

# SOMATIC SYMPTOM and RELATED DISORDERS

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# Learning Objectives

(the what, the why and the how?)

- 1. Why learning about “distressing somatic symptoms” is essential for your medical training?
- 2. What are “somatic symptom and related disorders”-SSRD?
- 3. How to recognize and conceptualize SSRD?
- 4. What are the best management plan strategies to deal with this spectrum of disorders?

# How to achieve the learning objectives?

- Building on your previous experience- KS&A
- Questions
- Simulation- video and pictures
- Clinical cases
- Compare and contrast
- MCQs
- The “red” sign
- What is on the exam?
- DSM4 vs DSM5
- What is clinically relevant?

# Clinical case

- 40 yo married mother of an 11 yo son. She regularly sees her GP over many years. Her complaints have varied and include abdominal pain, dysuria, dysmenorrhea, and tiredness. Over the years she has been referred to gynecologists, urologists, and general surgeons. Extensive investigations have revealed no clear cause for her symptoms. Despite this, she remains convinced that she has a serious physical illness that remains undiagnosed. She demands further referrals and further investigations. She is disabled by her symptoms and is unable to work.
- What to do next **if you are the GP?**
- What would you advise the GP, **if you are a specialist?**

# Why you need to know?

- You will see these patients in Cardiology, GI, Rheumatology, Orthopedics, Ob/Gyn, Urology, Family practice, Psychiatry ...
- Physical symptoms are common:  
85-90% of community sample has at least one symptom q 2-4 days (White, 1961; Demers, 1980)



**"Yoo-hoo! Oh, yoo-hoo! ...  
I think I'm getting a blister."**

# Somatoform disorders-DSM IV

1. Somatization disorder\*
2. Undifferentiated disorder
3. Conversion disorder\*
4. Pain disorder
5. Hypochondriasis\*
6. Body dysmorphic disorder\*
7. Somatoform disorder NOS

# DSM V

1. Somatization disorder → SSD
2. Undifferentiated disorder → SSD
3. Conversion disorder
4. Pain disorder
5. Hypochondriasis → illness anxiety disorder
6. Body dysmorphic disorder → moved to OCD
7. Somatoform disorder NOS



# Somatic Symptom and Related Disorders- DSM V

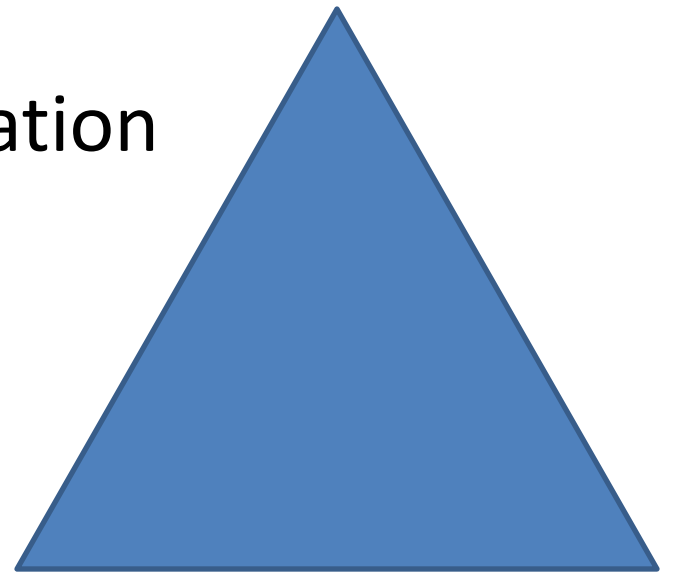
1. Somatic Symptom Disorder\*
2. Illness Anxiety Disorder\*
3. Conversion Disorder (Functional Neurological Symptom Disorder)\*
4. Psychological Factors Affecting Medical Condition
5. Factitious Disorder\*
6. Somatic Symptom Disorder Not Elsewhere Classified

\* you will need to know about for exams

# What do they share?

## \*Somatic symptom(s)

- Causing distress
- Plus abnormal thoughts, feelings, and behaviours in response
- “Can” have medical explanation



# How can you explain somatic complaints?

- Masked presentation of psychiatric illness
- Amplifying perceptual style
- Attention obtained from illness
- Lack of attention to nonsomatic expression of distress
- Social/cultural norms- devalue psychological suffering

# Somatic symptom disorder

- Prevalence- 5-7%
- More females
- Lower education and SES
- History of sexual abuse
- Concurrent chronic physical or Psychiatric illnesses
- Underdiagnosed in older adults ( why? )
- What about the children?

# Somatic symptom disorder (criteria)

- A. One or more somatic symptoms that are distressing
- B. Excessive thoughts, feelings or behaviours to the symptoms as manifested by at least one of the following:
  1. persistent or disproportionate thoughts about the seriousness of the illness
  2. persistently high level of anxiety about the symptoms
  3. excessive time and energy devoted to these symptoms
- C. Typically a state of being symptomatic for more than 6 months

Specifier: with predominant pain

Specifier: mild, moderate or severe

# How do you ask questions?

- When did the symptoms start?
- Have you been frustrated with getting no answers?
- What has been your experience with other doctors?
- What is your understanding of your symptoms?
- How have the symptoms affected your life?
- Ask about mood later

# SSD vs GAD

In GAD:

1. the worries are about “multiple” events, situations and activities
2. If the worry is about health patients will have other worries
3. the main focus is not somatic or fear of illness

# SSD vs Depression

In depression:

1. temporal relationship between mood and symptoms
2. resolution of symptoms with the resolution of the mood syndrome
3. affect reflecting the severity
4. core low mood and anhedonia



# What is the Differential Diagnosis?

- GAD
- Depressive disorders
- Delusional disorder
- Body dysmorphic disorder- BDD
- OCD
- Other medical conditions

Who is this man?



# Conversion Disorder

- The wandering uterus- Hippocrates
- Hypnosis- Charcot
- Unconscious conflict- Freud
  
- More than ½ of patients develop clear neurological signs in 10 years (Slater, 1965) BUT recent meta analysis: 5 %
- PET scan- dorsolateral prefrontal cortex; primary sensorimotor and premotor cortex; anterior cingulate

# Conversion Disorder Criteria

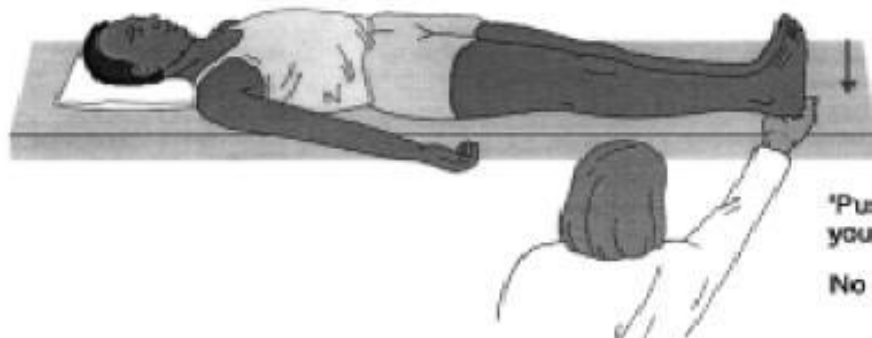
- One or more symptoms of altered **voluntary motor** or **sensory** function
- Clinically: **incompatibility** between symptom and neurological condition
- Symptom not better explained by another medical or mental disorder
- There is significant **distress**
- SPECIFIERS: acute vs persistent
- SPECIFIERS: with paralysis, with abnormal movement, with swallowing symptoms, with speech symptom, with seizures, with anesthesia, with special sensory symptom, or mixed

# Functional Neurological Symptom Disorder

What is Incompatibility---!!!!

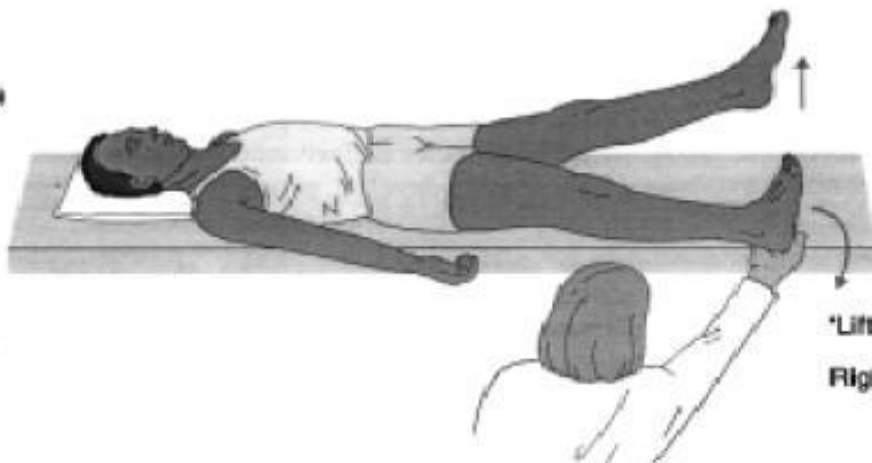
- Hoover's sign
- Positive findings on the tremor entrainment test
- Resistance to eye opening in attacks resembling epilepsy
- Tubular visual field

(a)



"Push down with  
your right heel"  
No effect

(b)



"Lift your left leg"  
Right hip extends

# WHEN TO SUSPECT PSYCHOGENIC MOVEMENT DISORDER?

## *History*

Sudden onset of symptoms with rapid progression

Waxing and waning of symptoms with sudden remissions and reappearances of symptoms, often in different body parts.

Paroxysmal exacerbations of symptoms, particularly provoked by psychological stress.

Multiple additional neurological and systemic symptoms.

## *Examination*

Resolution or diminution of symptoms with distraction.

Exacerbation of symptoms when the affected body part is examined.

Improvement of symptoms with suggestion (for example with a non-physiological manoeuvre such as placing a vibrating tuning fork on the patient's forehead with prior suggestion that it might reduce symptoms).

“Give-way” weakness of the limbs

Non-organic patterns of sensory disturbance

Non-organic patterns of speech disturbance.

Excessive response to startle.

Disability out of proportion to examination findings

Non-organic gait disturbance (see below)

ASTASIA /ABASIA GAIT

# Conversion Disorder

- Up to 20-25% on neuro floor and 5% on psych floor
- More common in rural areas, women and lower SES
- **La belle indifference- so what?**

**Good prognosis:** a. if acute b. precipitating event  
c. good pre-morbid functioning and d. absence of other co-morbid disorders



# Functional Neurological Symptom d/o

Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize

1. the essential importance of the neurological examination, and
2. recognition that relevant psychological factors may not be demonstrable at the time of diagnosis.

# Case example

- 31 yo female with no previous neuro or psych history- divorced with 3 kids
- “Type A” personality
- Admitted with “seizures”
- MRI, EEGs, LPs, EMGs, ....
- Minimal “organic”
- Waxing and waning
- Stress related
- Little distress

# Illness Anxiety Disorder

- Preoccupation with fears of having a serious illness
- Somatic symptoms are not present or if present they are mild
- High level of anxiety re health
- Excessive illness related behaviours or maladaptive avoidance
- 6 months
- Specifiers: Care seeking vs Care avoidant

# Is illness anxiety disorder?

- 50 year old male
- Banker
- Referred re “conviction of abdominal cancer”
- Investigations initially PUD- treated
- Investigations later PUD- healed
- Requires repeated reassurance
- Ruminative worries

# Is it illness anxiety disorder?

- How to differentiate from delusional disorder or psychotic disorder?

# Illness Anxiety Disorder

- Affects **women and men** equally
- Starts **early** in life
- Prevalence: 3-8% of patients seen by primary care physicians
- Doctor shop and multiple workups and have increased risk of substance problems

# Factitious & Malingering

## Factitious disorder

Falsification of physical or psychological signs and symptoms

Presents self as ill

Absence of obvious external award

Single episode

Recurrent episodes

If imposed on another

## Malingering

- Intentional
- External incentive
- Medicolegal population
- Forensic population
- Not a mental illness

## **What are the symptoms of Factitious Disorder?**

1. Dramatic but inconsistent medical history
2. Unclear symptoms that are not controllable, become more severe, or change once treatment has begun
3. Extensive knowledge of hospitals and/or medical terminology, as well as the textbook descriptions of illness
4. Presence of many surgical scars
5. Appearance of new or additional symptoms following negative test results
6. Presence of symptoms only when the patient is alone or not being observed
7. Willingness or eagerness to have tests or procedures
8. History of seeking treatment at many hospitals, clinics, and doctors' offices, even in different cities
9. Reluctance by the patient to allow health care professionals to meet with or talk to family members, friends, and prior health care providers



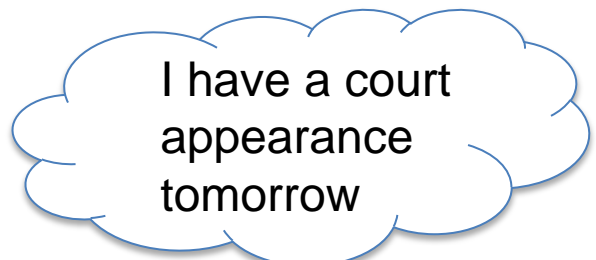
A cartoon illustration of a man in a black suit, white shirt, and red tie. He is pointing his right hand towards the left. A speech bubble on the left contains the text "I cannot see". Three small thought bubbles are positioned above his head.

I cannot see

A thought bubble containing the text "I cannot see".

I cannot see

Is it conversion or malingering?

A thought bubble containing the text "I have a court appearance tomorrow".

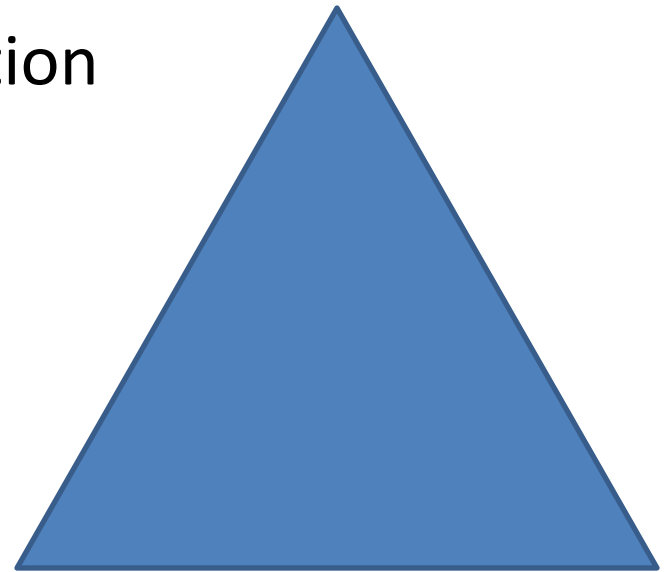
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I cannot see

# Management

- What is the goal of treatment?
- **Patient**-reduction of physical and psychiatric symptoms as well as distress and return to functioning
- **Clinician**- reduction of frustration
- **System**- reduction of costs



# Management

Describe the somatic symptoms/concerns:  
chronic, relapsing, and of low mortality and morbidity

Symptom validation

Regular appointment q4-6 weeks

Physical examination

Avoid hospitalization and procedures

Do not tell patients “all in your head”

# Management- EBM

- Consultation
- Decreased utilization cost by 53%
- Increased physical function
  - Smith, NEJM

**Table 3** Ingredients of a successful explanation for patients with functional symptoms

Ingredient	Example
Explain what they do have...	"You have functional weakness" "You have dissociative seizures"
Emphasise the mechanism of the symptoms rather than the cause	Weakness: "Your nervous system is not damaged but it is not functioning properly" Seizures: "You are going into a trance-like state a bit like someone being hypnotised"
Explain how you made the diagnosis	Show the patient their Hoover's sign or dissociative seizure video.
Explain what they don't have	"You do not have MS, epilepsy" etc
Indicate that you believe them	"I do not think you are imagining/making up your symptoms/mad"
Emphasise that it is common	"I see lots of patients with similar symptoms"
Emphasise reversibility	"Because there is no damage you have the potential to get better"
Emphasise that self-help is a key part of getting better	"This is not your fault but there are things you can do to help it get better"
Metaphors may be useful	"The hardware is alright but there's a software problem"; "It's like a car/piano that's out of tune"; "It's like a short circuit of the nervous system" (dissociative seizures)
Introducing the role of depression/anxiety	"If you have been feeling stressed/low/worried that will tend to make the symptoms even worse" (often easier to achieve on a second visit)
Use written information	Send the patient their clinic letter. Give them some written information
Stop the antiepileptic drug in dissociative seizures	If you have diagnosed dissociative seizures and not epilepsy, stop the antiepileptic drug. Leaving the patient on the drug is illogical, makes no sense to the patient and will hamper recovery
Suggesting antidepressants	"So-called antidepressants often help these symptoms even in patients who are not feeling depressed. They are not addictive."
Making the psychiatric referral	"I don't think you're mad but Dr X has a lot of experience and interest in helping people like you to manage and overcome their symptoms. Are you willing to overcome any misgivings about their specialty to try to get better?"
Involve the family/friends	Explain it all to them as well

# Management -what about meds?

## Pharmacotherapy

- **Antidepressants**- intolerance, partial response, resistance, and best evidence for **pain**
- SSRIs has been used in **illness anxiety disorder**
- **Benzodiazepines**- associated with worse outcome over 1-3 months

# Take Home Message

- Physical symptoms are common
- Validate the distress
- Empathic approach helps
- Schedule brief and frequent visits
- Goal is to improve function
- Use of meds to be minimized
- Medical evaluations to be minimized

# Questions? Answers need to know

- Is there a role for meds in “somatic symptom disorder” ?
- Think of maladaptive thoughts, feelings and behaviours in addition to the somatic symptoms
- Neuro findings are not there or exaggerated
- How to differentiate SSD from anxiety and from depression?
- What about factitious and malingering?
- How to manage somatic symptom and related disorders?



# MCQs

Q1. Medications such as SSRI s have been found to be helpful in certain cases of: ( choose 2 )

- a) Somatic symptom disorder
- b) Illness anxiety disorder
- c) conversion disorder
- d) Pain disorder

Q2. Which of the following is NOT a common motor symptom in Conversion Disorder?

- a)paralysis,
- b)impaired balance
- c)urinary retention
- d)double vision

# More MCQs

Q3. Individuals with functional neurological symptom disorder may often display a surprising indifference about their symptoms- especially when the symptoms to most people would be disturbing (e.g. blindness, paralysis). This is sometimes known as what?

Q4. Which of the following is **NOT** a disadvantage of adopting a sick role ?

- a) Loss of power
- b) loss of pleasure
- c) Loss of influence
- d) Loss of responsibility

# Answers MCQS

Q1

b and d

Q2

c

Q3

La belle indifference

Q4

d

# Thank you

- If you have questions please e-mail me at:  
raed.hawa@uhn.ca
- Please do not forget to fill out the evaluations

