Somatization Disorder

Outline

- History
- Etiology
- Epidemiology
- Clinical features
- Diagnostic guidelines
- Differential Diagnosis
- Evaluation
- Management
- Course and prognosis

History

- 1859 - French neurologist Pierre Briquet - syndrome with multiple motor & sensory symptoms - **Briquet syndrome**
- Initial separation of somatization from conversion phenomenon
- Feighner's crtiteria - 25/59 physical symptoms; onset before 30yrs
- Modification of Feighner's criteria used in DSM-III

History

- 1911 - term “somatization” used by Wilhelm Stekel - corporeal expression of deep somatic neurosis/ neurotic conflicts present as physical symptoms
- 1960s - Lipowski - broader view of somatization - tendency to experience, conceptualize and/or communicate psychological states or contents as corporeal sensations, functional changes or somatic metaphors

Definition

Somatization disorder:

- Illness of multiple somatic complaints in multiple organ systems that occurs over a period of several years and results in significant impairment or treatment seeking, or both
- Polysymptomatic syndrome with idiopathic physical symptoms coming from several organ systems and causing significant distress & disability

Etiology

Genetic:

- No direct evidence
- Few family & twin study conducted
- Familial etiology for somatization disorder but not for hypochondriasis
- Small amount of variance for developing a preoccupation with body sensation/propensity to amplify bodily sensations - genetically determined

Etiology

Learning & sociocultural:

- Early experiences and learning - primary etiological factors of somatic sensitivity and bodily preoccupation
- Children's symptoms - copy of other f/m symptoms
- Adult symptoms - similar to those symptoms that were given attention by parents in childhood
- Habitual attention to a given body part improves the ability of person to detect sensations in that part

Etiology

Learning & sociocultural:

- Differential conditioning of physiological arousal across different culture groups.
- Cultures also teaches people what is acceptable to express and what is not; influences manifestation of emotional and body sensation
- Socioeconomic class, education level, subcultural influence the rates of expressing emotional distress as somatic complaint.

Etiology

Psychodynamic factors:

- Development of narcissism - turned into bodily preoccuption.
- Process of separation & identity formation - parental figures intermittently present & absent - sense of anxiety, fear of abandonment & betrayal
- Child becomes afraid of the emerging other, not certain of self

Etiology

Psychodynamic factors:

- Ambivalent anger at the other turns inward as guilt to protect self-other complex
- Child doesn’t learn to trust others/self - self-focus, self-criticism, increased mistrust of self through self-reproach and mistrust
- Becomes associated with body sensations & perceptions and affect

Stressors & Coping:

- Day to day stressors create somatic experiences, learned through continued selective perception to sensation
- Coping mechanisms predict response to stressors (anger, impulsivity, hostility, isolation, lack of confiding in others)
- Coping styles linked to physiological reactivity - a/w somatic sensation and amplification
- Individuals with multiple, persistent, high-impact stressors and poor coping mechanisms - highest risk

Epidemiology

- Prevalence: Males: < 0.2% Females: 0.2-2%
- Course: chronic, fluctuating; rarely remits completely
- Onset: adolescence; usu. before 25 yrs old
- Common among unmarried, female, & from lower socio-economic groups

Clinical features

- Classical patient - subjectively “sickly”
- Most common in females
- May occur at any age, commonly begin in adolescence
- Most common presentation: 20-60 years
- Symptoms in any body part or organ system
- Multiple symptoms

DSM IV

Somatization Disorder (300.81)

A. Multiple physical complaints before 30 yrs., occurring over several years and result in treatment being sought/significant socio-occupational impairment

DSM IV

Somatization Disorder (300.81)

B. Each of the following criteria met with individual symptoms occurring at any time:

1) **4 pain symptoms** (head, abdomen, neck, joints, extremities, chest, rectum, during menstruation/intercourse/urination)
2) **2 GI symptoms** other than pain (nausea, bloating, vomiting, diarrhea, intolerance to several foods)

DSM IV

Somatization Disorder (300.81)

3) 1 sexual symptom other than pain (sexual indifference, erectile/ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)
4) 1 pseudoneurological symptom (impaired coordination/balance, paralysis/localized weakness, difficulty in swallowing/lump in throat, aphonia, hallucinations, loss of sensations, double vision/blindness, deafness, seizures, dissociative symptoms like amnesia, loss of consciousness)

DSM IV

Somatization Disorder (300.81)

C. Either 1) or 2):

1) Appropriate investigations cannot fully attribute symptoms to a known general medical condition/effects of substance
2) Related general medical condition - excess physical complaints socio-occupational impairment

D. Symptoms not intentionally produced or feigned

DSM5

Somatic Symptom Disorder (300.82)

A. ≥ 1 somatic symptoms - distressing/significant disruptinon of life

B. Excessive thoughts, feelings, behaviours related to symptoms:
   1. Disproportionate, persistent thoughts about the seriousness of symptoms
   2. Persistently high anxiety about symptoms
   3. Excessive time & energy devoted to these symptoms

C. Persistent symptoms (≥ 6 months)

DSM5

Somatic Symptom Disorder (300.82)

Specifiers:

- With predominant pain
- Persistent
- Severity:
  - Mild (1 Criterion B symptom)
  - Moderate (≥ 2 Criterion B symptoms)
  - Severe (Moderate + multiple somatic complaints/ one very severe somatic symptom)

ICD 10

Somatization Disorder (F45.0)

Presence of all of the following:

a) At least 2 years of multiple, variable physical symptoms for which no adequate physical explanation has been found

b) Persistent refusal to accept the advice or reassurance of several doctors that there is no physical explanation for the symptoms

c) Some degree of impairment of social and family functioning attributable to the nature of the symptoms and resulting behaviour

ICD 11

Bodily Distress Disorder: (6C20)

- Distressing bodily symptoms which are given excessive attention, manifested by repeated contact with health care providers
- Another health condition causing/contributing to symptoms - excessive attention in relation to its nature & progression - not alleviated by appropriate clinical examination, investigations & reassurance.
- Persistent bodily symptoms (most days for several months)
- Multiple bodily symptoms - vary over time.
- Single symptom (pain/fatigue)

ICD 11

Bodily Distress Disorder: (6C20)

Excludes:

- Tourette syndrome (8A05.00)
- Hair pulling disorder (6B25.0)
- Dissociative disorders (6B60-6B6Z)
- Hair-plucking (6B25.0)
- **Hypochondriasis (6B23)**
- Body dysmorphic disorder (6B21)
- Excoriation disorder (6B25.1)

Comorbidities

- ≥ 90% pts. with physical symptoms have comorbid depression/anxiety
- ≥ 60% pts. - dissociative disorder
- Personality disorders: Cluster B, C, paranoid personality disorder
- Substance abuse

Assessment

- Composite international diagnostic interview (CIDI)
- DSM-5 & ICD 10 diagnostic criteria
- Seven symptom screening test
- Somatosensory amplification scale (SSAS)
- Kellner’s symptom questionnaire
- Bradford somatic inventory

Differential Diagnosis

Idiopathic physical symptoms may have psychiatric etiology if symptoms:

- Coexist with major psychiatric disorders
- Closely follow traumatic events
- Lead to physiological “gratification” or “secondary gain”
- Represent predictable personality traits (coping mechanisms)
- Become persistent and increasing in number, resulting in overuse of medical services and dissatisfaction with medical care

Differential Diagnosis

- **Medical conditions:** irritable bowel syndrome, fibromyalgia, multiple sclerosis, brain tumour, hyperparathyroidism, hyperthyroidism, lupus erythematosus
- **Panic disorder:** somatic symptoms and anxiety in acute episodes only
- **Generalized anxiety disorder:** worry about multiple events, situations, or activities, main focus is not usually somatic symptoms
- **Depressive disorders:** low mood and anhedonia
- **Hypochondriasis:** patient´s focus is on presence of underlying progressive and serious disease process and its consequences

Differential Diagnosis

- **Delusional disorders:** (SCZ + somatic delusions/depressive disorder with hypochondriacal delusions) bizarre quality of beliefs, fewer physical symptoms
- **Conversion disorder:** loss of function
- **Undifferentiated somatization disorder:** - short duration, less striking symptoms
- **Persistent somatoform pain disorder:** one or two unexplained pain complaints, not a lifetime history of multiple complaints

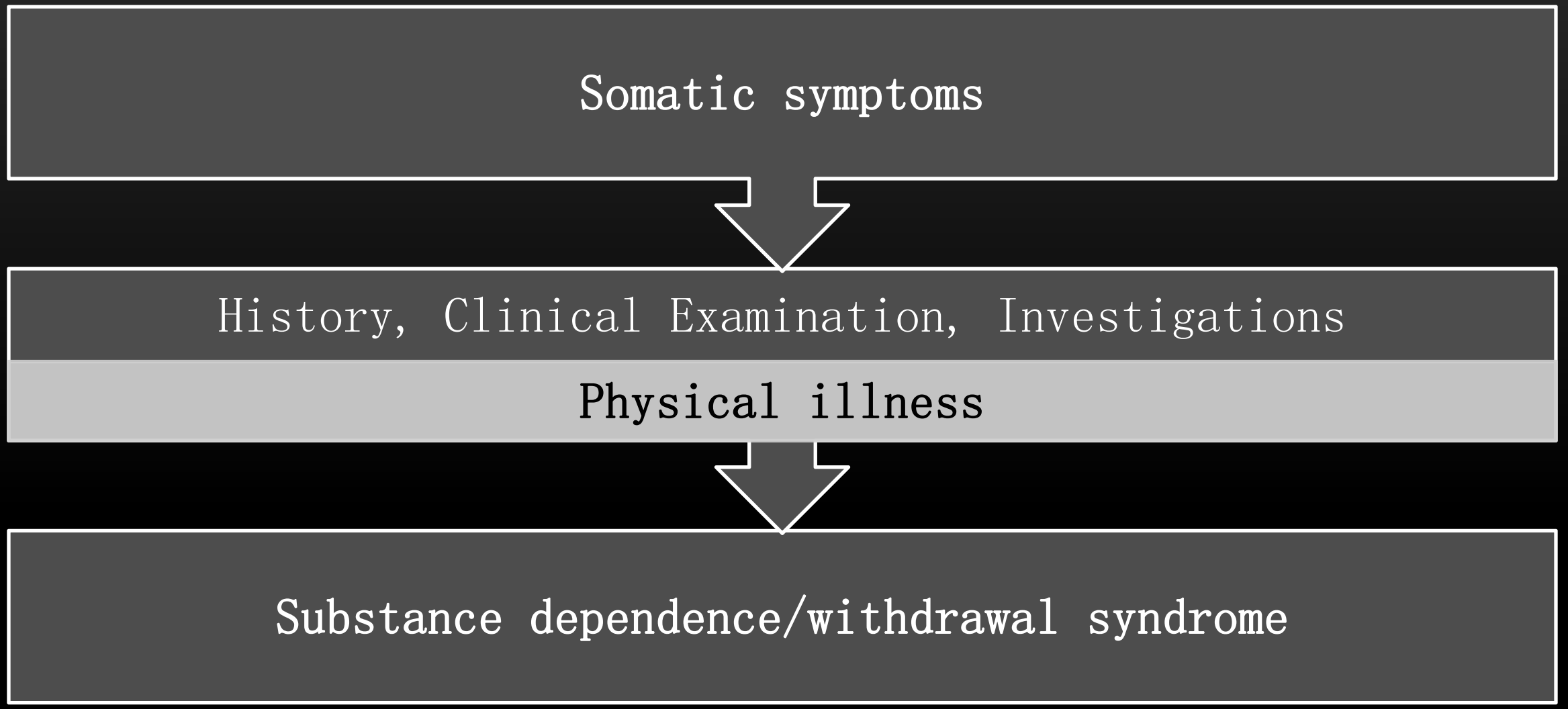
Differential Diagnosis

Somatization Disorder	Hypochondriasis	Body Dysmorphic Disorder	Delusional Disorder
• More concerned with symptoms • More abnormal personality characteristics • More depressive & anxiety features • Seek treatment • Usual age of onset ~ 25yrs., more common in females	• Preoccupied obsessive thought about serious disease • Fearful of dying • Incidence equal in males & females • Seek investigations • Concerned with diagnosis of serious illness	• Focus on specific presumed defect • Obsessive preoccupation with their body • Not fearful of having a serious illness or fear of death • Seek medical care such as cosmetic surgery or dermatological advice	• Fixed & unfounded belief that a disease is present • Bizarre explanation of belief • Gross impairment of reality • Socio-occupational functioning impaired

Differential Diagnosis

Somatization Disorder	Factitious Disorder	Malingering
• Symptoms are produced unconsciously • No secondary gain • Sometimes primary gain present; physical and social benefits for illness	• Patient has some awareness that he/she intentionally produces the symptoms • Awareness usually less than complete • No secondary gain	• Symptoms produced consciously for secondary gains • Psychopathology absent

Evaluation


Somatic symptoms
History, Clinical Examination, Investigations
Physical illness
Substance dependence/withdrawal syndrome

Evaluation

Symptoms produced by patient intentionally

Malingering

Patient plays sick role

Factitious Disorder

Symptoms not produced by patient unintentionally

Somatization Disorder

Investigations

- Patient subject to multiple investigations and diagnostic procedures
- Detailed history and thorough physical examination to r/o physical illness- reassures patient
- Review previous investigations
- Cautious use of investigations

Treatment

1. Reassurance and supportive therapy
2. Pharmacotherapy
3. Smith’s consultation letter
4. Psychotherapy

Patient Physician Relationship Structure of Treatment

1. Attention (looking, watching, listening)
2. Unconditional care (understand patient & illness & provide care)
   - Acceptance & respect for the person and his/her symptoms, how they are affecting him/her
   - Hearing and intentional watching of body posture, movement & affect
   - Reflecting back to the patient what has been said via all forms of communication, letting him/her know he/she is attended to
   - Not expecting/needing appreciation

3. Skillful treatment
   - Attend to transference & countertransference
   - Formulate without labels when diagnosis is uncertain
   - Evaluate appropriately with standard and limited workup
   - Frame and make boundaries
   - Connect for the patient the languages of psyche and soma
   - Reassure appropriately and sparingly
   - Communicate clearly
4. Structure of treatment including timely follow-ups

Reassurance Supportive Therapy

- Patients respond poorly to simple reassurance regarding no positive findings in clinical examination and investigations
- Therapeutic benefits from:
  - Accepting attitude of the therapist
  - Shift in pts' attention from somatic to emotional features
  - Group approaches to focus on explanation, support, relaxation and CBT approaches for adapting to chronic somatic distress

Pharmacotherapy

- No evidence that a purely pharmacological approach beneficial
- Avoid medications except in presence of anxious, depressive or psychotic symptoms
- Tendency to somatize increases sensitivity & probability of A/E (SSRI > TCA)
- Start low & go slow to minimize A/E (Fluoxetine & Paroxetine)
- Minimize use of habit-forming drugs
- Newer agents under study: SNRI & Gabapentin

Smith's Consultation Letter

- Richard Smith et al at University of Arkansas for Medical Sciences
- Brief "consultation letter" for primary care physicians listing "do's & don'ts" for patients with multiple medically unexplained physical symptoms and key management techniques
- No significant change in somatic symptom relief, but functional capacity improved significantly, thus decreasing their utilization of health resources

Smith's Consultation Letter

Do's and don'ts:

- Regularly scheduled appointments
- Perform brief physical examinations focusing on the area of discomfort at each visit
- Avoid unnecessary diagnostic procedures, invasive treatments, and hospitalizations
- Avoid using statements such as "symptoms are all in your head,"
- Briefly allow/encourage patients to talk about "stressors"

Psychotherapy

- Brief psychodynamic therapy of unexplained somatic symptoms may be effective
- Most of the recent evidence in RCTs - CBT efficacious
- Approaches:
  - **Psychotherapeutic approach (Guthrie):**
    - Close and trusting relationship
    - Chronic patients
  - **Directive approach (Benjamin):**
    - Treat patient as though he or she has a physical problem
    - Hostile patients

Cognitive Behaviour Therapy

- Set realistic short- and long-term goals
- Focus on practical ways of coping with symptoms & limitations
- Encourage patient to keep a daily log of thoughts, feelings & coping behaviours
- Promote daily physical, social, recreational & occupational activities
- Promote daily relaxation activities & exercises
- Promote patient control and autonomy

- CBT - improvement in functioning & symptomatology - decrease

Affective Cognitive Behaviour Therapy

- **Relaxation training:** direct action on physical symptoms (breathing, heart rate, muscle tension)
- **Behavioral management:** improve overall mood, provides distraction from somatic symptoms
- **Cognitive strategies:** look for variations in adaptability of thoughts and discuss their effect with the patient

Course Prognosis

- Chronic, undulating & relapsing disorder
- Complete remission rare
- Patient with somatization disorder has 80% chance to be diagnosed again with the same disorder after 5 years
- Likely to develop another medical illness in next 20 years

Summary

- Repeated presentation with medically unexplained symptoms affecting multiple organ systems, usually chronic in adults, associated with significant psychological distress and socio-occupational impairment
- Etiology not fully understood
- Needs to be differentiated from other disorders
- Reassurance and CBT more effective than pharmacotherapy
- Chronic and relapsing course

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Thank You