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Somatic Symptom and Related Disorders

Developed by Geraldine Huynh and Dr. Heidi Wilkes for PedsCases.com.
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Hi, my name is Geraldine Huynh and I am a fourth year medical student at the University of Alberta. This podcast was kindly reviewed by Dr. Heidi Wilkes, a child psychiatrist at the Stollery Children's hospital and Dr. Melanie Marsh, an adult psychiatrist at the Royal Alexandra Hospital in Edmonton.

Objectives:

1. Discuss an approach to somatization and somatoform disorders
2. List risk factors for somatization & somatoform disorders
3. Outline key signs and symptoms concerning for somatization and somatoform disorders
4. Review the DSM-V criteria for somatization & somatoform disorders
5. Summarize the treatment and management from a Bio-Psycho-Social-Cultural-Spiritual approach

Case:
Emily is a 14yo F, who for the past year has been experiencing episodes, several times a month, when she becomes overwhelmed, anxious and experiences significant bilateral leg weakness. She is unable to walk or stand and requires the use of a wheelchair intermittently. The episodes last between 20-45min. She has a past medical history of generalized anxiety disorder and is currently taking escitalopram. There is a family history of depression. She is in grade 9 and finds school anxiety provoking and challenging. Her family dynamics are very tense and there is a lot of verbal conflict between her parents. All Investigations completed to date are normal. This includes blood work, an LP, MRI and head CT. Her general physical exam including a detailed neurologic exam are also completely unremarkable. Emily and her family wonder what's going on.

Somatization
Somatization is a universal part of the human experience. Psychological distress is often experienced as physical symptoms e.g. butterflies in the tummy, or dry mouth, diaphoresis and nausea with public speaking. However, it becomes pathological when it becomes the primary way of behaving and/or it interferes with our ability to function.

What are somatoform disorders?
Somatoform disorders are a groups of disorders in which physical symptoms (e.g. pain or loss of function) are inconsistent and cannot be explained by a known medical condition. Transient symptoms, as “signals of distress”, are responsible for up to 50% of outpatient visits in the pediatric age group, somatoform disorders represent only the severe end of this continuum.
They can have a detrimental effect on the child’s schooling, home life and relationships, becoming the primary focus of the patient and the family’s life.

Epidemiology:
Lifetime prevalence of somatoform disorders is 3% and that of subclinical somatoform illness as high as 10%. Adolescent girls tend to report nearly twice as many functional somatic symptoms as adolescent boys. Prior to puberty the ratio is equal.

What are the risk factors for somatoform disorders?
Affected children are more likely to have difficulty expressing emotional distress, come from families with a history of marital conflict, experienced maltreatment (including emotional, sexual, physical abuse), have a lower SES, or have a history of diagnosed medical illness. The family history should be examined for somatoform disorders, the presence of depression or anxiety disorder, and anniversaries of deaths of loved ones with similar symptoms.

Common comorbidities include depressive disorders (ie. Major Depressive Disorder), anxiety disorder (ie. Generalized Anxiety Disorder) and personality disorders where the patient struggles to form and maintain interpersonal relationships across multiple domains of function including social, occupational and educational as a result of severe difficulties identifying and coping with emotions. Clinical experts suggest that there is also an association between somatic symptom disorder and learning disorders and social anxiety disorders.

Signs and symptoms:
Somatoform disorders often start early in life. In early childhood, symptoms often include recurrent abdominal pain (RAP). Later on, in childhood and adolescence, neurologic symptoms, insomnia and fatigue are more common.

Diagnosis:
Screening tools for somatoform disorders include the Children’s Somatization Inventory (child and parent versions) and the Illness Attitude Scales and Soma Assessment Interview (parental interview questionnaires). The Functional Disability Inventory assesses the severity of symptoms.

One of the distinctions between the DSM IV and V, is that the DSM IV required that symptoms not be explained by a known general condition or the direct effects of a

substance. The DSM V, doesn't require this, meaning that you don't have to prove the symptoms are not "organic". The main issue is that the response is seen as excessive and disruptive to life. In addition, they are also at an increased risk of somatic and non-somatic comorbidities. For example, for children with Irritable Bowel Syndrome, GI disorders such as GERD, functional constipation and anal incontinence, occur in almost half of patients. For fibromyalgia, chronic fatigue syndrome and chronic pelvic pain may appear in up to 65% of patients.

According to the DSM-V, the Somatic Symptom disorder criteria are:

A. One or more somatic symptoms that are distressing OR result in significant disruption of daily life
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns. Manifested by at least 1 of the following:
    a. Persistent thoughts about the seriousness of the symptoms
    b. Persistently high level of anxiety about health or symptoms
    c. Excessive time and energy devoted to these symptoms or health concerns
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (>6mos)

There are specifiers:

- With predominant pain
- Persistent >6mo
- Mild: one symptom of criterion B
- Moderate: two or more symptoms of criterion B
- Severe: two or more symptoms of criterion B, multiple somatic complaints (or one very severe complaint)

There are several other diagnoses with clear distinctions like illness anxiety disorder, delusional disorder (somatic subtype) or body dysmorphic disorder, but these will not be discussed in this podcast.

Today, we'd like to highlight conversion disorder (or functional neurological symptom disorder). The criteria includes:

A. One or more symptoms of altered voluntary motor or sensory function.
B. Clinical findings provide evidence of incompatibility between symptom and recognized neurological or medical condition
C. The symptom or deficit is not better explained by another physical or mental disorder
D. The symptom or deficit causes clinically significant distress or impairment or warrants medical evaluation.

Specifiers include:

- With weakness or paralysis
- With abnormal movement
- With swallowing symptoms

- With speech symptoms (dysphonia, slurred speech)
- With attacks or seizures
- With anesthesia or sensory loss
- With special sensory symptom (visual, olfactory, or hearing disturbance)
- With mixed symptoms

Back to our case. Emily has conversion disorder with weakness and paralysis. She has neurological symptoms that are associated with psychological conflict or need, which affects her voluntary motor function. These episodes have an acute onset and she has an associated comorbidity of GAD and her social history includes marital conflict and tense family dynamics, which are risk factors. After discussing the diagnosis with the family, Emily and her parents wonder if there are any treatments or medications that might help improve her functioning? They also ask, "how often do somatic symptoms end up being a diagnosed medical condition in the future?"

Treatment:
It is essential to have a complete and thorough history and physical and to have a broad differential diagnosis. But once narrowed to somatoform disorder, this can often be good news and reassure patients that there is no evidence of a life-threatening illness. The treatment for somatoform disorders consist of an integrated medical and psychiatric approach with regular follow up. It is important to also provide reassurance that it is "not all in your head." The focus is on managing, not necessarily curing the symptoms. The goals are to identify concurrent psychiatric disorders, rule out concurrent medical disorders, improve overall functioning and minimize unnecessary invasive tests and doctor shopping.

The main objective is to use the least invasive treatment with a focus on active therapy (e.g. physiotherapy, CBT) vs. passive therapy (e.g. antidepressants) to encourage the patient to take responsibility for one's own health. In some cases, it may be helpful to walk two paths e.g. the patient is followed by both psychiatry and pediatrics. Somatic symptoms and related disorders do not have to be life-long and with CBT and other active modalities, children can have a good prognosis and return to typical functioning. Early treatment also improves prognosis. However due to limited number of studies and their high heterogeneity, there is not a lot of empirical evidence to provide reliable prognostic factors besides the severity of initial symptoms.

Dr. Melanie Marsh, a psychiatrist at the Royal Alexandra hospital has an "AVN approach" to develop and foster a strong therapeutic alliance:

Acknowledge the symptoms
Her leg weakness and inability to stand or walk is very real and that the patient's body is responding physically and involuntarily.

Validate their experience

Validate that it is natural for Emily to feel the way that she does especially given the stressors in her life.

Normalize
Discuss how the body and mind are very connected and sometimes stressful events can cause a series of reactions in our bodies that lead to the symptoms she is experiencing.

We can discuss with Emily's family the **3 main interventions available:**

1. Withdraw medical and social attention from these episodes of falling down and not being able to walk or stand. Encourage sticking to a schedule (e.g. going to school) Provide attention and special activities on days when child does not have symptoms. Limit activities and interactions on sick days.
2. Connect with physical and occupational therapy to retrain the patient in normal movement, strength and gait behaviors.
3. Psychotherapeutic treatment targeted at developing appropriate methods of coping with stress

Discussions around primary and secondary gain are beyond the scope of this podcast. But it's important to note that somatic symptom and related disorders occur when the patient is unaware of the connection between the symptoms and the underlying emotional distress.

Rene Descartes developed and proposed the theory of mind-body dualism in 1641. He was one of the first to believe in the idea of "interactionism" where mental states, beliefs and desires were believed to causally interact with physical states. Our modern beliefs about holistic care have stemmed from those progressive ideas, and we now recognize that so many biological, psychological, social, cultural and spiritual factors must be considered in evaluating and caring for each individual's sense of well-being.

In summary the main take away points from this podcast are:

1. A thorough history and physical exam and broad initial differential diagnosis is essential when first encountering a potential case of a somatoform disorder
2. Remember the AVN approach: Acknowledge, Validate & Normalize
3. Management will likely require a multi-disciplinary approach that may include: psychiatry, psychology, pediatrics, family medicine and rehab therapists (PT/OT)

Thanks for listening!

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