure, not true effort
    - If affects hip extension
      - Place hand under affected ankle, ask to raise unaffected leg
      - Normally, should NOT feel affected ankle push down
      - If pushing down, not true paresis

Conversion Disorder – Diagnostic Features

- REQUIRES that sx **not** explained by neurological disease
  - **Ankle plantar-flexion:** weakness when supine, but able to tiptoe
  - **Tremor entrainment test:** unilateral tremor that changes when distracted
    - Copy examiner with unaffected hand → functional tremor entrains
  - **Non-epileptic attacks:** resisting eye opening, normal EEG
  - **Tubular visual field (tunnel vision)**

Conversion Disorder – Associated Features

- May be history of multiple similar somatic sx
  - Onset may be assoc with **stress or trauma** (psychological/physical)
  - Often assoc with **dissociative symptoms**
    - Depersonalization, derealization, dissociative amnesia

- Does NOT require that symptoms are unintentionally produced
  - Absence of feigning may not be reliably discerned

- **"la belle indifference"** → lack of concern about symptom
  - NOT SPECIFIC for conversion disorder

- **? secondary gain** → deriving external benefits
  - NOT SPECIFIC for conversion disorder
  - If evidence of feigning → consider factitious disorder or malingering

Conversion Disorder – Prevalence

- Precise prevalence of conversion disorder = UNKNOWN
  - Transient conversion sx common
  - **5% of referrals to neurology clinics**
  - Persistent conversion sx = 2-5 per 100,000 per year

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Conversion Disorder – Development & Course

- Onset → throughout life course
  - **Non-epileptic attacks** → peak in 30s
  - **Motor symptoms** → peak in 40s

- Course
  - Symptoms can be transient or persistent
  - Prognosis may be better in **younger children** (vs adolescents/adults)

Conversion Disorder – Risk & Prognostic Factors

- Temperamental
  - **Maladaptive personality traits** common
- Environmental
  - May have hx of childhood abuse/neglect
  - Stressful life events common
- Genetic & Physiological
  - Presence of **neurological disease with similar sx** = RISK FACTOR
  - (non-epileptic seizures common in patients with epilepsy)
- Course modifiers
  - POSITIVE prognostic factors → **short duration** of sx, **acceptance** of dx
  - NEGATIVE prognostic factors → **maladaptive personality** traits, **comorbid physical disease**, **disability benefits**

Conversion Disorder – Culture-Related Issues

- Similar sx may be part of culturally sanctioned rituals
  - Do not dx if fully explained or not causing distress/disability

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Conversion Disorder – Gender-Related Issues

- More common in **FEMALES (2-3x)**

Conversion Disorder – Functional Consequences

- Substantial disability → similar to comparable medical diseases

Conversion Disorder – Differential Diagnosis

- Neurological disease → may coexist
- Somatic symptom disorder → can dx BOTH
  - Most SSD cannot be demonstrated as clearly incompatible
  - Conversion disorder → often do not have excessive thoughts/behaviors
- Factitious disorder, malingering
  - If definitive evidence of feigning → primary vs secondary gain
- Dissociative disorders → can dx BOTH
- Body dysmorphic disorder → perceived defect
- Depressive disorders → more general heaviness, core sx
  - Conversion disorder → more focal + prominent weakness
- Panic disorder
  - Neurological sx → transient, acutely episodic
  - Non-epileptic attacks → loss of awareness with amnesia, violent limb movements

Conversion Disorder – Comorbidity

- Common comorbidities
  - Anxiety disorders (esp panic disorder)
  - Depressive disorders
  - Neurological/medical conditions

- **Somatic symptom disorder**
- **Personality disorders** (more common than the general pop)

- Uncommon
  - Psychosis
  - Substance/alcohol use disorder

Psychological Factors Affecting Other Medical Conditions

Psychological Factors & AMC – Diagnostic Criteria

A. Medical symptom or condition present

B. Psychological/behavioral factors adversely affecting AMC (1+/4):
   1. Temporal assoc with **development/exacerbation/delayed recovery**
   2. **Interferes with treatment**
   3. Adds **additional health risks** (well-established)
   4. Influences underly pathophysiology/precipitating/exacerbating/needing medical attention

C. Not better explained by AMD

Psychological Factors & AMC – Diagnostic Specifiers

- *Specify current severity:*
  - **Mild:** incr medical risk (poor medication adherence)
  - **Moderate:** aggravates underlying medical condition (anxiety + asthma)
  - **Severe:** results in medical hospitalization, ER visit
  - **Extreme:** results in severe, life-threatening risk (ignoring MI sx)

Psychological Factors & AMC – Diagnostic Features

- Adverse effect on medical condition
  - Increasing risk for suffering, death, disability
  - Affects course or treatment, or
  - Constitutes additional well-established health risk factors, or
  - Influences underlying pathophysiology (to precipitate/exacerbate sx or to necessitate medical attention)

- Examples of factors
  - Psychological distress, interpersonal interaction, coping styles
  - Depression, anxiety, stressful life events, relation style, personality traits
  - Maladaptive health behaviors → denial of sx, poor adherence to tx

- Example of effects
  - Anxiety-exacerbating asthma, denial of need for tx for acute chest pain
  - Manipulation of insulin to lose weight

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Psychological Factors & AMC – Diagnostic Features

- Variety of adverse effects
  - Acute → **Takotsubo cardiomyopathy**
  - Chronic → chronic occupational stress incr risk for hypertension
  - Clear pathophysiology → diabetes, cancer, CAD
  - Functional syndromes → migraine, IBS, FM
  - Idiopathic medical sx → pain, fatigue, dizziness

- Effect of psychological factor ON AMC → EVIDENT
  - Sig effect on course/outcome of AMC
  - If develops in RESPONSE to AMC → dx adjustment disorder

Psychological Factors & AMC – Prevalence

- Prevalence = UNCLEAR
  - May be more common than SSD (US billing data)

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Psychological Factors & AMC – Development & Course

- Occurs across lifespan
  - Some conditions characteristic of particular life stages
    - Older adults → caregiver stress

Psychological Factors & AMC – Culture-Related Issues

- Influence of cultural differences
  - Language/communication style, explanatory models of illness
  - Patterns of seeking health care, service availability/organization
  - Doctor-patient relationships, other healing practices
  - Family/gender roles, attitudes toward pain/death

- Differentiate from culturally specific behaviors
  - Faith, spiritual healers → represent attempt to help AMC
  - May complement evidence-based interventions

Psychological Factors & AMC – Functional Consequences

- Affects the course of many medical diseases

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Psychological Factors & AMC – Differential Diagnosis

- Mental disorder due to AMC
  - Caused by AMC via direct physiological mechanism
- Adjustment disorders
  - Psychological/behavioral sx in **response** to stressor
- Somatic symptom disorder
  - SSD → emphasis on excessive thoughts/feelings/behavior
  - PFAMC → emphasis on **exacerbation of AMC**
- Illness anxiety disorder
  - IAD → emphasis on worry about having disease

Psychological Factors & AMC – Comorbidity

- By definition
  - Relevant psychological/behavioral syndrome/trait
  - Comorbid AMC

Factitious Disorder

Factitious Disorder (Imposed on Self) – Diagnostic Criteria

A. **Symptom falsification** or **induction of disease/injury,** associated with identified deception

B. **Presents self as ill/impaired/injured** to others

C. No obvious external rewards

D. Not better explain by AMD

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Factitious Disorder (Imposed on Other) – Diagnostic Criteria

A. **Symptom falsification** or **induction of disease/injury, IN ANOTHER,** associated with identified deception

B. **Presents victim as ill/impaired/injured** to others

C. No obvious external rewards

D. Not better explain by AMD

*** Perpetrator receives this diagnosis (not victim)**

Factitious Disorder – Diagnostic Specifiers

- *Specify:*
  - **Single episode**
  - **Recurrent episodes**

Factitious Disorder – Diagnostic Features

- Falsification of medical/psychological signs/symptoms
  - Or induction of injury/disease, with **identified deception**
  - Intention to **misrepresent, simulate or cause symptoms**
  - Absence of obvious rewards

- Methods
  - Exaggeration, fabrication, simulation, induction
  - May report feelings of depression/suicidality after death of spouse (but no spouse, or spouse still alive)
  - May report neurological sx or manipulate lab tests
  - May falsify medical records
  - May ingest a substance to induce abnormal lab results
  - May physically injure self/others to produce disease

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Factitious Disorder – Associated Features

- By causing harm to self or others
  - At risk of great psychological distress or functional impairment
  - Family, friends, HCPs often adversely affected
- Intentional efforts to conceal disordered behavior
  - Similar to SUD, EDs, ICDs, pedophilic disorder
- May be **criminal behavior**
- **REQUIRES objective identification of falsification**
  - Not just inference

Factitious Disorder – Prevalence

- Prevalence = UNKNOWN
  - Among hospital pts → **1% factitious disorder**

Factitious Disorder – Development & Course

- Usually intermittent episodes
  - Single episode, continuous episode → less common
  - May become lifelong

- Onset
  - Usually **early adulthood**
  - Often **after hospitalization** for AMC/AMD
  - If imposed on another, may begin after hospitalization of child/dependent

Factitious Disorder – Differential Diagnosis

- Somatic symptom disorder
- Malingering
  - Intentional reporting for personal gain
- Conversion disorder
- Borderline PD
  - No deception
- Medical condition/mental disorder not assoc with intentional symptom falsification
  - But diagnosis of factitious disorder DOES NOT exclude true AMC/AMD

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Other Specified Somatic Symptom & Related Disorder

Other Specified Somatic Disorder

- Does not meet full criteria
- Clinician choose to specify reason

- Brief somatic symptom disorder
- Brief illness anxiety disorder
- Illness anxiety disorder without excessive health-related behaviors
- Pseudocyesis
  - False belief of being pregnant
  - Objective signs + reported sx of pregnancy

Unspecified Somatic Symptom & Related Disorder

Unspecified Somatic Disorder

- Does not meet full criteria
- Clinician choose NOT to specify reason