02 - 13.2 Somatic Symptom Disorder

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Lesperance F, Frasure-Smith N, Theroux P, Irwin M. The association between major depression and levels of soluble intercellular adhesion molecule 1, interleukin-6, and C-reactive protein in patients with recent acute coronary syndromes. Am J Psychiatry. 2004;161:271–277. Lipsitt DR. Consultation-liaison psychiatry and psychosomatic medicine: The company they keep. Psychosom Med. 2001;63:896. Matthews KA, Gump BB, Harris KF, Haney TL, Barefoot JC. Hostile behaviors predict cardiovascular mortality among men enrolled in the multiple risk factor intervention trial. Circulation. 2004;109:66–70. Palta P, Samuel LJ, Miller ER, Szanton SL. Depression and oxidative stress: Results from a meta-analysis of observational studies. Psychosom Med. 2014;76(1):12–19. Schrag AE, Mehta AR, Bhatia KP, Brown RJ, Frackowiak RS, Trimble MR, Ward NS, Rowe JB. The functional neuroimaging correlates of psychogenic versus organic dystonia. Brain. 2013;136(3):770–781. Shorter E. From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era. New York: Free Press; 1992. 13.2 Somatic Symptom Disorder Somatic symptom disorder, also known as hypochondriasis, is characterized by 6 or more months of a general and nondelusional 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; and a subset of individuals with somatic symptom disorder has poor insight about the presence of this disorder. EPIDEMIOLOGY In general medical clinic populations, the reported 6-month prevalence of this disorder is 4 to 6 percent, but it may be as high as 15 percent. 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. Some evidence indicates that this diagnosis is more common among blacks than among whites, but social position, education level, gender, and marital status do not appear to affect the diagnosis. This disorder’s complaints reportedly occur in about 3 percent of medical students, usually in the first 2 years, but they are generally transient. 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. Somatic symptom disorder can also be understood in terms of a social learning model. The symptoms of this disorder are viewed as a request for admission to the sick role

made by a person facing seemingly insurmountable and insolvable problems. The sick role offers an escape that allows a patient to avoid noxious obligations, to postpone unwelcome challenges, and to be excused from usual duties and obligations. Somatic symptom disorder is sometimes a variant form of other mental disorders, among which depressive disorders and anxiety disorders are most frequently included. An estimated 80 percent of patients with this disorder may have coexisting depressive or anxiety disorders. Patients who meet the diagnostic criteria for somatic symptom disorder may be somatizing subtypes of these other disorders. The psychodynamic school of thought holds that aggressive and hostile wishes toward others are transferred (through repression and displacement) into physical complaints. The anger of patients with this disorder originates in past disappointments, rejections, and losses, but the patients express their anger in the present by soliciting the help and concern of other persons and then rejecting them as ineffective. This disorder is also viewed as a defense against guilt, a sense of innate badness, an expression of low self-esteem, and a sign of excessive self-concern. Pain and somatic suffering thus become means of atonement and expiation (undoing) and can be experienced as deserved punishment for past wrongdoing (either real or imaginary) and for a person's sense of wickedness and sinfulness. 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 (Table 13.2-1). 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. Clinicians may specify the presence of poor insight; patients do not consistently recognize that their concerns about disease are excessive. Table 13.2-1 DSM-5 Diagnostic Criteria for Somatic Symptom Disorder

CLINICAL FEATURES Patients with somatic symptom disorder believe that they have a serious disease that has not yet been detected and they cannot be persuaded to the contrary. They may maintain a belief that they have a particular disease or, as time progresses, they may transfer their belief to another disease. Their convictions persist despite negative laboratory results, the benign course of the alleged disease over time, and appropriate reassurances from physicians. Yet, their beliefs are not sufficiently fixed to be delusions. Somatic symptom disorder is often accompanied by symptoms of depression and anxiety and commonly coexists with a depressive or anxiety disorder. A severe case of somatic symptom disorder that highlights diagnostic, prognostic, and management issues is described in the case study. Mr. K, a white man in his mid-30s, consulted a general medicine clinic complaining of gastrointestinal problems. Major presenting symptoms were a long list of physical symptoms and concerns mostly related to the gastrointestinal system. These included

abdominal pain, left lower quadrant cramps, bloating, persistent sense of fullness in stomach hours after eating, intolerance to foods, constipation, decrease in physical stamina, heart palpitations, and feelings that “skin is getting yellow” and “not getting enough oxygen.” A review of systems disclosed disturbances from virtually every organ system, including tired eyes with blurred vision, sore throat and “lump” in throat, heart palpitations, irregular heartbeat, dizziness, trouble breathing, and general weakness. The patient reported that symptoms started prior to the age of 30 years. For more than a decade, he had been seen by psychiatrists, general practitioners, and all kinds of medical specialists, including surgeons. He used the Internet constantly and traveled extensively in search of expert evaluations, seeking new procedures and diagnostic assessments. He had undergone repeated colonoscopies, sigmoidoscopies, and computed tomographic (CT) scans, magnetic resonance imaging (MRI) studies, and ultrasound examinations of the abdomen that had failed to disclose any pathology. He was on disability and had been unable to work for more than 2 years due to his condition. About 3 years before his visit to the medicine clinic, his abdominal complaints and his fixed belief that he had an intestinal obstruction led to an exploratory surgical intervention for the first time, apparently with negative findings. However, according to the patient, the surgery “got things even worse,” and since then he had been operated on at least five other occasions. During these surgeries he has undergone subtotal colectomies and ileostomies due to possible “adhesions” to rule out “mechanical” obstruction. However, available records from some of the surgeries do not disclose any specific pathology other than “intractable constipation.” Pathological specimens were also inconclusive. The physical examination showed a well-developed, well-nourished male, who was afebrile. A complete physical and neurological examination was normal except for examination of the abdomen, which revealed multiple abdominal scars. Right ileostomy was present, with soft stool in the bag and active bowel sounds. There was no point tenderness and no abdominal distension. During the examination, the patient kept pointing to an area of “hardness” in the left lower quadrant that he thought was a “tight muscle strangling his bowels.” However, the examination did not disclose any palpable mass. Skin and extremities were all within normal limits, and all joints had full range of motion and no swelling. Musculature was well developed. Neurological examination was within normal limits. The patient was scheduled for brief monthly visits by the primary care physician, during which the doctor performed brief physicals, reassured the patient, and allowed the patient to talk about “stressors.” The physician avoided invasive tests or diagnostic procedures, did not prescribe any medications, and avoided telling the patient that the symptoms were mental or “all in his head.” The primary care physician then referred the patient back to psychiatry. The psychiatrist confirmed a long list of physical symptoms that started before the age of 30 years, most of which remained medically unexplained. The psychiatric

examination revealed some anxiety symptoms, including apprehension, tension, uneasiness, and somatic components such as blushing and palpitations that seemed particularly prominent in front of social situations. Possible symptoms of depression included mild dysphoria, low energy, and sleep disturbance, all of which the patient blamed on his “medical” problems. The mental status examination showed that Mr. K’s mood was rather somber and pessimistic, although he denied feeling sad or depressed. Affect was irritable. He was somatically focused and had little if any psychological insight. The examination revealed the presence of a few life stressors (unemployment, financial problems, and family issues) that the patient quickly discounted as unimportant. Although the patient continued to deny having any psychiatric problems or any need for psychiatric intervention or treatment, he agreed to a few regular visits to continue to assess his

situation. He refused to engage anyone from his family in this process. Efforts to engage the patient with formal therapy such as cognitive-behavioral therapy (CBT) or a medication trial were all futile, so he was seen only for “supportive psychotherapy,” with the hope of developing rapport and preventing additional iatrogenic complications. During the follow-up period, the patient was operated on at least one more time and continued to complain of abdominal bloating and constipation and to rely on laxatives. The belief that there was a mechanical obstruction of the intestines continued to be firmly held by the patient and bordered on the delusional. However, he continued to refuse pharmacological treatment. The only medication he accepted was a low-dose benzodiazepine for anxiety. He continued to monitor his intestinal function 24 hours per day and to seek evaluation by prominent specialists, traveling to high-profile specialty centers far from home in search of solutions. (Courtesy of J. I. Escobar, M.D.) Although DSM-5 specifies that the symptoms must be present for at least 6 months, transient manifestations can occur after major stresses, most commonly the death or serious illness of someone important to the patient or a serious (perhaps lifethreatening) illness that has been resolved but that leaves the patient temporarily affected in its wake. Such states that last fewer than 6 months are diagnosed as “Other Specified Somatic Symptom and Related Disorders” in DSM-5. Transient somatic symptom disorder responses to external stress generally remit when the stress is resolved, but they can become chronic if reinforced by persons in the patient’s social system or by health professionals. DIFFERENTIAL DIAGNOSIS Somatic symptom disorder must be differentiated from nonpsychiatric medical conditions, especially disorders that show symptoms that are not necessarily easily diagnosed. Such diseases include acquired immunodeficiency syndrome (AIDS), endocrinopathies, myasthenia gravis, multiple sclerosis, degenerative diseases of the nervous system, systemic lupus erythematosus, and occult neoplastic disorders.

Somatic symptom disorder is differentiated from illness anxiety disorder (a new diagnosis in DSM-5 discussed in Section 13.3) by the emphasis in illness anxiety disorder on fear of having a disease rather than a concern about many symptoms. Patients with illness anxiety disorder usually complain about fewer symptoms than patients with somatic symptom disorder; they are primarily concerned about being sick. Conversion disorder is acute and generally transient and usually involves a symptom rather than a particular disease. The presence or absence of la belle indifférence is an unreliable feature with which to differentiate the two conditions. Patients with body dysmorphic disorder wish to appear normal, but believe that others notice that they are not, whereas those with somatic symptom disorder seek out attention for their presumed diseases. Somatic symptom disorder can also occur in patients with depressive disorders and anxiety disorders. Patients with panic disorder may initially complain that they are affected by a disease (e.g., heart trouble), but careful questioning during the medical history usually uncovers the classic symptoms of a panic attack. Delusional disorder beliefs occur in schizophrenia and other psychotic disorders, but can be differentiated from somatic symptom disorder by their delusional intensity and by the presence of other psychotic symptoms. In addition, schizophrenic patients’ somatic delusions tend to be bizarre, idiosyncratic, and out of keeping with their cultural milieus, as illustrated in the case below. A 52-year-old man complained “my guts are rotting away.” Even after an extensive medical workup, he could not be reassured that he was not ill. Somatic symptom disorder is distinguished from factitious disorder with physical symptoms and from malingering in that patients with somatic symptom disorder actually experience and do not simulate the symptoms they report. 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. Although no well-conducted large outcome studies have been reported, an estimated one third to one half of all patients with somatic symptom disorder eventually improve significantly. 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 nonpsychiatric medical condition. Most children with the disorder recover by late adolescence or early adulthood. 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 individual insight-oriented psychotherapy, 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. Invasive diagnostic and therapeutic procedures should only be undertaken, however, when objective evidence calls for them. When possible, the clinician should refrain from treating equivocal or incidental physical examination findings. Pharmacotherapy alleviates somatic symptom disorder only when a patient has an underlying drug-responsive condition, such as an anxiety disorder or depressive disorder. When somatic symptom disorder is secondary to another primary mental disorder, that disorder must be treated in its own right. When the disorder is a transient situational reaction, clinicians must help patients cope with the stress without reinforcing their illness behavior and their use of the sick role as a solution to their problems. OTHER SPECIFIED OR UNSPECIFIED SOMATIC SYMPTOM DISORDER This DSM-5 category is used to describe conditions characterized by one or more unexplained physical symptoms of at least 6 months’ duration, which are below the threshold for a diagnosis of somatic symptom disorder. The symptoms are not caused, or fully explained, by another medical, psychiatric, or substance abuse disorder, and they cause clinical significant distress or impairment. Two types of symptom patterns may be seen in patients with other specified or unspecified somatic symptom disorder: those involving the autonomic nervous system and those involving sensations of fatigue or weakness. In what is sometimes referred to as autonomic arousal disorder, some patients are affected with symptoms that are limited to bodily functions innervated by the autonomic nervous system. Such patients have complaints involving the cardiovascular, respiratory, gastrointestinal, urogenital, and dermatological systems. Other patients complain of mental and physical fatigue, physical weakness and exhaustion, and inability to perform many everyday activities because of their symptoms. Some clinicians believe this syndrome is neurasthenia, a diagnosis used primarily in Europe and Asia. The syndrome may overlap with chronic fatigue syndrome, which various research reports have hypothesized to involved psychiatric, virological, and immunological factors. (See Chapter 14, which discusses chronic fatigue syndrome in depth.) Other conditions included in this unspecified category of somatic symptom disorder are pseudocyesis (discussed in Chapter 27) and conditions that may not have met the 6-month criterion of the other somatic symptom disorders.

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