Somatic Symptom and Related Disorders

Classification according to DSM-V:
- Somatic Symptom Disorder.
- Illness Anxiety Disorder.
- Functional Neurological Symptom Disorder.
- Psychological Factors Affecting Other Medical Conditions.
- Factitious Disorder.
- Other Specified Somatic Symptom and Related Disorder.

Somatic Symptom Disorder: Somatic symptom disorder, also known as hypochondriasis, is characterized by 6 or more months of a general and non-delusional 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.

EPIDEMIOLOGY: 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.

ETIOLOGY: Persons with this disorder augment and amplify their somatic sensations; they have low thresholds for, and low tolerance of, physical discomfort. For example, what persons normally perceive as abdominal pressure, persons with somatic symptom disorder experience as abdominal pain. They may focus on bodily sensations, misinterpret them, and become alarmed by them because of a faulty cognitive scheme.

DIAGNOSIS: According to the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the diagnostic criteria for somatic symptom disorder require that patients be preoccupied with the false belief that they have a serious disease, based on their misinterpretation of physical signs or sensations. The belief must last at least 6 months, despite the absence of pathological findings on medical and neurological examinations. The diagnostic criteria also require that the belief cannot have the intensity of a delusion (more appropriately diagnosed as delusional disorder) and cannot be restricted to distress about appearance (more appropriately diagnosed as body dysmorphic disorder). The symptoms of somatic symptom disorder must be sufficiently intense to cause emotional distress or impair the patient’s ability to function in important areas of life.

COURSE AND PROGNOSIS: The course of the disorder is usually episodic; the episodes last from months to years and are separated by equally long quiescent periods. There may be an obvious association between exacerbations of somatic symptoms and psychosocial stressors. A good prognosis is associated with high socioeconomic status, treatment-responsive anxiety or depression, sudden onset of symptoms, the absence of a personality disorder, and the absence of a related non-psychiatric medical condition.

TREATMENT: 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 behavior therapy, cognitive therapy, and hypnosis, may be useful.

- Frequent, regularly scheduled physical examinations help to reassure patients that their physicians are not abandoning them and that their complaints are being taken seriously.

- Pharmacotherapy alleviates somatic symptom disorder only when a patient has an underlying drug-responsive condition, such as an anxiety disorder or depressive disorder.

**Illness Anxiety Disorder**: Illness anxiety disorder is a new diagnosis in the (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) . 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.”

**DIAGNOSIS**
The major DSM-5 diagnostic criteria for illness anxiety disorder are that patients be preoccupied with the false belief that they have or will develop a serious disease and there are few if any physical signs or symptoms. The belief must last at least 6 months, and there are no pathological findings on medical or neurological examinations. The belief cannot have the fixity of a delusion (more appropriately diagnosed as delusional disorder) and cannot be distress about appearance (more appropriately diagnosed as body dysmorphic disorder). The anxiety about illness must be incapacitating and cause emotional distress or impair the patient’s ability to function in important areas of life.

**TREATMENT**
As with somatic symptom disorder.

**Functional Neurological Symptom Disorder (Conversion Disorder):**
Conversion disorder, also called functional neurological symptom disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5), is an illness of symptoms or deficits that affect voluntary motor or sensory functions, which suggest another medical condition, but that is judged to be caused by psychological factors because the illness is preceded by conflicts or other stressors. The symptoms or deficits of conversion disorder are not intentionally produced, are not caused by substance use, are not limited to pain or sexual symptoms, and the gain is primarily psychological and not social, monetary, or legal.
The syndrome currently known as *conversion disorder* was originally combined with the syndrome known as *somatization disorder* and was referred to as hysteria, conversion reaction, or dissociative reaction. Paul Briquet and Jean-Martin Charcot contributed to the development of the concept of conversion disorder by noting the influence of heredity on the symptom and the common association with a traumatic event. The term conversion was introduced by Sigmund Freud, who hypothesized that the symptoms of conversion disorder reflect unconscious conflicts.

**EPIDEMIOLOGY**
Several studies have reported that 5 to 15 percent of psychiatric consultations in a general hospital involve patients with conversion disorder diagnoses. The ratio of
women to men among adult patients is at least 2 to 1. Symptoms are more common on
the left than on the right side of the body in women. Women who present with
conversion symptoms are more likely subsequently to develop somatization disorder
than women who have not had conversion symptoms. An association exists between
conversion disorder and antisocial personality disorder in men. Men with conversion
disorder have often been involved in occupational or military accidents.

ETIOLOGY:
Psychoanalytic Factors
According to psychoanalytic theory, conversion disorder is caused by repression of
unconscious intrapsychic conflict and conversion of anxiety into a physical symptom.
The conflict is between an instinctual impulse (e.g., aggression or sexuality) and the
prohibitions against its expression.

Learning Theory
In terms of conditioned learning theory, a conversion symptom can be seen as a piece
of classically conditioned learned behavior; symptoms of illness, learned in
childhood, are called forth as a means of coping with an otherwise impossible
situation.

Biological Factors
Increasing data implicate biological and neuropsychological factors in the
development of conversion disorder symptoms. Preliminary brain imaging
studies have found hypometabolism of the dominant hemisphere and
hypermetabolism of the nondominant hemisphere and have implicated impaired
hemispheric communication in the cause of conversion disorder.

DIAGNOSIS
The DSM-5 limits the diagnosis of conversion disorder to those symptoms that affect
a voluntary motor or sensory function, that is, neurological symptoms. Physicians
cannot explain the neurological symptoms solely on the basis of any known
neurological condition. The diagnosis of conversion disorder requires that clinicians
find a necessary and critical association between the cause of the neurological
symptoms and psychological factors, although the symptoms cannot result from
malingering or factitious disorder.

CLINICAL FEATURES
Paralysis, blindness, and mutism are the most common conversion disorder
symptoms. Conversion disorder may be most commonly associated with passive-
aggressive, 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.

Sensory Symptoms
In conversion disorder, anesthesia and paresthesia are common, especially of the
extremities. All sensory modalities can be involved, and the distribution of the
disturbance is usually inconsistent with either central or peripheral neurological
disease.

Motor Symptoms
The motor symptoms of conversion disorder include abnormal movements, gait
disturbance, weakness, and paralysis. Gross rhythmic tremors, choreiform
movements, tics, and jerks may be present. The movements generally worsen when
attention is called to them.
Seizure Symptoms
Pseudoseizures are another symptom in conversion disorder. Clinicians may find it difficult to differentiate a pseudoseizure from an actual seizure by clinical observation alone. Moreover, about one third of the patient’s pseudoseizures also have a coexisting epileptic disorder. Tongue-biting, urinary incontinence, and injuries after falling can occur in pseudoseizures, although these symptoms are generally not present. Pupillary and gag reflexes are retained after pseudoseizure, and patients have no postseizure increase in prolactin concentrations.

Other Associated Features
Primary Gain. Patients achieve primary gain by keeping internal conflicts outside their awareness.
Secondary Gain. Patients get tangible advantages and benefits as a result of being sick; for example, being excused from obligations and difficult life situations, receiving support and assistance and controlling other persons’ behavior.
La Belle Indifférence. that is, the patient seems to be unconcerned about what appears to be a major impairment.
Identification. Patients with conversion disorder may unconsciously model their symptoms on those of someone important to them. For example, a parent or a person who has recently died may serve as a model for conversion disorder. During pathological grief reaction, bereaved persons commonly have symptoms of the deceased.

Prognosis: A good prognosis is heralded by acute onset, presence of clearly identifiable stressors at the time of onset, a short interval between onset and the institution of treatment, and above average intelligence. Paralysis, aphony, and blindness are associated with a good prognosis, whereas tremor and seizures are poor prognostic factors.

TREATMENT: Resolution of the conversion disorder symptom is usually spontaneous, although it is probably facilitated by insight-oriented supportive or behavior therapy. With patients who are resistant to the idea of psychotherapy, physicians can suggest that the psychotherapy will focus on issues of stress and coping. Telling such patients that their symptoms are imaginary often makes them worse. Parenteral amobarbital or lorazepam may be helpful in obtaining additional historic information, especially when a patient has recently experienced a traumatic event. Psychodynamic approaches include psychoanalysis and insight-oriented psychotherapy, in which patients explore intrapsychic conflicts and the symbolism of the conversion disorder symptoms.

Factitious Disorder: Patients with factitious disorder simulate, induce, or aggravate illness to receive medical attention, regardless of whether or not they are ill. Thus, they may inflict painful, deforming, or even life-threatening injury on themselves, their children, or other dependents. The primary motivation is not avoidance of duties, financial gain, or anything concrete. The motivation is simply to receive medical care and to partake in the medical system.
voluntary, even if they cannot be controlled. Also known as *Munchausen syndrome*.

**B. Epidemiology.** Unknown. More common in men than in women. Usually adult onset. Factitious illness, especially feigned fever, accounts for 5% to 10% of all hospital admissions. More common in health care workers.

**C. Etiology.** Early real illness coupled with parental abuse or rejection is typical. Patient recreates illness as an adult to gain loving attention from doctors. Can also express masochistic gratification for some patients who want to undergo surgical procedures. Others identify with an important past figure who had pathological or physical illness. No genetic or biological etiological factors have been identified.

**D. Psychodynamics.** Mechanisms of repression, identification with the aggressor, regression, and symbolization may be present.

**E. Diagnosis, signs, and symptoms**

1. **With predominantly physical signs and symptoms.** Intentional production of physical symptoms—nausea, vomiting, pain, or seizures. Patients may intentionally put blood in feces or urine, artificially raise body temperature, or take insulin to lower blood sugar. Gridiron abdomen sign is the result of scars from multiple surgical operations.

2. **With predominantly psychological signs and symptoms.** Intentional production of psychiatric symptoms—hallucinations, delusions, depression, or bizarre behavior. Patients may make up a story that they suffered major life stress to account for symptoms. *Pseudologia fantastica* consists of making up extravagant lies that the patient believes. Substance abuse, especially of opioids, is common in both types.

3. **With combined physical and psychological signs and symptoms.** Intentional production of both physical and psychological symptoms.

4. **Factitious disorder not otherwise specified.** Includes disorders that do not meet criteria for factitious disorder (e.g., factitious disorder by proxy—intentionally feigning symptoms in another person who is under the person’s care so as to assume the sick role indirectly). *Factitious*
disorder by proxy is most common in mothers who feign an illness in their child, but accounts for fewer than 1,000 of the almost 3 million cases of child abuse reported annually.

F. Differential diagnosis

1. Physical illness. Physical examination and laboratory workup should be performed; results will be negative. The nursing staff should observe carefully for deliberate elevation of temperature or alteration of body fluids.

2. Somatoform disorder. Symptoms are voluntary in factitious disorder and not caused by unconscious or symbolic factors. La belle indifférence is not present in factitious disorder. Hypochondriacs do not want to undergo extensive tests or surgery.

3. Malingering. Most difficult differential diagnosis to make. Malingers have specific goals (e.g., insurance payments, avoidance of jail term). Evidence of an intrapsychic need to maintain the sick role (e.g., to satisfy dependency needs) is more characteristic of factitious disorder.

4. Ganser's syndrome. Found in prisoners who give approximate answers to questions and talk past the point. Classified as a dissociative disorder not otherwise specified.

5. Personality disorder. Antisocial personalities are manipulative but do not usually feign illness or agree to invasive procedures or hospitalization. Borderline personalities usually have more chaotic lifestyles, parasuicidal behavior, and more disturbed interpersonal relationships.

G. Course and prognosis. Course is usually chronic. Begins in adulthood, but onset may be earlier. Frequent consultation with doctors and history of hospitalizations as patient seeks repeated care. High risk for substance abuse over time. Prognosis improves if associated depression or anxiety is present that responds to pharmacotherapy. Risk for death if patient undergoes multiple life-threatening surgical procedures.

H. Treatment

1. Avoid unnecessary laboratory tests or medical procedures. Confront patient with diagnosis of factitious disorder and feigned symptoms. Patients rarely enter psychotherapy because of poor motivation; however, working alliance with doctor is possible over time, and patient may gain insight into behavior. Good management, however, is more likely than a cure. A databank of patients with repeated hospitalizations for factitious illness is available in some areas of the United States.

2. Psychopharmacological therapy is useful for associated anxiety or depression. Substance abuse should be treated if present.

3. Contact child welfare services if a child is at risk (e.g., with factitious disorder by proxy).
Pain Disorder: In the current fifth edition (DSM-5), it is diagnosed as a variant of somatic symptom disorder. A pain disorder is characterized by the presence of, and focus on, pain in one or more body sites and is sufficiently severe to come to clinical attention. Psychological factors are necessary in the genesis, severity, or maintenance of the pain, which causes significant distress, impairment, or both. Patients with pain disorder are not a uniform group, but a heterogeneous collection of persons with low back pain, headache, atypical facial pain, chronic pelvic pain, and other kinds of pain. Patients with pain disorder often have long histories of medical and surgical care. They visit many physicians, request many medications, and may be especially insistent in their desire for surgery. Indeed, they can be completely preoccupied with their pain and cite it as the source of all their misery. Such patients often deny any other sources of emotional dysphoria and insist that their lives are blissful except for their pain. Their clinical picture can be complicated by substance-related disorders, because these patients attempt to reduce the pain through the use of alcohol and other substances.

Treatment: Clinicians should discuss the issue of psychological factors early in treatment and should frankly tell patients that such factors are important in the cause and consequences of both physical and psychogenic pain.

Pharmacotherapy: Analgesic medications do not generally benefit most patients with pain disorder. In addition, substance abuse and dependence are often major problems for such patients who receive long-term analgesic treatment. Sedatives and antianxiety agents are not especially beneficial and are also subject to abuse, misuse, and adverse effects. Antidepressants, such as tricyclics and selective serotonin reuptake inhibitors (SSRIs), are the most effective pharmacological agents.

Psychotherapy: Some outcome data indicate that psychodynamic psychotherapy can benefit patients with pain disorder. Clinicians should not confront somatizing patients with comments such as “This is all in your head.” For the patient, the pain is real, and clinicians must acknowledge the reality of the pain, even as they understand that it is largely intrapsychic in origin. Cognitive therapy has been used to alter negative thoughts and to foster a positive attitude.

Somatization disorder: The essential feature of somatization disorder is multiple somatic complaints of long duration, beginning before the age of 30. The criteria for diagnosis require four pain symptoms, two gastrointestinal symptoms, one sexual symptom, and one pseudoneurological symptom. The above symptoms are not intentionally produced or feigned and none of which is completely explained by physical or lab. examinations. The disorder is chronic and is associated with significant psychological distress, impaired social and occupational functioning, and excessive medical–help-seeking behavior.

Treatment: Treatment is difficult and patients often consume large amounts of resources. Continuing care by one doctor using only the essential investigations, can reduce the use of health services and may improve patient’s functional state, avoid psychotropics except during periods of acute anxiety and depression. It also important to follow the patient to prevent substance abuse, doctor shopping, unnecessary procedures and diagnostic tests.