Somatization, Somatoform disorders, and functional somatic syndromes:
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UOB
• Topic relevant to all clinical disciplines in medicine/surgery/primary care

• Examined on

• Other related topics include Liaison Psychiatry (blackboard) and the somatoform disorders tutorial (blackboard) which you should do prior to the presentation.
Somatization:

- A way of responding or living
- Ubiquitous – everyone does it
- At times problematic, warranting clinical attention
- Maybe transient in response to life stress
- V. Common in clinical setting
- V. common amongst C-L referrals
- Not all have somatoform disorder
What enables somatization?

**Physiological**
- Autonomic arousal
- Hyperventilation
- Physiological effects of inactivity
- Sleep disturbance

**Somatizer**

**Other**
- Healthcare
- Disability
- Carers

**Psychological**
- Mood
- Beliefs
- Perception factors
- Personality

Other factors include:
- Perceptual factors
- Personality
Somatization patterns:

• MUS
• Hypochondriacal somatization
• Somatic presentations of psychiatric illness

• Somatization can be seen as normal human experience cf anxiety. Impt to distinguish transient from chronic. If latter and impairs eg pt or health system, then action needed!
Three year incidence (%) of symptoms in general practice
(Total and with organic cause) (Kroenke & Mangelsdorff 1989)
What are symptoms?

- Bodily sensations AND cortical interpretation
Somatosensory amplification:

- Tendency to experience somatic sensations as noxious, intense or disturbing

Relates to: hypervigilance to bodily sensations, selection and focus, cognitive intensification
Illness vs disease:

- Response to sx by individual and family vs Drs definition based on pathophysiological findings
- Mismatch common
- Root of many management problems
Illness behaviour:

• How people monitor bodies, define and interpret symptoms, take remedial action, utilise sources of help including formal health care system

• Effected by wide variety of social, psychiatric and cultural factors

• Often used to achieve a variety of social and personal objectives, having little to do with biological systems of pathogenesis of disease
Abnormal illness behaviour:

• Physician determined

• But…

• What about abnormal treatment behaviour!
Psychiatry vs general medicine

- Classification in this area is confusing!
- Psychiatrists have defined disorders with marked somatisation as somatoform disorders. General med drs call functional somatic syndromes often with specific names eg Irritable bowel syndrome, fibromyalgia, temporomandibular joint disorder, chronic pelvic pain, non specific chest pain etc
Somatoform disorders and functional somatic syndromes:

- Somatic sx, which suggest a physical disorder, but where there is no organic cause/physiological mechs
- Sig functional impairment and distress
- Linked to psychological factors/conflict
Diff diagnosis:

- Depression
- Anxiety
- Substance misuse
- Psychotic
- Organic mental
- Factitious + malingering – interesting! - see later
- Somatoform/functional somatic syndrome
- Personality
• Thorough Hx and exam

• Dep – “not worth treating”
• Anxiety – biases attention and distorts cognition. If comorbid pain ↓ threshold
• Substance abuse – esp alcohol
• Psychosis – dep vs schizophrenia
• Organic mental – no specific locus. Check cog
Somatoform disorders:

- Somatization Disorder
  - women predominate
  - early onset, before age 30
  - Multiple vague somatic symptoms:
    - four pain symptoms
    - two gi symptoms
    - one sexual symptom
    - one pseudoneurological sx
• **Common symptoms of somatization disorder**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Patients</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>nervousness</td>
<td>92%</td>
<td>15%</td>
</tr>
<tr>
<td>weakness</td>
<td>84%</td>
<td>11%</td>
</tr>
<tr>
<td>joint pain</td>
<td>84%</td>
<td>27%</td>
</tr>
<tr>
<td>dizziness</td>
<td>84%</td>
<td>9%</td>
</tr>
<tr>
<td>fatigue</td>
<td>84%</td>
<td>47%</td>
</tr>
<tr>
<td>abdominal pain</td>
<td>80%</td>
<td>22%</td>
</tr>
<tr>
<td>nausea</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>headache</td>
<td>80%</td>
<td>32%</td>
</tr>
</tbody>
</table>
• Somatization Disorder (cont.)
  – sx unexplained or impairment disproportional
  – medical hx complicated, often with iatrogenic complications
  – dramatic presentation
  – chaotic lifestyle, hx of abuse, impulsive personality disorder
Hypochondriasis:

- Fear of illness based on misinterpretation of bodily sensations
- persists despite reassurance
- duration > 6 months
- no gender differences
- risk factors unknown
Hypochondriasis:

- Illness phobia a subtype (e.g. AIDS, cancer)
- Obsessional personality, exaggerated health consciousness, alternative medical care common
- High comorbidity with depression and anxiety disorders
Conversion disorder:

- Characterized by the loss or alteration in physical functioning suggestive of a physical disorder.
- NOT intentionally producing the symptoms.
- Onset of symptoms is temporally related to a stressful life event.
Management of somatoform disorders:

- Aim for positive diagnosis rather than “I’ll just do more tests”
- Thorough review of notes/charts
- Often meds may be excacerbating probs. Drs often add these in, because they want to help and that is what they are trained to do, for patients (ie people who suffer). These pts tend to become dependent on meds easily
- Reduce iatrogenicity
Clinical:

- Collaborate with referral source
- Review medical notes
- Collaborate with family/friends
- Build alliance
- MSE Quality of pts description of sx
  - Associated thoughts, behaviours and emotions
  - Range and depth of emotional response
  - Level of denial
  - Pts explanation for –ve tests
  - Presence of abnormal hostility to physicians
Clinical cont’d:

- Physical examination
- Contract
- Tender anterior chest wall
- Tender abdomen
- Spurious breathing
- Short breath holding time
Psychometric tests:

- SCL-90
- MMPI
Clinical:

- Experiential – biofeedback, pharmacotherapy eg anxiety/depression
- Cognitive – reattribution. 3 step process ie psychosocial stressors → physiological mechanisms → physical sx
- Behavioural including contracts

- Psychotherapeutic focuses on trusting relationship
- Directive med model approach may be useful for hostile deniers
• Emphasize explanation
• Treat mood or anxiety disorders
• Minimise polypharmacy
• Change social dynamics
• Resolve difficulties in Dr-Pt relationship
• Recognise and control negative reactions and countertransference
Establish an empathic relationship to reduce the patient’s tendency to doctor-shop
  • Try to be the patient’s only physician

Focus on psychosocial problems, not the physical symptoms
  • Don’t try to talk patients out of their symptoms, or tell them that it is “all in their heads”
  • To the patient, the symptoms are real and distressing

Schedule the patient for brief, but frequent visits
  • As the patient improves, the time between visits can be extended
Related disorders:

• Factitious Disorder
  – Conscious, deliberate and surreptitious feigning of physical or psychological symptoms to simulate disease. The goal is the attainment of the patient role.
  – May show unusual submissiveness for hospitalization, procedures, and tests.
• Factitious Disorder (cont.)
  
  - Multiple hospitalizations, in widely different geographical locations, with multiple surgeries is classic for chronic factitious disorder (or Munchausen’s)
  
  - Age of onset in late teens, early 20’s
• **Factitious Disorder (cont.)**
  - Methods used to produce factitious sx
    - inject/insert contamination 29%
    - surreptitious use of meds 24%
    - exacerbation of wounds 17%
    - thermometer manipulation 10%
    - urinary tract manipulation 7%
    - falsified medical record 7%
    - self-induced bruises/deformities 2%
Factitious

- Complex!
- No obvious advantage
- Often places them at sig risk
- Liars
- Driven by pathological motives
FD - detection

- ? Room search
- Also psychological sx eg factitious bereavement
- Factitious Munchausens!
- Proxy
FD and Psychopathology:

- Female
- <40
- Nursing/medical
Treatment:

• Do you confront?
• How
• Initially allies rather than adversaries
• List pts strengths and suffering
• Also clear that severe emotional issues
• Don’t need to get them to admit
• Give pt opportunity to discuss but also quiet conviction
• Focus on what is best for pt ie support from psychiatry
• Pt often angry – quiet firm countering
Malingering:

- Defined as the intentional production of physical or psychological symptoms motivated by an identifiable external incentive.

- Obvious goal

- High suspicion if medicolegal, marked discrepancy, lack of cooperation, ASPD
• **MALINGERING** - Suspicion is aroused when:
  
  – History, physical inconsistent with complaints
  – symptoms vague, ill-defined
  – complaints over-dramatized
  – patient elusive, uncooperative with work-up
  – announcement of a favorable prognosis is met with resistance
  – medical records have been altered
  – injuries appear self-induced
**Differentiation**

<table>
<thead>
<tr>
<th>Mechanism of illness</th>
<th>Motivation for illness</th>
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<tbody>
<tr>
<td>Disorder production</td>
<td>production</td>
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<table>
<thead>
<tr>
<th></th>
<th>Unconscious</th>
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<tbody>
<tr>
<td>Somatoform d/o</td>
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<tr>
<td>Factitious Disorder</td>
<td>Conscious</td>
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<tr>
<td>Malingering</td>
<td>Conscious</td>
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<td>Conscious</td>
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Q and A:

- Somatisation is rare in the general population
- IBS is a somatoform disorder
- Somatisation disorder is commoner in females
- In malingering motivation for symptom presentation is unconscious
- In factitious disorder motivation for symptom presentation is conscious
Answers:

- F
- F
- F
- T
- F
- F
• If you need to discuss any of above or would like to find out more re contents of this presentation please contact:

• John.Potokar@bristol.ac.uk
Aetiological factors in somatization and somatoform disorders:

- Genetic
- Developmental
- Personality
- Psychodynamic
- Abuse
- Sociocultural
- Gender
- Iatrogenesis