Overview of Somatisation, Somatoform Disorders/Somatic Symptom Disorder, Medically Unexplained Symptoms and Factitious Illness

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Overview

- Definitions
- Classification
- Prevalence
- Epidemiology
- Aetiology
- Theoretical Models
- Clinical Features
- Differential Diagnosis
- Biopsychosocial Model
- Management

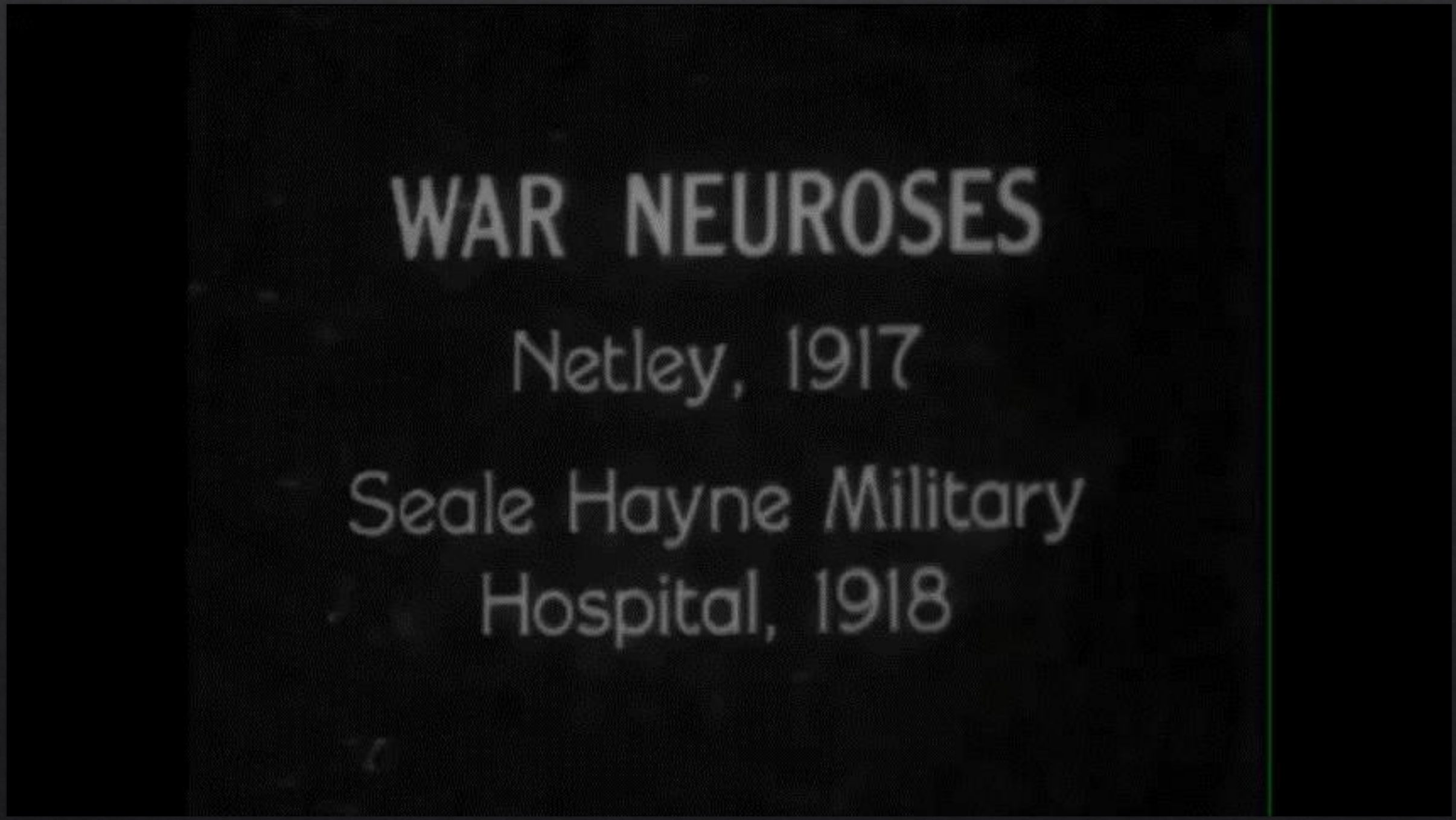
Somatisation - Definition

Expression of psychological distress through somatic symptoms

Repeated presentation of physical symptoms, together with persistent requests for medical investigations in spite of repeated negative findings and reassurances from doctors that the symptoms have no physical basis.

Somatic symptoms for which there is inadequate medical explanation (disease) and impairment of functioning

Multiple recurrent and frequently changing physical symptoms which have usually been present for several years before referral to a psychiatrist


WAR NEUROSES
Netley, 1917
Seale Hayne Military
Hospital, 1918

Taylor's model of 'sickness'

- Taylor, S. (1983). Adjustment to threatening events: A theory of cognitive adaptation. American Psychologist , 1161–1173

- Disease – organ dysfunction
- Illness – behaviour that characterises illness state
- Predicament – social ramifications of illness

Taylor's model of 'sickness'

- This is a way of thinking about health/disease.
- ie. Can have disease and not know it so don't show any illness ie cancer.
- Can have a lot of illness and not much disease – 'man flu'.
- The predicament part can be small or large – "I don't want to go to a party, I've got a headache", or someone with a history of sexual abuse who develops physical symptoms that mean can't have an intimate relationship
- All sickness can be broken down into these components.
- Predicaments might be evident before illness or disease, or come afterwards, as a result of the other 2 – it's interactive and dynamic.

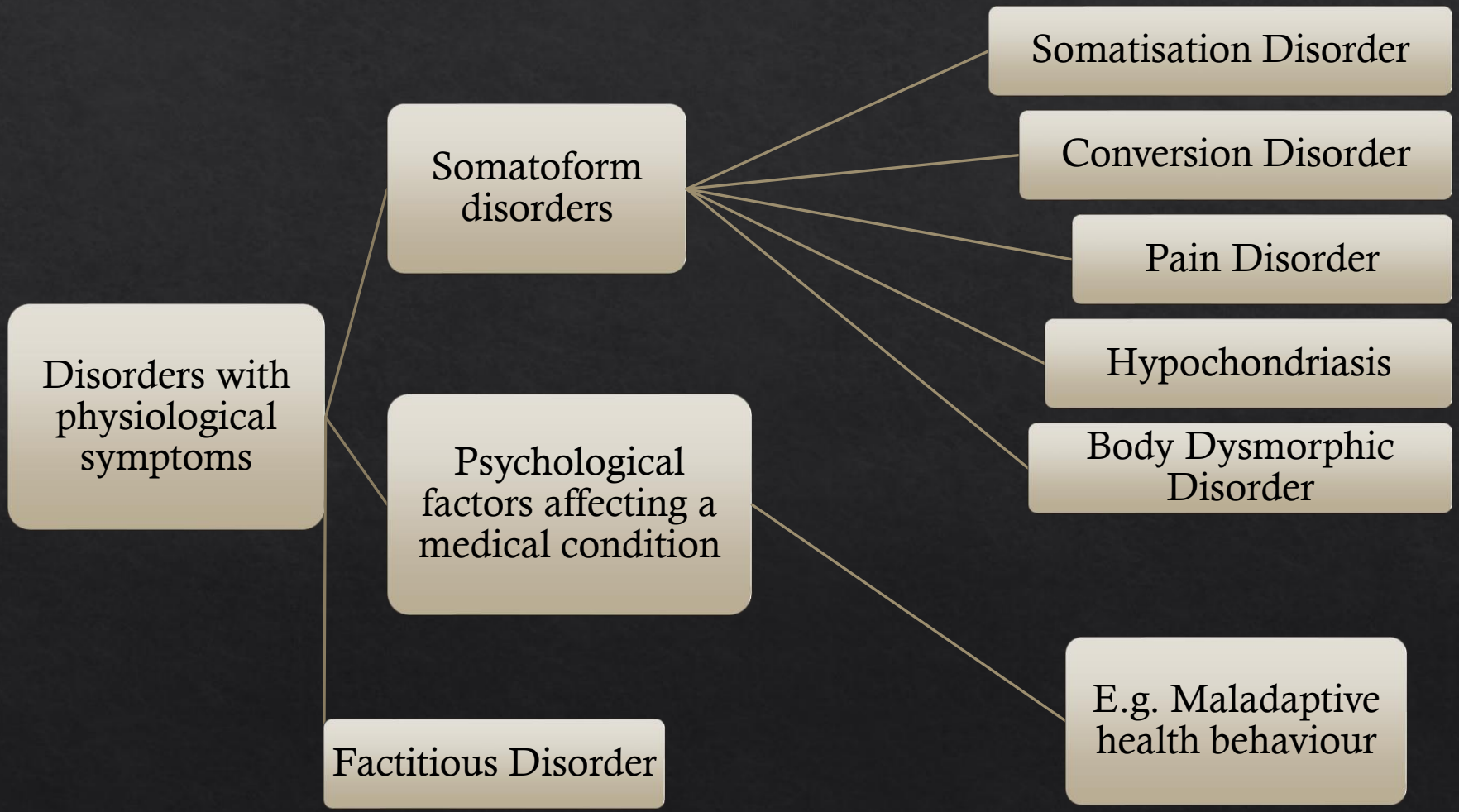
Role of Illness Behaviour

- Children are dependant on adults to respond to (or not) their presentations of illness
- Parents sanction (or don’t) sick role
- Parental beliefs significant

Role of Illness Behaviour

- Important developmental and contextual issue is that children are dependant on adults – therefore their illness behaviour will be dictated somewhat by that of their parents.
- Complain of being ill (children as young as 3 can understand illness behaviour) – parent gives you calpol and sends you to nursery, ignores you, reassures you or rushes you to the dr – this is how we learn what is ok or not and what is attended to or not.
- School refusal can be related to these kind of issues

‘Classification’



Classification- ICD 10

Diagnostic criteria for Somatisation Disorder is not particularly relevant

- (4 pain symptoms, 2 GI symptoms,1 sexual symptom, one pseudoneurological symptom)
- Generally simpler presentation in children.

Poly-symptomatic vs. Mono-symptomatic in both ICD 10 and DSM IV

Mono-symptomatic Pain Disorder: Headache and abdominal pain

Conversion Disorder: Presence of motor or sensory symptoms, such as paralysis, convulsions

Hypochondriasis: Absence of symptoms, fear of illness, negative medical examination

DSM V vs ICD-10:Somatic Symptom Disorders

- **Conversion Disorder**: A somatic symptom disorder involving the actual loss of bodily function such as blindness, paralysis, and numbness due to excessive anxiety (ICD 10 classes as dissociative disorder)

- **Illness anxiety disorder**: A somatic symptom disorder involving persistent and excessive worry about developing a serious illness.

- **Body Dysmorphic Disorder**: An individual is concerned with body image, manifested as excessive concern about and preoccupation with a perceived defect of their physical appearance.

- **Pain Disorder**

DSM V vs ICD-10:Somatic Symptom Disorders

- **Undifferentiated somatic symptom disorder**
  - only one unexplained symptom is required for at least 6 months.
  - previous -somatization disorder and undifferentiated somatoform disorder
  - ICD -10 retains somatization syndrome

- Included among these disorders are false pregnancy, psychogenic urinary retention, and mass psychogenic illness.
- Somatoform disorder Not Otherwise Specified (NOS)

Dissociative Disorders

- Loss of functionality in any modality
- Blindness, deafness, non-epileptic seizures, paralysis, loss of sensation
- Middle childhood onwards
- Can occur as ‘mass hysteria’
- Most recover quickly
- Persistent cases have more risk factors

Chronic Fatigue Syndrome

- Disabling fatigue
- Aches and pains, sleep disturbance, concentration problems
- Definite onset
- Minimum duration 6 months
- Anxiety/depression may be present as well

Factitious Disorders

- Symptoms produced by young person
- Variable severity
- May be unsophisticated communication to resolve a predicament
- Overlap with other somatising disorders
- Can be history of disturbed early relationships and abuse

Epidemiology

- Prevalence rates: 2-10%
  - Average age- 10-12 (¼ under 10yrs)
  - ¼ - previous episodes
  - 7:3 F:M (but 1:1 in <10yrs)
- Annual incidence (Australia)
  - Conversion disorder: 3.5-5 / 100000 population
  - (0.8/100000 in under 10's)

Aetiology

- Consider disorder being reached by different pathways
- No single factor necessary or sufficient to explain disorder
- Combination of vulnerabilities and triggers
- Aetiology can be very different for children presenting with similar symptoms

Aetiology

- Family History Mental Illness
  - 30% – Maternal depression
- Family stressors
  - Caring for parents with illness
- Life Events
  - 62% -1 antecedent life event
  - 34%- 2 or more significant events
- Abuse – sexual/physical/neglect
- Prior contact with medical services

Life Events

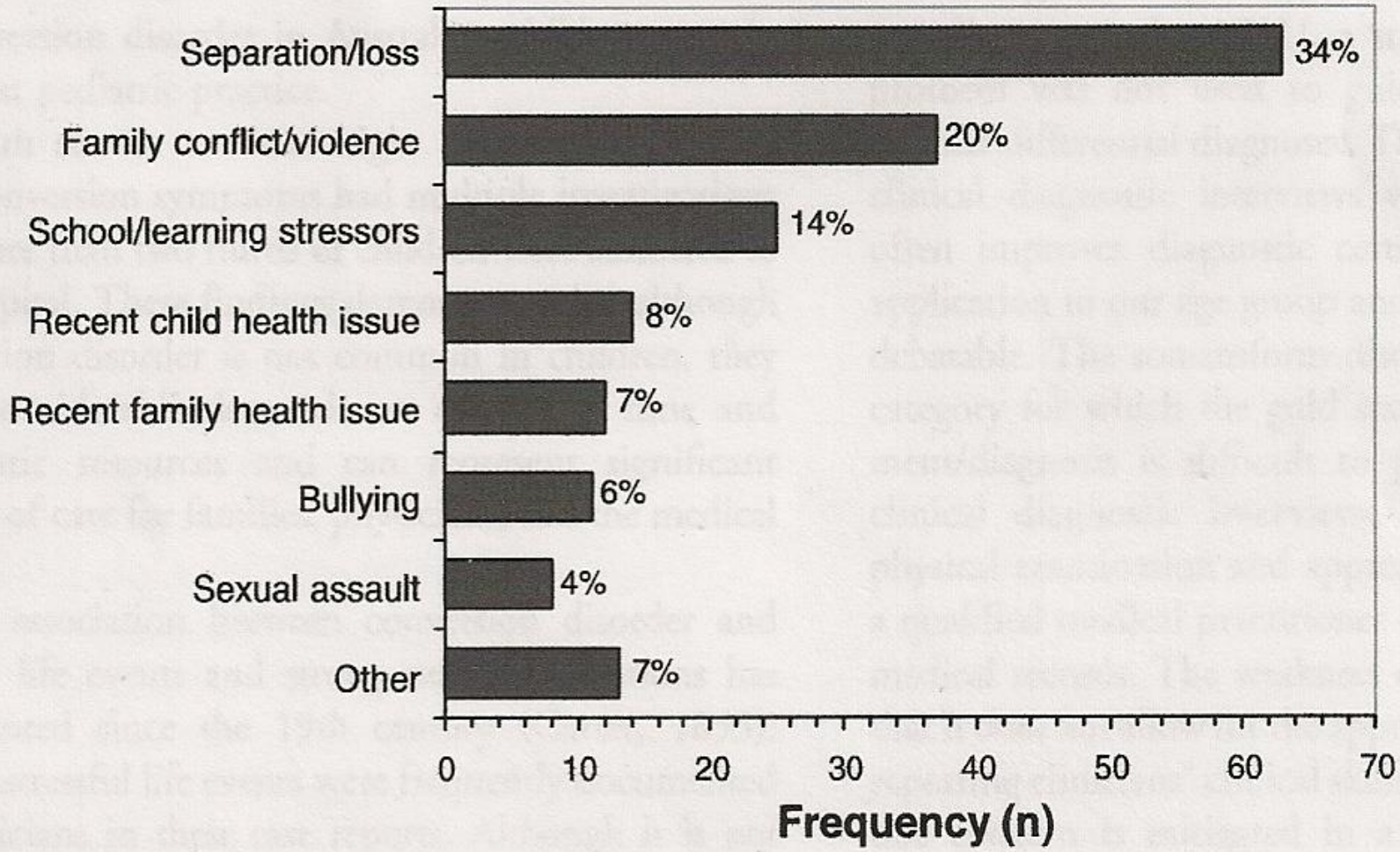


Fig. 4 Antecedent stressors reported by clinicians.

Theoretical Models

- Biological theories
  - Biological Vulnerability Model
    - Genetic /developmental – biological systems vulnerable, to stress/infection
    - Asthma- biological FHx bronchial hyperactivity – stress- asthma
  - General Adaptation Syndrome Theory
    - Built up stress, leads to generalised stress response; autonomic arousal, exhaustion, poor immune function, vulnerability to stress/infection

Theoretical Models

- Intrapsychic theories
  - Psychoanalytic theories
    - Anxiety aroused by unconscious conflict, converted into physical symptoms (anxiety reduction) and solicit kindness
  - Psychosomatic theories
    - Symptoms allow communication of distressing emotion

Theoretical Models

- Interpersonal theories
  - Behavioural theory
    - Symptoms, pain assoc with chronic illness are reinforced by rewards assoc with illness behaviour
  - Cognitive behavioural theory
    - Pain-complex interaction between biology, sensory, cognition, emotion, behavioural and interpersonal dimensions
  - Stress and coping
    - Adjustment to chronic strains entailed by illness depends on balance of risk and resistance factors
      - Risk: severity of illness, handicap, functional independence, psychosocial stressors
      - Resistance: Personal-competence, easy temperament, problem solving ability
      - Socio-ecological: family environment, social support, economic resources
      - Stress processing; cognitive appraisal, coping strategies

Theoretical Models

- Family Systems theory
  - Specific maladaptive family processes determine extent to which child develops somatisation or conversion symptoms or adjustment problems to chronic illness

- Processes are:
  - Enmeshment
  - Disengagement
  - Overly rigid or flexible boundaries
  - Triangulation – engage in conflict about symptom management, to detour marital conflict
  - Marital discord/ negative parental relationship
  - Responsivity to illness -high or low
- Severity depends upon:
  - Childs personal psychophysiological reactivity.
- Symptoms displayed depend upon:
  - Child's physiological vulnerabilities

Clinical Features

- Single symptom
- Multi symptom
  - Central complaint (head,stomach,limb pain)
    - Recurrent Abdominal Pain (RAP):nausea,GI disturbance
    - Headache, chest pain, dizziness
    - Limb pain, abnormal gait, paralysis, anaesthesia
- High rates co morbidity (12-32%)
  - (anxiety/mood disorders)

Features Associated with Non-Organic Abdominal Pain include:

A) Occurrence related to eating meals

- False

B) The pain being severe enough to wake the patient from sleep

- False

C) A peak age of occurrence between 3 and 5 years

- False

D) Triggering by stressful events

- **TRUE**

E) An abnormal EEG in 10% of cases

- False

Clinical Features

- Somatic symptoms due to psychological causes can be very common – without coming to attention of medical staff.

- Abdominal pain reported by 32% Swedish adolescents once a month and headache by 67%
  - (Larson 1991)

- Abdominal pain/headaches most common pre-pubertal
- Neurological symptoms increase with age.

Clinical Features

- RAP – Recurrent Abdominal Pain
  - common – 10% of children. Only 10% have organic cause.
- 20% Non-epileptic seizure
- 15%-respiratory problems
- Pain – 50-60%
- Voluntary motor disturbance (Abnormal gait (70%)/paralysis)
- Symptoms onset to diagnosis (1week-2yrs)

Differential Diagnosis

Rule out diagnosable disease

- History
  - Nature of problem
  - Timing of problem
  - Direct questioning about associated symptoms
  - Exploration for precipitating/maintaining factors

- Physical examination
  - Growth
  - Pubertal status

Investigations

- Undertaken by physician with relevant expertise!
  - So underlying pathology not missed
- Basic reasonable investigations.
- Investigations do not reassure families.

Biopsychosocial Model

	Biological	Psychological	Social
Predisposing Factors			
Precipitating Factors			
Maintaining Factors			
Protective Factors			

Biopsychosocial Model – Predisposing Factors

- Biological
  - Physiological vulnerability
  - Psychophysiological reactivity
  - History of physical illness
- Psychological
  - Suggestibility
  - Perfectionistic
  - High Achievement/Conscientiousness
  - Anxious to please

Biopsychosocial Model – Predisposing Factors

- Psychological (cont.)
  - Low IQ
  - Low self esteem
  - External locus of control
- Social
  - Family culture, sick role/somatic expression of distress
  - Chaotic family
  - Parent history of physical or psychological illness

Biopsychosocial Model – Precipitating Factors

- Acute life stresses
- Personal or family illness or injury
- Peer difficulties
- Academic difficulties

Biopsychosocial Model – Maintaining Factors

- Biological
  - Autonomic hyperarousal
  - Poorly functioning immune system
- Psychological
  - Focused on physical sensations
  - Somatic attribution
  - Sick role behaviour (Child's predicament resolved by symptoms)
  - Non-adherence
  - External health locus of control
  - Cognitive distortion (catastrophizing)
  - Immature defence (Denial)
  - Dysfunctional coping strategies

Biopsychosocial Model – Maintaining Factors

- Social
  - Poor social support/ Social Disadvantage
  - High family stress /Family relationship difficulties
  - Professional behaviour that reinforces anxiety and sick role

- Parental factors
  - Parents have somatic complaints
  - Parents have inaccurate knowledge/ suspicion of medical knowledge
  - Low parental self esteem
  - Low parental self efficacy
  - Depressive attributional style
  - Distortions/denial/dysfunctional coping – Model of sickness and conflict avoidance

Biopsychosocial Model – Protective Factors

- Biological Factors
  - Low psychophysiological reactivity
  - Acute Condition
- Psychological Factors
  - High IQ
  - Easy temperament
  - High self esteem
  - Internal locus of control
  - High self efficacy
  - Optimistic attributional style
  - Mature defence mechanisms
  - Functional coping strategies

Biopsychosocial Model – Protective Factors

- Social
  - Good social support
  - Low family stress
  - High socioeconomic status
- Parental Factors
  - Good parental adjustment
  - Accurate expectations
  - High parental self esteem, efficacy
  - Optimistic attributional style
  - Mature defence mechanisms
  - Functional coping strategies

Biopsychosocial Model – Protective Factors

- Family Factors
  - Secure parent – child attachment
  - Authoritative parenting
  - Clear family communication
  - Flexible family organization
  - High marital satisfaction
  - Accepts problem
  - Committed to resolving problem
  - Accept formulation and treatment plan

Management - Aims

- Engage dialogue
- Reduce doctor visits
- Reduce investigations
- Treat underlying psychological difficulties

Management – who by?

- GPs and Paediatricians – adjustment, dissociative & factitious disorders
- CAMHS – if primary care unsuccessful and/or significant psychiatric symptoms
- Joint management – chronic fatigue, chronic dissociative disorders, somataform disorders
- CAMHS liaison: when overt involvement rejected

Management Principles in Primary Care

- Good history – identify stresses & recent life events
- Clear reassurance re: -ve physical findings
- Examine family beliefs about illness
- Encourage return to normal life style
- Provide model to explain psychosomatic symptoms to family
- LIMIT UNNECESSARY INVESTIGATIONS

Referral to CAMHS

- By definition families search for physical causes so likely to be reluctant to accept mental health input
- Professional needs to be positive and unapologetic – CAMHS can help young person recover
- All believe the young person is not ‘putting it on’

Management

- Psychiatric and medical team need to work closely and give the patient and family a consistent message.
- When all investigations are completed the family should be told this.
- The condition should be properly explained and reassurance given.
- Other interventions to address maintaining/precipitating factors should be used.
- Re assessment, if no improvement despite above.

Management

May include one or more of:

- Thorough child and family assessment
  - Paediatrician, GP, physiotherapist, nurse, psychologist, psychiatrist
- Careful contracting for treatment
- Family based approach
- Psychoeducation
- Monitoring of symptoms
- Relaxation skills training
- Coaching parents in contingency management
- Relapse management training
- Family membership of support group

Liaison Role of CAMHS

- Advice and support to other professionals
- Help prevent unnecessary investigations and treatment
- Prevent avoidable impairment

Management Principles in CAMHS

- Engagement crucial
- ‘Not knowing’ stance
- Careful narrative of family experience of this and other illnesses, beliefs, attitude to referral
- Assessment of young person’s mental and physical state and current functioning
- Explanation of psychosomatic symptoms

Management

Regular Appointments

Split consultation time equally between symptoms, general health,other issues

Cognitive Work

Anxiety Management

Symptom Checklists

Key Points

- Joint working essential
- Not helpful to directly challenge family beliefs
- ‘Not knowing’ stance helpful
- Expect slow progress
- May need intensive rehabilitation away from home

Prognosis

- Brief episodes don't show continuity to adulthood
- Excess or chronic physical symptoms in childhood associated with psychiatric disorder in adulthood
- Also with excess unexplained hospital admissions

- Majority of situations – recovery.
- However, some indication RAP sufferers are more likely to go on into chronic course into adulthood

Further reading

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