Psychiatry 5th year

Chapter 12: Somatization Disorders

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Somatization

prominent physical symptoms

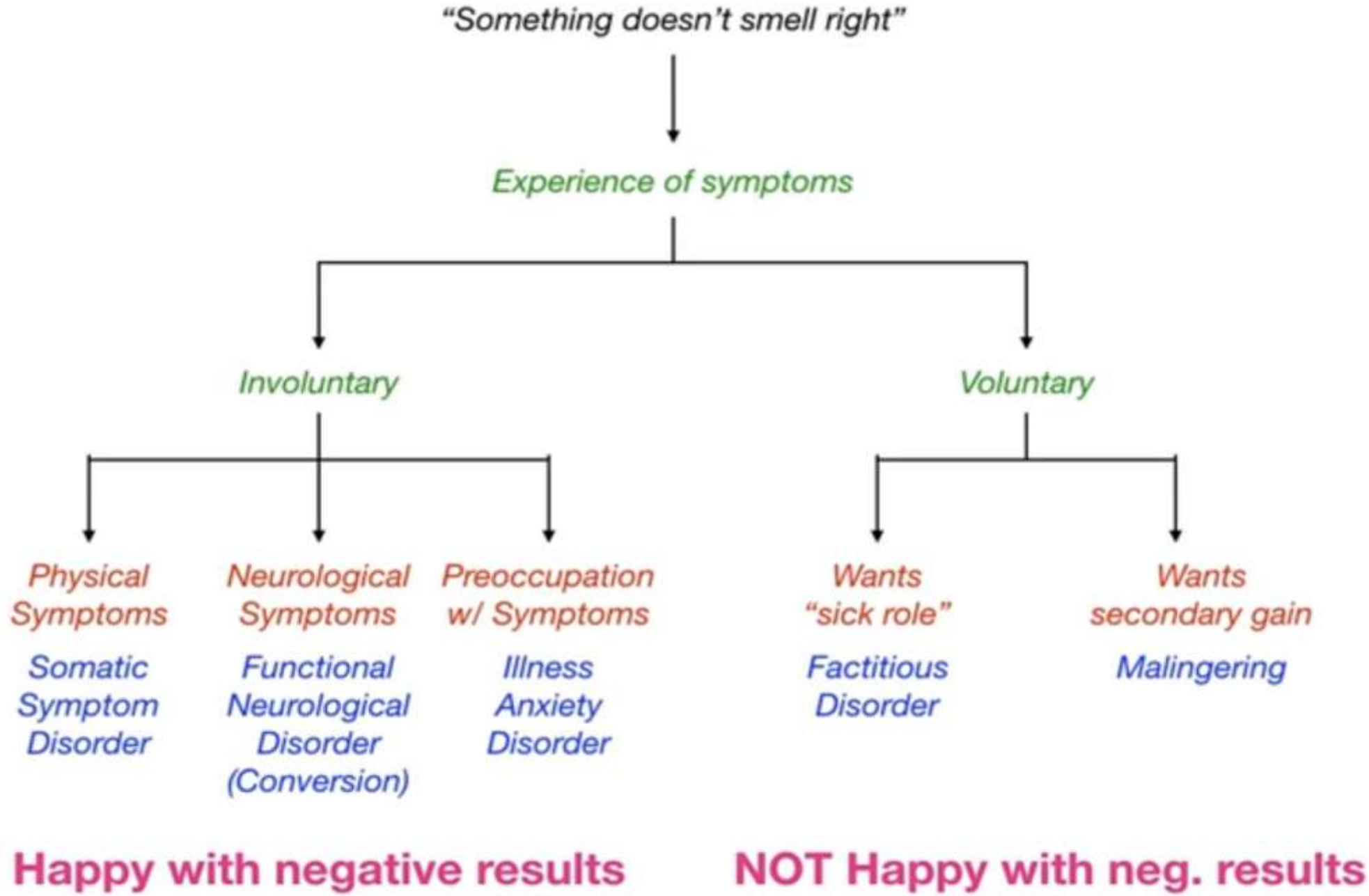
significant distress or impairment in social, occupational, or other areas of functioning.

may or may not have an associated medical condition

Pt; They believe it is real
- No organic cause
- Multiple doctors
- Multiple tests/workups
- Anxiety/ depression

To Dx= R/O organic dz First
R/O fictitious disorder +Malingering

Tx= psychotherapy + setting boundaries(one provider only)


"Something doesn't smell right"
Experience of symptoms
Involuntary
Voluntary
Physical Symptoms
Neurological Symptoms
Preoccupation w/ Symptoms
Wants "sick role"
Wants secondary gain
Somatic Symptom Disorder
Functional Neurological Disorder (Conversion)
Illness Anxiety Disorder
Factitious Disorder
Malingering
Happy with negative results
NOT Happy with neg. results

Disease	Symptoms	Preoccupation	Motivation
SSD= somatic symptom disorder	*At least 1 real somatic sx= pain/ /GI/ Fatigue *not neurological sx *>6months *	*somatic sx +/- medical dz *if they do=Disproprtionate	Unwanted
CD=conversion disorder/functional neurological symptom disorder	*>1 abnormal Neurological sx(sensory or motor) *Not better explained by another dx *stressors	*None (no concerns= la belle indifference) *wont hurt themselves	Unwanted
IAD= illness anexity disorder	*None or very minimal sx *>6 months *=	*Acquiring illness despite repeated reassurance	Unwanted /egodystonic= looking for help
Factitious (Munchhausen vs Munchhausen by proxy)	Can be any thing	*Attention seekers *sick role -Clues; Personality Disorders /Significant hx of abuse/ Healthcare experience	Intentional deception
Malingering	Can be any thing	*2ndry gain *external reward *Doesn't cooperate+ NOT	Intentional deception

Ms. Thomas is a 31-year-old woman who was referred to a psychiatrist by her gynecologist after undergoing multiple exploratory surgeries for abdominal pain and gynecologic concerns with no definitive findings. The patient reports that she has had extensive medical problems dating back to adolescence. She reports periods of extreme abdominal pain, vomiting, diarrhea, and possible food intolerances. The obstetrician is her fourth provider because "my other doctors were not able to help me." Ms. Thomas reports fear that her current physician will also fail to relieve her distress. She was reluctant to see a psychiatrist and did so only after her obstetrician agreed to follow her after her psychiatric appointment.

Ms. Thomas states that her problems worsened in college, which was the first time she underwent surgery. She reports that due to her health problems and severe lack of energy, it took her 5½ years to graduate from college. She did better for a year or two after college but then had a return of symptoms. She reports recently feeling very lonely and isolated because she has not been able to find a boyfriend who can tolerate her frequent illnesses. She also reports that physical intimacy is difficult for her because she finds sex painful. Additionally, she is concerned that she might lose her job due to the number of days she has missed from work due to her abdominal pain, fatigue, and weakness.

What is the diagnosis?

Somatic symptom disorder. Ms. Thomas has a history of multiple somatic complaints lasting at least 6 months, along with a high level of anxiety about her symptoms and excessive time and energy devoted to her health concerns. She has had multiple medical procedures and significant impairment in her social and occupational functioning.

Somatic symptom disorder
اضطراب الأعراض الجسدية

- Patients with somatic symptom disorder present with at least one (and often multiple) physical symptom.
- They frequently seek treatment from many doc tors, often resulting in extensive lab work, diagnostic procedures, hospital izations, and/or surgeries.

Note that somatic symptom disorder and a related medical illness are not mutually exclusive.

Diagnosis

1. One or more somatic symptoms (may be predominantly pain) that are distressing or result in significant disruption.
2. Excessive thoughts, feelings, or behaviors related to the somatic symp- toms or associated health concerns.
3. Lasts at least 6 months.

At least one

KEY FACT

Somatic symptom disorder patients typically express lots of concern over their condition and chronically perseverate over it. Conversion disorder patients often have an abrupt onset of their neu- rological symptoms (blindness, etc.) but appear unconcerned.

Epidemiology

- Incidence in females likely greater than males.
- Prevalence in general adult population: 5–7%.
- Risk factors include older age, fewer years of education, lower socioeconomicstatus, unemployment, and history of traumatic experiences in childhood.

Treatment

- The course tends to be chronic and debilitating. Symptoms may periodi cally improve and then worsen under stress.
- The patient should have regularly scheduled visits with a single primary care physician, who should minimize unnecessary medical workups and treatments.
- Address psychological issues slowly. Patients will likely resist referral to a mental health professional.

conversion Disorder (Functional Neurological Symptom Disorder) اضطراب التحويل

- Patients with conversion disorder have at least one neurological symptom (sensory or motor) which cannot be fully explained by a neurological condition. Examples include blindness, paralysis, and paresthesia. Patients may be surprisingly **calm and unconcerned (la belle indifference)** when describing their symptoms.

Q: Are patients with conversion disorder consciously faking their symptoms?
A: No. Patients with conversion disorder unconsciously produce symptoms, and cannot control when they occur. Symptoms may persist even after they becomeaware of their conversion disorder

Diagnosis

1. At least one symptom of altered voluntary motor or sensory function.
2. Evidence of incompatibility between the symptom and recognized neurological or medical conditions.
3. Not better explained by another medical or mental disorder.
4. Causes significant distress or impairment in social or occupational functioning or warrants medical evaluation.
5. Common symptoms: Paralysis, weakness, blindness, mutism, sensory complaints (paresthesias), seizures, globus sensation (globus hystericus or sensation of lump in throat).

Epidemiology

- Two to three times more common in women than men.
- Onset at any age, but more often in adolescence or early adulthood.
- High incidence of comorbid neurological, depressive, or anxiety disorders.
- Conversion-like presentations in elderly patients have a higher likelihoodof representing an underlying neurological deficit.

Treatment

- The primary treatment is education about the illness. Cognitive-behavioral therapy (**CBT**), with or without physical therapy, can be used if education alone is not effective.
- While patients often spontaneously recover, the prognosis is poor: symptoms may persist, recur, or worsen in 40–66% of patients.

Illness anxiety disorder
اضطرابات القلق

- Diagnosis :

1. Preoccupation with having or acquiring a serious illness.
2. Somatic symptoms are not present, or if present, are mild in intensity.
3. High level of anxiety about health.
4. Performs excessive health-related behaviors or exhibits maladaptive behaviors.
5. Persists for at least 6 months.
6. Not better explained by another mental disorder (such as somatic symptom disorder).

Epidemiology

- Men are affected as often as women.
- Average age of onset 20–30 years.
- Approximately 67% have a coexisting major mental disorder.

Q: In what setting are you most likely to diagnose a somatic symptom-related disorder?

A: Patients most commonly seek out care in medical settings–for example, primary care offices, medical specialty clinics, or emergency rooms. Patients are relatively unlikely to present to psychiatric settings, unless referred by a medical provider.

Treatment

- Regularly scheduled visits with one primary care physician.
- Psychotherapy (primarily CBT).
- Comorbid anxiety and depressive disorders should be treated with selective serotonin reuptake inhibitors (SSRIs) or other appropriate psychotropic medications.

Prognosis

- Chronic but episodic—symptoms may wax and wane periodically.
- Can result in significant disability.
- Up to 60% of patients improve significantly.
- Factors predicting better prognosis include fewer somatic symptoms, shorter duration of illness, and absence of childhood physical punishment.

psychological Factors affecting Other Medical conditions

- A patient with one or more psychological or behavioral factors (e.g., distress, coping styles, maladaptive health behaviors) adversely affecting a medical symptom or condition. Examples include anxiety worsening asthma, denial that acute chest pain needs treatment, and manipulating insulin doses in order to lose weight.

Diagnosis

- A medical symptom or condition (other than mental disorder) is present.
- Psychological or behavioral factors adversely affect the medical condition in at least one way, such as influencing the course or treatment, constituting an additional health risk factor, influencing the underlying pathophysiology, precipitating, or exacerbating symptoms or necessitating medical attention.
- Psychological or behavioral factors are not better explained by another mental disorder.

Epidemiology

- Prevalence and gender differences are unclear.
- Can occur across the lifespan.

Treatment

- Treatment includes education and frequent contact with a primary care physician.
- SSRIs and/or psychotherapy (especially CBT) should be used to treat underlying anxiety or depression.

Factitious Disorder
الاضطراب المفتعل

- Patients with factitious disorder intentionally falsify medical or psychological signs or symptoms in order to assume the role of a sick patient. They often do this in a way that can cause legitimate danger (central line infections, insulin injections, etc.). The absence of external rewards is a prominent fea ture of this disorder.

Diagnosis

1. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
2. The deceptive behavior is evident even in the absence of obvious external rewards.
3. Behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
4. Individual can present himself/herself, or another individual (as in factitious disorder imposed on another).

- Commonly feigned symptoms:
- Psychiatric—hallucinations, depression.
- Medical—fever (by heating the thermometer), infection, hypoglycemia, abdominal pain, seizures, and hematuria.

- Münchhausen syndrome:

is another, older name for factitious disorder with predominantly physical complaints.

- Münchhausen syndrome by proxy is intentionally producing symptoms in someone else who is under one's care (usually one's children).

Epidemiology

- May be at least 1% of hospitalized patients.
- More common in women.
- Higher incidence in hospital and health care workers (who have learned how to feign symptoms).
- Associated with personality disorders.
- Many patients have a history of illness and hospitalization, as well as childhood physical or sexual abuse.

Treatment

- Collect collateral information from medical providers and family. Collaborate with primary care physician and treatment team to avoid unnecessary procedures.
- Patients may require confrontation in a nonthreatening manner; however, patients who are confronted may leave against medical advice and seek hospitalization elsewhere.
- Repeated and long-term hospitalizations are common.

Malingering

A 37-year-old patient claims that he has frequent episodes of "seizures," starts on medications, and joins an epilepsy support group. It becomes known that he is doing this in order to collect social security disability money. *Diagnosis?* **Malingering**. In contrast, in **factitious disorder**, patients look for some kind of unconscious emotional gain by playing the "sick role," such as sympathy from the physician. The fundamental difference between malingering and factitious disorder is in the intention of the patient; in malingering, the motivation is external, whereas in factitious disorder, the motivation is internal.

Malingering

- Malingering involves the intentional reporting of physical or psychological symptoms in order to achieve personal gain. Common **external motivations i**nclude avoiding the police, receiving room and board, obtaining narcotics, and receiving monetary compensation. Note that malingering is not considered a mental illness.

Malingering is the conscious feigning of symptoms for some secondary gain (e.g., monetary compensation or avoiding incarceration).

Presentation

- Patients usually present with multiple vague complaints that do not con form to a known medical condition.
- They often have a long medical history with many hospital stays.
- They are generally uncooperative and refuse to accept a good prognosis even after extensive medical evaluation.
- Their symptoms improve once their desired objective is obtained.

Epidemiology

- Not uncommon in hospitalized patients.
- Significantly more common in men than women.

Management

Neuropsychological testing can help to identify feigned or exaggerated cognitive symptoms. Assessments routinely include embedded validity measures and tests more specifically designed to catch malingering or low effort, **such as the TOMM (Test of Memory Malingering).**

- Work with the patient to manage their underlying distress, if possible.
- Gentle confrontation may be necessary; however, patients who are con-fronted may leave the hospital AMA and seek treatment elsewhere.

Review of Distinguishing Features

- Somatic symptom disorders: Patients believe they are ill and do not intentionally produce or feign symptoms.
- Factitious disorder: Patients intentionally produce symptoms of a psychological or physical illness because of a desire to assume the sick role, not for external rewards.
- Malingering: Patients intentionally produce or feign symptoms for external reward

- Thank you