

MEDICINE 438's REVIEW OF

CLINICAL PSYCHIATRY



Psychosomatic Medicine

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Objectives

- ◀ Understand relevant concepts related to psychosomatic medicine which resides at interface of physical and mental illnesses.
- ◀ Appreciate that accurate diagnosis and treatment of depression in medically ill patients, improves quality of life, enhances engagement in treatment, decreases symptom quantity and severity, and decreases cost utilization, morbidity and mortality.
- ◀ Acquire preliminary skills to evaluate and intervene adequately to manage somatic symptoms and related disorders.



EDITING FILE

Introduction

Psychosomatic Medicine

- Psychosomatic medicine or **consultation-liaison psychiatry** is the subspecialty of psychiatry whose practitioners have particular expertise in the diagnosis and treatment of psychiatric disorders and difficulties in complex medically ill patients (Gitlin et al. 2004).
- Psychosomatic medicine resides at the interface of physical and mental illness (**archaic distinction, all illnesses are physical**)
- The clinical practice of psychosomatic medicine is sometimes called consultation-liaison psychiatry (CLP).
- Since 2001, Psychosomatic medicine has become a subspecialty recognized by the American Board of Medical Specialties.
- Medical factors/illnesses may affect individual vulnerability, course, & outcome of ANY psychiatric disorder.
- Psychosocial factors/illnesses may affect individual vulnerability, course, & outcome of ANY type of disease.
- Psychological factors may operate to facilitate, sustain, or modify the course of medical disease, even though their relative weight may vary:
 - From illness to illness.
 - From one individual to another.
 - Between 2 different episodes of the same illness in the same individual.
- **Psychosomatic medicine cares about disorders that are related to both psychiatry and medicine, this related could either be bi-directional, or one way.**
 - **Bi-directional: Diabetes Mellitus and Depression.**
 - **Psychology > Medicine: Nutritional deficiencies in patients with Anorexia Nervosa.**
 - **Medicine > Psychology: Hypothyroidism leading to depression.**

Illness Vs Disease

Illness	Disease
<ul style="list-style-type: none"> • The response of the individual and his/her family to symptoms. • Subjective (Psychosocial, cultural, religious factors). 	<ul style="list-style-type: none"> • Defined by physicians and associated with pathophysiological processes and documented lesions. • Objective.

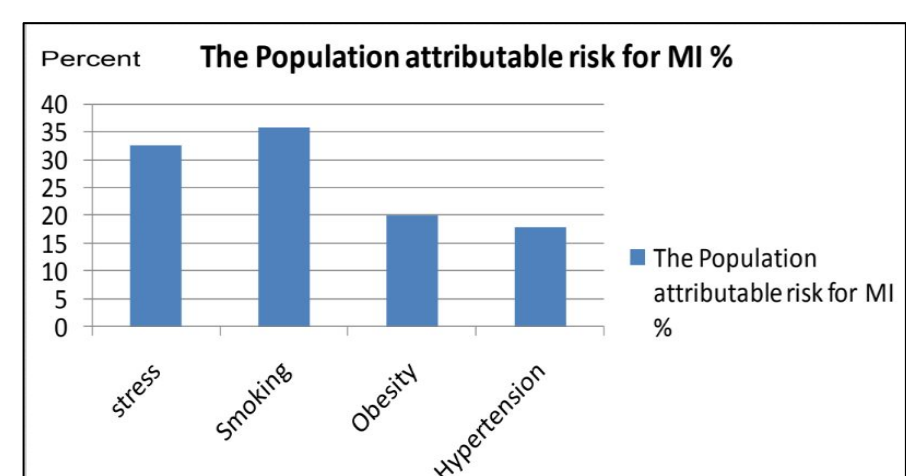
Illness Behavior

- The manner in which individuals monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the health care system; **depends on** variety of factors:
 - Achievement of objectives.
 - Abnormal illness behavior:
 - Inappropriate or maladaptive mode of perceiving, evaluating or acting in relation to one's own health status.

Illness Affirming ←————→ Illness Denying

Case control study of: n > 29000 in 52 countries.

- Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study. *Yusef S et al. Lancet 2004*



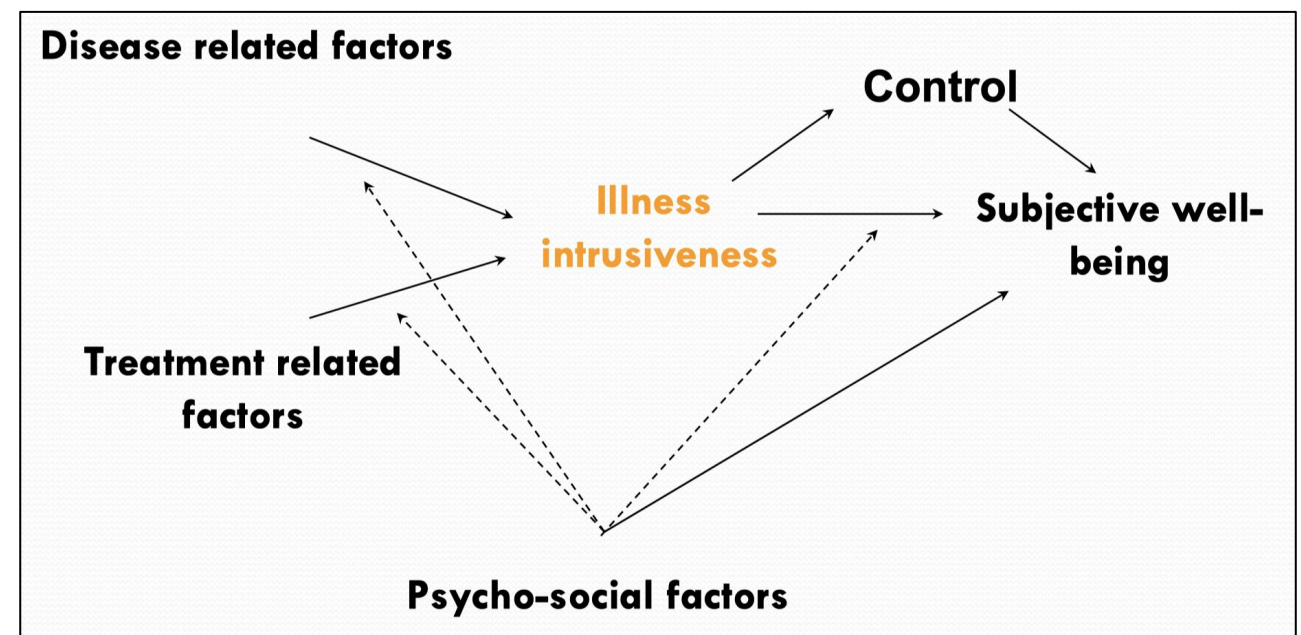
◀ Quality of life and illness Intrusiveness

- The concept of illness intrusiveness is introduced to represent the illness-induced disruptions to lifestyle, activities, and interests that can compromise psychosocial well-being and contribute to emotional distress in chronic disease.

It explains the suffocating feeling that the patient may develop.

People will start associating the patient's identity with that disease.

A good example of this concept are patients with HIV, the disease will affect the patient's life more than just medically, the social stigma around the patient will affect them psychologically, therefore metaphorically suffocating the patient.



◀ Example of Psychosocial Factors Affecting a Medical Disease (CHD)

- According to The Interheart study, the population attributable risk factor for MI of Hypertension was 17.9%, while the psychosocial risk factors, were responsible about **>30%**.

◀ Advantages of Psychosomatic Medicine (CLP) Service

1. Relieve symptoms of distress & improve the quality of life of some patient with serious diseases.
2. May improve the course and prognosis of several major medical illnesses.
3. Cost-effective:
 - a. Reduce the length of hospital stay.
 - b. Reduce the number of unnecessary investigations (performed for physical symptoms that may actually reflect underlying psychological distress).

◀ Approach to Referral to Psychosomatic Medicine

- How to do it (effective psych. Consultation).
 - Review patient charts, asking nurses and physician.
 - Obtain good psychiatric history (paying attention to psychological & social factors).
 - MSE & MMSE if cognitive problem is suspected and possibly neuropsychological assessment.
 - Making logical differential diagnosis among medical, neurological and psychiatric diseases (use multi-axial Dx).
 - Investigate based on that.
 - Make treatment plan.
 - Follow up plan (as inpatient & outpatient).
 - Collaborate with both the patient and the referring team.

Primary vs Secondary Psychiatric Disorders

Primary	Secondary
<ul style="list-style-type: none"> ● Etiology is: Multi-factorial. <ul style="list-style-type: none"> ○ e.g. schizophrenia Major depressive disorder. ● In medicine: like Essential hypertension. ● Clues suggestive of being primary: <ul style="list-style-type: none"> ○ Normal consciousness & vital signs. ○ Presence of: <ul style="list-style-type: none"> ■ Auditory hallucinations, soft neurological signs, Young age onset. 	<ul style="list-style-type: none"> ● Etiology: one diagnosable systemic medical disease, CNS disease or substance. <ul style="list-style-type: none"> ○ e.g. Depression due to SLE Psychosis due to amphetamine. ● In medicine: like secondary HTN due to renal artery stenosis. ● Clues suggestive of being secondary: <ul style="list-style-type: none"> ○ Disturbance of consciousness or vital signs. ○ Presence of: <ul style="list-style-type: none"> ■ non-auditory hallucinations e.g. visual, hard neurological signs, physical illness, old age onset.

Medical Illnesses that Can Induce Secondary Psychiatric Disorders

Three main types of medical illnesses leading to secondary psychiatric disorders are:

- 1- Flare ups of systemic medical illness.
- 2- CNS pathologies.
- 3- Substance use, either illicit or therapeutic substances.

Endocrine	Metabolic	Infectious	Autoimmune	CNS
Thyroid disorder	Hepatic disorder	> Neurocystercosis	> Systemic Lupus	Seizure DO
> Hypo-	> Wilson's	> Tuberculosis (TB)	Erythematous	> TLE
> Hyper-	> Encephalopathy	> PANDAS	> Multiple Sclerosis	> Frontal LE
Adrenal disorder	> Porphyrin	> Neuroborriosis	> Pernicious	> Paraneoplastic
> Hypo-	Vitamin def	> Neurosyphilis	Anemia (B12 def)	Syndrome
> Hyper	> B-1	> Herpes	> Addison's	Dementia
> Pheochromocytoma	> B-12	> HIV	Disease	> NPH
Parathyroid DO	Electrolyte	Sepsis	(hypoadrenalism)	> Delirium
> Hypo-	imbalances	Malaria	> Grave's Disease	Subdural hematoma
> Hyper	Hypoxia	Legionnaire disease	(hyperthyroidism)	Tumor
Pancreatic DO	Lead toxicity	Typhoid	> Fibromyalgia	Meningitis
> Hyperglycemia		Diphtheria	> PANDAS	Encephalitis
> Hypoglycemia		Rheumatic fever		> Multiple Sclerosis
> Pancreatic tumor		Pneumonia		NMS
		UTI		

Prescription drugs	
	■ Chemotherapeutic Rx's
	■ Immunosuppressants (e.g., cyclosporin [Gengraf, Neoral, Sandimmune])
	■ Antiviral Rx's (e.g., interferons)
	■ Antiparkinsonian Rx's
	■ Cardiovascular Rx's
	■ Thyroid Rx's
	■ Anticholinergic Rx's
	■ Corticosteroids
	■ Psychostimulants
	■ Sympathomimetics
	■ Sedative & CNS-depressants (e.g., barbiturates, benzodiazepines)
	■ Opioids

Investigations to Suggest Secondary Psychiatric Disorders

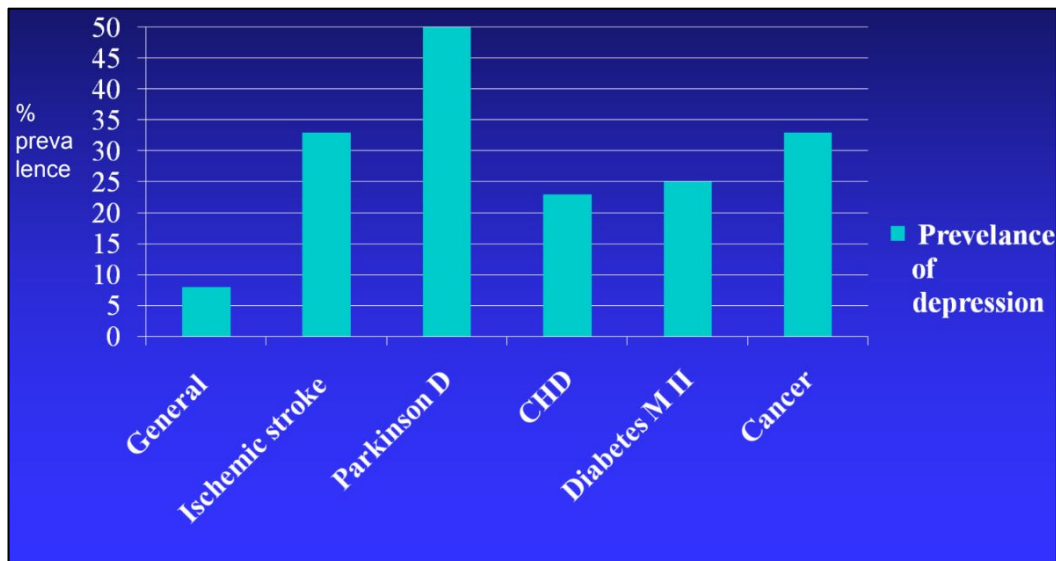
<ul style="list-style-type: none"> • Hormonal levels • CBC • Chemistry panel • Thyroid Function Test • Screening test for syphilis (VDRL or RPR) • HIV serology for high risk patients • B12 and folate • Urinalysis (with protein and glucose levels) 	<ul style="list-style-type: none"> • Toxicology screening • Urine for uroporphyrins and porphobilinogen • Serum ceruloplasmin • Chest X-ray • ECG • EEG • CT/MRI
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◀ Clues Suggestive of Psychiatric Disorder 2ndary to Another Medical Condition (previously called "Organic" Mental Disorders)

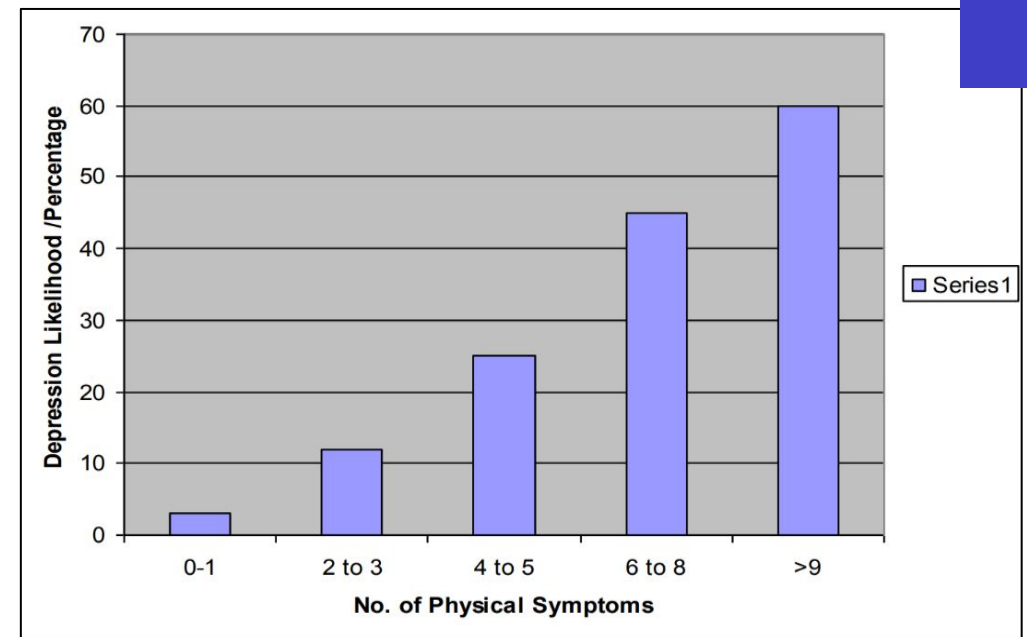
- **History:**
 - Psychological symptoms occurring.
 - New onset psychiatric symptoms presenting after age 40.
 - During the course of a major medical illness which had impaired some organ function (e.g., neurological, endocrine, renal, hepatic, cardiac, pulmonary). While taking medications/illicit substance, he had psychoactive effects.
- **Family history of:**
 - -ve for primary psychiatric illness.
 - +ve for medical disease that may present with psychiatric symptoms (e.g. Degenerative or Inheritable neurological disorders (e.g., Alzheimer's disease, Huntington's disease).
 - Inheritable metabolic disorders (e.g., DM, Pernicious Anemia, Porphyrria).
- **Clinical Exam:**
 - Abnormal vital signs.
 - Evidence of organ dysfunction, focal neurological deficits.
 - Eye exam:
 - Pupillary changes—asymmetries.
 - Nystagmus (often a sign of drug intoxication).
 - Presence of altered states of mind, LOC, mental status changes, cognitive impairment; episodic, recurrent, cyclic course.
 - Presence of visual, tactile or olfactory hallucinations.
 - Signs of:
 - Cortical dysfunction (e.g., dysphagia, apraxia, agnosia).
 - Diffuse subcortical dysfunction (e.g., slowed speech/mentation/movement, ataxia, incoordination, tremor, chorea, asterixis, dysarthria).

◀ Global Burden of Disease Attributable to Mental and Substance Use Disorders: Findings from the Global Burden of Disease Study 2010

- As part of the GBD 2010, epidemiological data was collected for 20 mental and substance abuse disorders in 187 countries.
- In 2010, mental and substance use disorders accounted for 183.9 million DALYs or 7.4% of all DALYs worldwide.
- Mental and substance abuse disorders were the leading cause of non-fatal illness worldwide in 2010 (22.8%).
- The burden of mental and substance use disorders increased by 37.6% between 1990 and 2010.
- Depressive disorders were responsible for 40% of the burden of illness due to mental and substance abuse disorders.

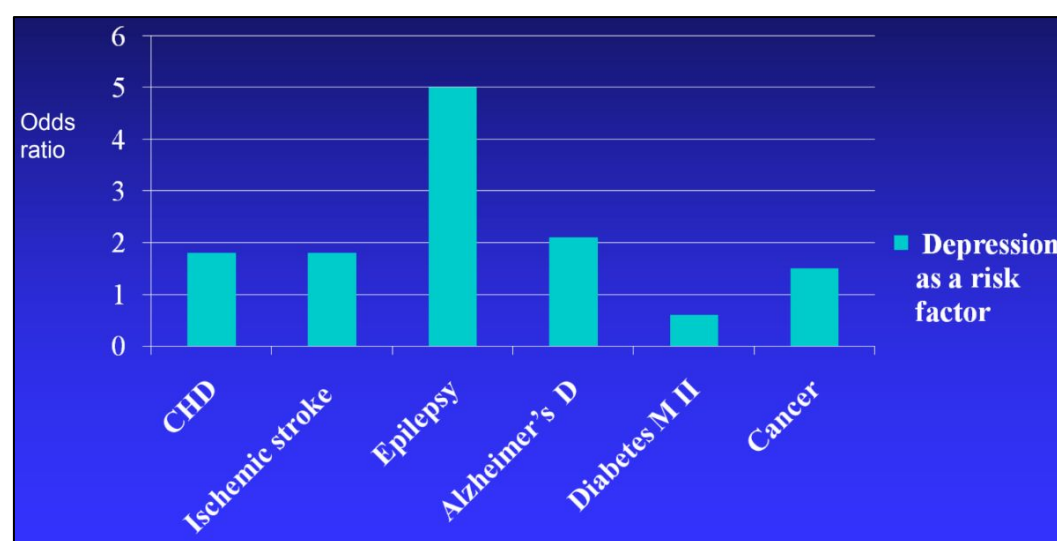


Epidemiology of depression in some medical illnesses



Likelihood of depression increases with the number of physical symptoms at presentation

Depression as a risk factor for the development of medical illness



Depression Plus Medically Illness

1. Poor outcomes of the medical illness Increased mortality in cardiovascular disease, stroke, diabetes, and cancer. (Cancer is controversial, there's a lot of debate about it)
2. Chronic medical conditions and depression are interrelated and that treatment of one condition can affect the outcomes for the other.
3. Worse adherence to medical regimens, tobacco smoking, sedentary lifestyle, and overeating.
4. Increased functional disability, decreased self-care.
5. Four to five times greater levels of morbidity, premature mortality, health services use and health care expenditures compared to non- depressed patients with no GMC.

Pathophysiology: Mediating Factors Between Depression, Stress and Medical Illnesses

- We need a way to figure out if the medical issues are caused by psychological issues or if it's the other way around.
- One way of doing so is by asking the patient which symptoms came first.

● Physiological

- hyperactivity of the hypothalamic- pituitary- adrenal (HPA) axis.
- Immune activation with release of proinflammatory cytokines.
- Activation of the sympathetic nervous system.
- Stress → activation of sympathetic nervous system (CRH can directly bind to brainstem autonomic centers [e.g., locus coeruleus]) → immune system activation (IL-1, IL-6 and TNF-alpha) → these inflammatory cytokines cause further release of CRH → stress response all over again

● Behavioural

- Physical inactivity.
- Smoking.
- High carbohydrate & high fat diet.
- Poor adherence to medications.
- Social isolation.

◀ DSM-5 Criteria for Major Depression (Physical & Psychological Symptoms)

<p>A. Five (or more) of the following symptoms during the same two week period and represent a change from previous functioning, at least one of the symptoms is: (1) depressed mood. or (2) loss of interest or pleasure.</p>	<p>A. Must have at least five of the following symptoms for at least two weeks (must include either number 1 or 2)</p> <ol style="list-style-type: none"> 1. Depressed mood most of the time. 2. Interest: Loss of interest (anhedonia). 3. Weight: Change in appetite or weight (↑ or ↓). 4. Sleep: Insomnia or hypersomnia 5. Motor: Psychomotor agitation or retardation 6. Energy: Fatigue or loss of energy 7. Guilt: excessive feeling of guilt or worthlessness 8. Concentration: Diminished concentration 9. Suicide: Recurrent thoughts of suicide and death <p>Depression Is Worth Solidly Memorizing An Extremely Grueling Criteria. Sorry</p>
<p>B. The symptoms cause significant distress or impairment in functioning.</p>	
<p>C. The episode is not attributable to the physiological effects of a substance or another medical condition.</p>	
<p>D. The occurrence is not better explained by another mental disorder.</p>	
<p>E. There has never been a manic episode or a hypomanic episode.</p>	

Physical	Psychological
1. Sleep disorder	1. Low self-esteem/guilt
2. Appetite or weight change	2. Poor concentration/indecisiveness
3. Fatigue	3. Thoughts of death/suicidal ideation
4. Psychomotor retardation or agitation	4. Depressed mood
	5. Loss of interest/pleasure

◀ Diagnostic Approach in the Medically Ill

- **Inclusion approach: count all physical symptoms as part of depression even if possibly explained by the medical illness (to give patients, the benefit of doubt, by treating disabling illness like depression)** (it's difficult to diagnose a patient with a major depressive disorder when they have a medical illness like cancer, because both of them have fatigue and loss of appetite. We use inclusion criteria in this case to diagnose, however research relies on exclusive approach)

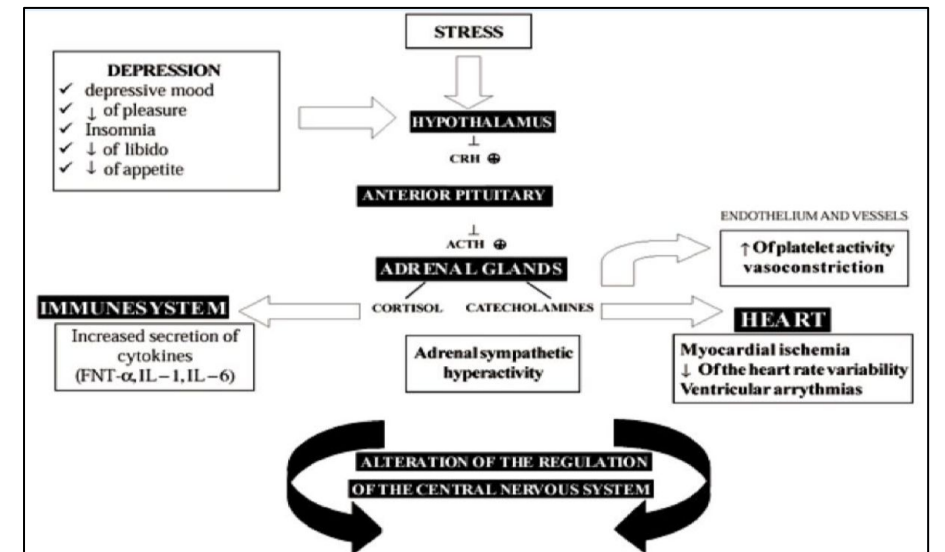
◀ Differential diagnosis:

- Depressive disorder due to another medical condition
- Substance-induced depressive disorder, iatrogenic versus other illicit substances
- Bipolar I/II disorder, most recent episode depressed
- Major depressive disorder (unipolar)
- Persistent depressive disorder (dysthymia)
- Adjustment disorder with depressed mood (common in medical setting)

Examples of depression in medically ill patients

◀ Depression & coronary heart disease

- Depression has repeatedly been found to predict:
 - Early onset CHD
 - post-MI mortality (1.5-5.07 times risk), especially severe and chronic types (e.g. **HAM-depression**) scale score in the first 2 weeks post CHD event predict 7 years mortality risk
 - Increased CHD symptoms (chest pain, fatigue)
 - Noncompliance on exercise/medication/smoking



◀ Post-Stroke Depression

- After stroke, 25-40% of patients meet criteria for depression
- Studies in the 80's and 90's demonstrated that post-stroke depression (PSD) was associated with left frontal brain lesions, worse physical and cognitive recovery, and increased mortality.
- These depressions were shown to be treatable with antidepressants and successful treatment led to both improved recovery and survival
- There have now been RCTs showing PSD may be treated and prevented effectively with **citalopram**, **nortriptyline**, or **reboxetine** (norepinephrine reuptake inhibitor)
- Later, antidepressants shown to improve physical and cognitive recovery over 1 year independent of depression
 - Being non-active after a stroke leaves ischemic lesion in a pond of inflammation
 - The primary stimulus for brain healing is mental exertion (use it or lose it principle, a neuroplastic principle)
 - Antidepressants promote angiogenesis, synaptogenesis and neurogenesis (discussed in depression lecture)
 - It has been reported that mice treated with imipramine following stroke had 70% more brain cells in comparison to controls, this effect was especially prominent in the hippocampus, contributing to enhanced memory and cognitive functions following strokes (Huang et al., 2011). [Click here](#) for full paper.
- Over 7 years, antidepressants shown to decrease mortality by 50% even among non-depressed patients, how? (inflammatory proteins are released both by stroke and depression and can have long lasting negative effects on brain function)
- Antidepressants have been shown to decrease these inflammatory proteins → neurogenesis and synaptogenesis → improved recovery and decreased mortality following stroke
 - Anti-TNF agents have been shown to improve and induce remission of depression in patients with connective tissue diseases (e.g., psoriasis)
- However patients who take both NSAIDs and antidepressants should be monitored for intracranial hemorrhage (e.g., Antiplatelet function of SSRIs)
- Prevention of depression by antidepressants in stroke patients (prophylaxis):
 - Family history of depression
 - Ischemic stroke
 - Personal hx of stroke
 - Left frontal lobe stroke

◀ Illness Behavior

Illness Affirming



Illness Denying

Summary of Depression in the Medically Ill

Historically, depression in the medically ill was often considered a natural and expected response to medical illness

- Treatment of depression was often considered secondary to treatment of the medical illness, if the depression was even treated at all
- Today, this perspective can no longer be accepted
- **Depression is a systemic disease**
- The effect of depression on the course of medical illness is multifaceted because there are systemic pathophysiologic implications, as well as psychological and behavioral ramifications
- The accurate diagnosis and appropriate treatment of depression in the medically ill improves quality of life, enhances the patient's ability to be actively engaged in his or her treatment, decreases symptom quantity and severity, and decreases cost utilization
- Most important, it decreases morbidity and mortality

Four Important Messages About Meds in ESRD

- Most **psychotropic** medications are **fat soluble**, easily pass the blood-brain barrier, are not dialyzable, are **metabolized** primarily by the **liver**, and are excreted mainly in bile (**lithium is a notable exception**).
- The majority of these drugs can be **safely used** with the ESRD populations.
- Dosing often involves trial and error. The majority of patients with ESRD both tolerate and require **ordinary doses** of most psychotropic medications.
- Toxicity is usually obvious, and we would **caution** more **against undermedicating** patients than against overmedication.

Summary of psychopharmacology for patients with liver disease:

- To guide pharmacotherapy in liver disease, use Child-pugh scores with closer monitoring to help increase the safety and tolerability
- When choosing psychotropic agents for patients with liver disease, consider the following:
 - **Drug interactions :**
 - e.g. NSAIDs + SSRI → GI bleed
 - **Medical diseases:**
 - E.g. severity of liver disease, protein binding
 - **Age:**
 - E.g. decreased risk hepatotoxicity in adults
 - **Drug profile:**
 - E.g. hepatotoxicity, hyperammonemia
 - **Hepatic modifications:**
 - E.g. bupropion vs citalopram (increased risk of seizures upon combination)

Perinatal Psychiatry

◀ Consequences of Depression in Pregnancy

It's crucial to treat depression in pregnant ladies, we should not wait until the baby is born.

Mother	Baby
<ul style="list-style-type: none"> ● Suicide ● unhealthy practices e.g. smoking ● Poor nutrition ● Less compliant with prenatal care ● Increased pain ,nausea, stomach pain, SOB, GI symptoms..etc 	<ul style="list-style-type: none"> ● low birth weight, smaller head circumferences, premature delivery, etc ● poor mother-infant attachment, delayed cognitive and linguistic skills, impaired emotional development, and behavioral issues ● emotional instability and conduct disorders, attempt suicide, and require mental health services

◀ Depression in Pregnant Women

- 10% to 16% of pregnant women fulfill the diagnostic criteria for MDD, and even more women experience subsyndromal depressive symptoms
- Many of depressive symptoms overlap with the physical and mental changes experienced during pregnancy
 - **The organicity of depression is no longer debatable**

◀ Treatment of Depression in Pregnant Women

- Antidepressants reduce risk for preterm birth and cesarean delivery compared with Depressed women untreated BUT has more neonatal complications, including low Apgar score (?Withdrawal syndrome) (Heli Malm, AJP, 2015).
- Sertraline, Escitalopram and Citalopram are the Safest SSRIs in Pregnancy (Reefhuis J et al, BMJ 2015)
- All SSRIs are category C except for paroxetine (D)
- **SSRIs** : exposure show NO consistent information to support specific morphological teratogenic risks.
- NO association between TCA use in pregnancy and structural malformations.
- Presumed associations between antidepressants and malformations may be complicated by polydrug interactions
- Bupropion, venlafaxine, duloxetine, nefazodone, and mirtazepine (all discussed in depression lecture): NO statistically significant difference or higher than expected rate of congenital anomalies
- **ECT** has long been regarded as a safe and effective treatment for severe depression, life threatening depression, or failure to response to antidepressant drugs.
- Psychotherapy: is considered to be an evidence-based treatment of mood disorders.
- Mild depression: interpersonal psychotherapy (IPT) or cognitive behavioral therapy (CBT), both having solid evidence-based outcomes data for the treatment of depression.
- Couples counseling

◀ Treatment of Mania & Psychosis during Pregnancy

- Typical antipsychotics especially high potent (e.g., haloperidol) considered as relatively safe compared to other medications.
- Atypical antipsychotics (e.g., clozapine): no major malformations were found. However, limited data so far, Metabolic syndrome is more with olanzapine and clozapine.
- Lithium is considered first line mood stabilizer during pregnancy despite rare cardiac anomaly (Ebstein anomaly) .
- If the lady was already on Lithium, do not stop it when she gets pregnant.
- However, if she was pregnant you should NOT initiate therapy with Lithium, instead use an alternative until she gives birth.
- Lamotrigine is the safest anticonvulsant among mood stabilizers.
- Avoid valproate & carbamazepine in child bearing women and pregnancy,

◀ Why Avoid Valproate in Childbearing Women and Pregnancy?

- Neural tube defects secondary to interference with folate metabolism with first trimester exposure
 - Risk = 7-16%
- Craniofacial defects: mid-face hypoplasia, short nose with anteverted nostrils, and long upper lip
- Hypoglycemia, hepatic dysfunction, fingernail, hypoplasia, cardiac defects, cleft palate, hypospadias, polydactyly
- Neonatal toxicity possible
- Significantly lower mean IQ and verbal IQ

◀ Postpartum Depression

- 10% to 20% of women who give birth
- Undetected and commonly underdiagnosed
- Continuum of Affective Symptoms
- Baby blues (does not meet criteria for MDD) → Peripartum depression (MDD during pregnancy or four weeks after delivery) → postpartum psychosis (2 weeks postpartum)

Table 2. Distinguishing Between "Baby Blues" and Postpartum Major Depression

Characteristic	Baby blues	Postpartum major depression
Duration	Less than 10 days	More than two weeks
Onset	Within two to three days postpartum	Often within first month; may be up to one year
Prevalence	80 percent	5 to 7 percent
Severity	Mild dysfunction	Moderate to severe dysfunction
Suicidal ideation	Not present	May be present

- SSRIs are medications prescribed most commonly but other agents should be considered
- Do not advise the mother to stop breastfeeding, unless absolutely necessary.
- More positive response to SSRIs and Venlafaxine, than to TCAs
- Pharmacotherapy should continue for at least 6 months to prevent a relapse of symptoms
- Breastfeeding: All antidepressants are secreted to some degree into the breast milk!
- **Recommend sertraline or Paroxetine**: Infant serum levels are low to undetectable.
- **Fluoxetine**: higher rate of secretion into breast milk, long half-lives of metabolites, they can accumulate in an infant's blood, reaching detectable levels
 - NOT considered the first-line SSRI for breastfeeding women
- **Mirtazapine**: no negative effects on infants with maternal use
- Research on long-term effects of SSRI and TCA exposure through breast milk on children shows NO alteration in IQ, language development, or behavior
- IPT and CBT are effective.

◀ Postpartum Psychosis

- Rare: 1 in 500-1000 deliveries.
- Typically presents within 2 weeks of delivery.
- Often is a manifestation of bipolar disorder.
- Signs/symptoms: Severe insomnia, Rapid mood swings, Anxiety, Psychomotor restlessness, Delusions (childbirth themes), hallucinations, cognitive disturbance, neglecting the infant.
- Assess for suicidal, homicidal/ infanticidal ideations.
- Treatment: mostly similar to treatment of bipolar disorder, consider ECT.

Somatic Symptoms and Related Disorders

◀ Medically Unexplained Symptoms

Factitious vs Malingering:

A patient with factitious disorder (AKA Munchausen disorder) enjoys the attention of being medically investigated.

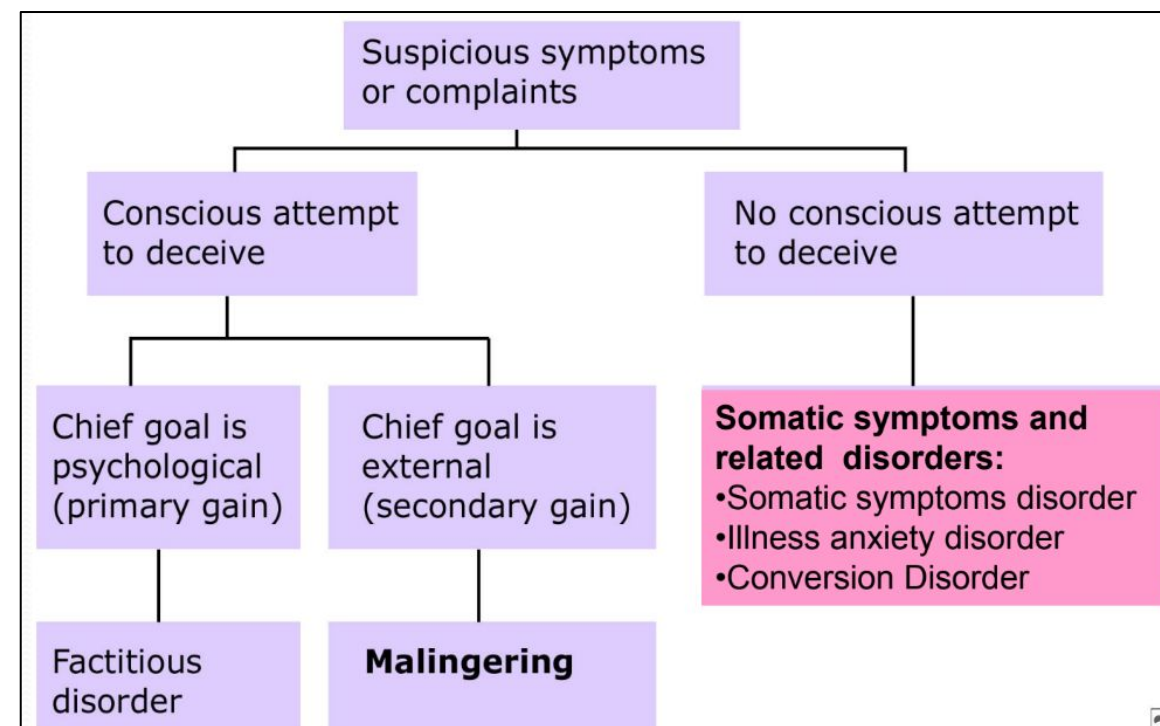
If you told them that you needed to do a surgery to figure out what's wrong with them, they'd be down to do it.

Malingering patients come to the hospital with another goal in mind (sick leaves, medication prescription etc).

If you suggest doing a procedure like a surgery on a malingering patient they'd refuse immediately.

You should also read about factitious disorder by proxy, it's very interesting.

[Or don't, I'm not your mother]



◀ DSM-5 Criteria of Somatic Symptom Disorder

- 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 as **manifested by at least one of the following:**
 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
 2. Persistently high level of anxiety about health or symptoms.
 3. Excessive time and energy devoted to these symptoms or health concerns.
- D. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (**typically more than 6 months**).

Specify if: With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if: Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

- **Mild:** Only one of the symptoms specified in Criterion B is fulfilled.
- **Moderate:** Two or more of the symptoms specified in Criterion B are fulfilled.
- **Severe:** Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom)

Carol, a 26-year-old homemaker, presented for evaluation of weakness and malaise of 1 year's duration. She also reported a burning pain in her eyes, muscular aches and pains in her lower back, headaches, a stiff neck, abdominal pain "on both sides and below the navel," and vomiting "glassy white stuff—as if I were poisoned."

Six months earlier, Carol had developed blurry vision, complained of a sharp shooting pain in her rectum with walking, and reported passing blood and mucus in her stools. A sigmoidoscopic examination was unremarkable, but she was nevertheless given a diagnosis of mild ulcerative colitis and started on sulfasalazine therapy. Another barium enema examination produced negative results. Five months before her clinic visit, she noted "wasting" of her hands and reported needing a larger glove size for the right hand. She also was concerned with a pulsating vessel and whitish nodules on her hand.

Carol identified additional symptoms during her clinic visit: a burning pain in her pelvis, hands, and feet; heavy vaginal bleeding, passing "clots as large as a fist"; abdominal bloating; malodorous stools with "bits of sudsy mucus"; urinary urgency; cough incontinence; tingling in hands and feet; and a belief that her bowel movements "just don't look right."

Carol was next seen at the same clinic 21 years later, at age 47, for evaluation of multiple somatic complaints. Her symptoms were remarkably similar to those reported earlier, and it was clear that she had never been free of them. Her complaints included a right-sided tremor that caused her to spill food, migratory aches and pains, a feeling of coldness in her extremities, and a heavy menstrual flow ("I used 48 sanitary pads in a single day"). In addition, she reported feeling sick; having abdominal bloating, flatulence, and frequent nausea and vomiting; and being constipated. She was concerned that her skin was becoming darker and that her scalp hair was falling out. An extended medical workup was negative.

Six years later, she was admitted to the psychiatric service. During the intervening years, she had received a total hysterectomy and oophorectomy, but apart from menstruation-related symptoms, she continued to have the same unrelenting physical complaints. Again, a protracted medical workup was negative.

A case presentation of somatic symptom disorder, purely for clarity

TABLE 10-2. Medical symptoms reported by a patient with a somatic symptom disorder

Organ system	Complaint
Neuropsychiatric	"The two hemispheres of my brain aren't working properly." "I couldn't name familiar objects around the house when asked." "I was hospitalized with tingling and numbness all over, and the doctors didn't know why."
Cardiopulmonary	"I had extreme dizziness after climbing stairs." "It hurts to breathe." "My heart was racing and pounding and thumping. ...I thought I was going to die."
Gastrointestinal	"For 10 years I was treated for nervous stomach, spastic colon, and gallbladder, and nothing the doctor did seemed to help." "I got a violent cramp after eating an apple and felt terrible the next day." "The gas was awful—I thought I was going to explode."
Genitourinary	"I'm not interested in sex, but I pretend to be to satisfy my husband's needs." "I've had red patches on my labia, and I was told to use boric acid." "I had difficulty with bladder control and was examined for a tipped bladder, but nothing was found." "I had nerves cut going into my uterus because of severe cramps."
Musculoskeletal	"I have learned to live with weakness and tiredness all the time." "I thought I pulled a back muscle, but my chiropractor says it's a disc problem."
Sensory	"My vision is blurry. It's like seeing through a fog, but the doctor said that glasses wouldn't help." "I suddenly lost my hearing. It came back, but now I have whistling noises, like an echo."
Metabolic/endocrine	"I began teaching half days because I couldn't tolerate the cold." "I was losing hair faster than my husband."

◀ DSM-5 criteria of Illness Anxiety Disorder

Patient is preoccupied with having or acquiring a specific serious disease, the concern is directed towards the meaning of symptoms or what they represent rather than a direct discomfort from a somatic complaint as in somatic symptom disorder. **It is important to make the distinction!**

- A. **Preoccupation with having or acquiring a serious illness.**
- B. **Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.**
- C. There is a **high level of anxiety about health**, and the individual is easily alarmed about personal health status.
- D. The **individual performs excessive health-related behaviors** (e.g., repeatedly checks his or her body for signs of illness) or **exhibits maladaptive avoidance** (e.g., avoids doctor appointments and hospitals).
- E. Illness preoccupation has been present for **at least 6 months**, but the specific illness that is feared may change over that period of time.
- F. The illness-related preoccupation is **not better explained by another mental disorder**, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether:

- **Care-seeking type:** Medical care, including physician visits or undergoing tests and procedures, is frequently used.
- **Care-avoidant type:** Medical care is rarely used.

Mabel, an 80-year-old retired schoolteacher, was admitted for evaluation of an 8-month preoccupation with having colon cancer. The patient had a history of single vessel coronary artery disease and diabetes mellitus (controlled by oral hypoglycemic agents) but was otherwise well. She had no history of mental illness. On admission, Mabel reported her concern about having colon cancer, which her two brothers had developed. As evidence of a possible tumor, she reported having diffuse abdominal pain and cited an abnormal barium enema examination 1 year earlier. (The examination had revealed diverticulosis.) Because of her concern about having cancer, Mabel had seen 11 physicians, but each in turn had been unable to reassure her that she did not have cancer. Mabel was pleasant and cooperated well with the ward team. Her physical examination and routine admission laboratory tests were unremarkable. Despite her complaint, Mabel denied depressed mood and displayed a full affect. She reported sleeping less than usual but attributed this to her abdominal discomfort. She chose not to socialize with other patients, whom she characterized as "crazy." She remained preoccupied with the possibility that she had cancer, despite our reassurance. A benzodiazepine was prescribed for her sleep disturbance, but she refused any other type of psychiatric treatment.

A case presentation of illness anxiety disorder, purely for clarity

◀ DSM-5 criteria of Conversion Disorder (Functional Neurological Symptom Disorder)

- A. **One or more symptoms of altered voluntary motor or sensory function.**
 - B. **Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.**
 - C. The symptom or deficit is **not better explained by another medical or mental disorder.**
 - D. The symptom or deficit **causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.**
- **Specify symptom type:**
 - With weakness or paralysis
 - With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)
 - With swallowing symptoms
 - With speech symptom (e.g., dysphonia, slurred speech)
 - With attacks or seizures
 - With anesthesia or sensory loss
 - With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
 - With mixed symptoms
 - **Specify if:**
 - **Acute episode:** Symptoms present for less than 6 months.
 - **Persistent:** Symptoms occurring for 6 months or more
 - **Specify if:**
 - With psychological stressor (specify stressor)
 - Without psychological stressor

◀ DSM-5 criteria of Psychological Factors Affecting Other Medical Conditions

- A. A medical symptom or condition (other than a mental disorder) is present.
- B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
 1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
 2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
 3. The factors constitute additional well-established health risks for the individual.
 4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
- C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

Specify current severity:

- **Mild:** Increases medical risk (e.g., inconsistent adherence with antihypertension treatment).
- **Moderate:** Aggravates underlying medical condition (e.g., anxiety aggravating asthma).
- **Severe:** Results in medical hospitalization or emergency room visit. **Extreme:** Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms).

Example: Asthma worsened by panic disorder.

◀ DSM-5 Criteria of Factitious Disorder

Factitious Disorder Imposed on Self

- A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
- B. The individual presents himself or herself to others as ill, impaired, or injured.
- C. The deceptive behavior is evident even in the absence of obvious external rewards.
- D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify: Single episode Recurrent episodes (two or more events of falsification of illness and/ or induction of injury)

Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy)

- A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- B. The individual presents another individual (victim) to others as ill, impaired, or injured.
- C. The deceptive behavior is evident even in the absence of obvious external rewards.
- D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

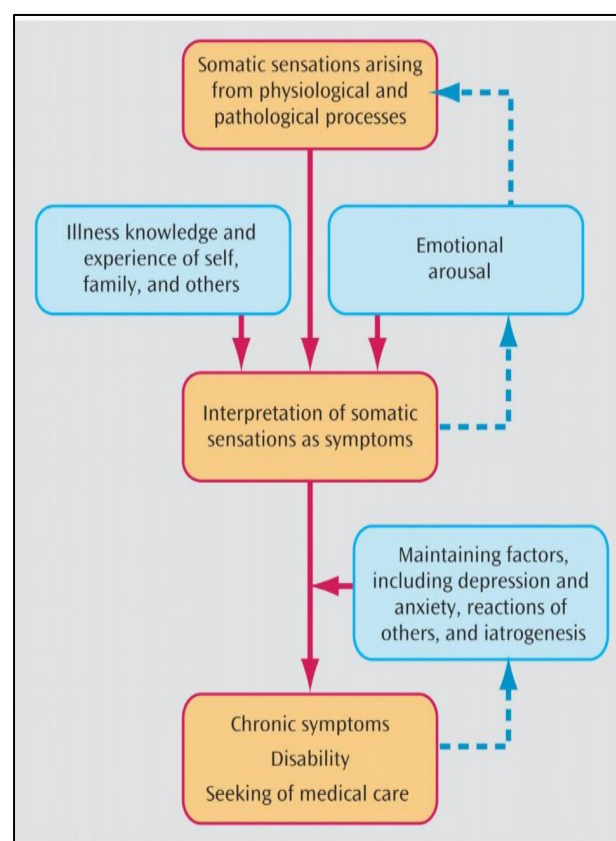
Note: The perpetrator, not the victim, receives this diagnosis. Specify: Single episode Recurrent episodes (two or more events of falsification of illness and/ or induction of injury)

◀ Malingering

Not a DSM-5 diagnosis

- Patient often presents with vague complaints that improve once their desired objective is obtained (e.g., sick leave)

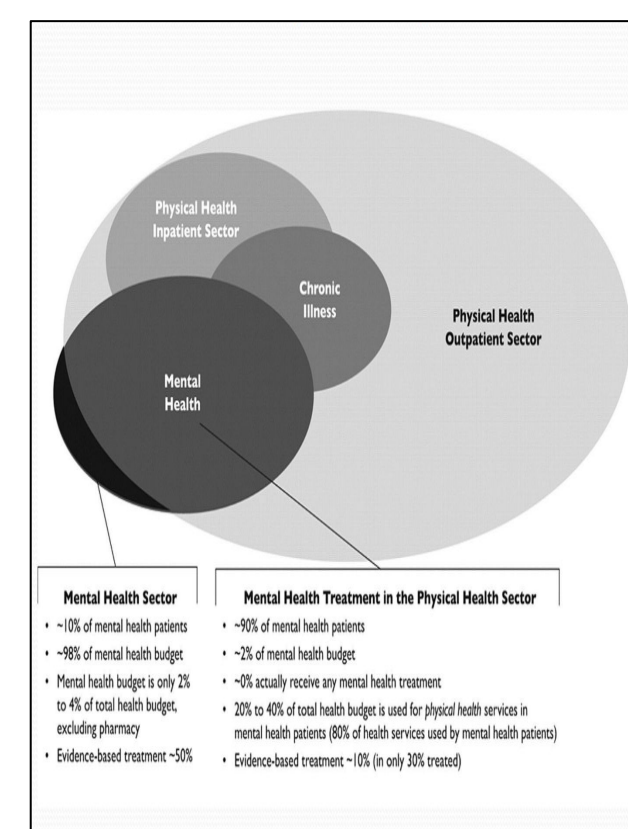
◀ Etiology of Somatic Symptoms And Related Disorders



Diagnosis	Prevalence	Gender	Age	Course
Hypochondriasis (somatic symptom disorder+illness anxiety d)	1-5% (community) 2-7% (primary care outpatients)	M=F	early adulthood	chronic, waxes and wanes
Conversion disorder	0.01-0.5% Esp. rural areas, lower SES, developing areas, and lower educational levels	F>M 2- 10	Late childhood – early adulthood	acute or sudden remit in about 2w - recur in 25%
Pain disorder (subtype of somatic symptom d)	Unknown 10-15% of U.S. adults experience chronic, disabling pain/year	M=F	Any age	Can be acute or chronic
Factitious Disorder	unknown, 1% of hospital cases in which mental health professionals are consulted	F > M	early adulthood	Episodic

◀ Management of Somatic Symptoms And Related Disorders

Do	Avoid
<ul style="list-style-type: none"> ● Allow patient role ● Concentrate on functions ● Frequent, short visits ● Single doctor ● Group therapy ● May individual Tx ● Drug treatment for psych comorbidity. ● SSRIs, high doses for Hypochondriasis and BDD 	<ul style="list-style-type: none"> ● Concentrating on Symptoms. ● Say (It's just in your mind, take it easy..) ● Tests or Rx without Dx ● Unnecessary Referrals / consults.



Future of Psychiatry

- Prescribe medication only for concurrent psychiatric disorders
- SSRIs may help in the treatment of illness anxiety disorder (psychotherapy is main treatment, especially CBT)

Special thanks to Medicine 437 & 436, for we merely attempted to embellish their already outstanding corpus of work with what we perceived to be most servient to Medicine 438. We aimed for concision and educational enrichment throughout the process of creating the material and we could not have done it without the careful refining eye of our academic leader **Tariq Alanezi**.

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We wish you the the best of luck to prosper in your remaining years in medical school.
Regards,

Nayef Alsaber & Abdulrahman Bedaiwi



MEDICINE 438's REVIEW OF

CLINICAL PSYCHIATRY



Quiz

1. Patient went to GI specialist and was checked for liver cirrhosis and he was normal. But he insists that he has vague abdominal pain. What does he have?
 - a. Illness anxiety disorder
 - b. Somatic symptom disorder
 - c. Factitious disorder
 - d. Delirium

2. Patient done multiple tests because he is concerned to have a specific physical disease, what is your diagnosis?
 - a. Illness anxiety disorder
 - b. Malingering
 - c. Somatic symptom disorder
 - d. None of the above

3. Which of the following is a bad prognostic factor in illness anxiety disorder?
 - a. Insomnia absence
 - b. Absence of hallucinations
 - c. Presence of panic attack
 - d. Presence of secondary gain

4. Which of the following is considered an alternative form of psychosomatic medicine?
 - a. Consultation-liaison psychiatry
 - b. Somatopsychology
 - c. Somatopsychiatry
 - d. Medical psychiatry

5. Which of the following is true regarding pain disorder?
 - a. It reflects a recognizable organic abnormality
 - b. It's routinely managed by gabapentin
 - c. It's a subset of somatic symptom disorder
 - d. It's a subset of illness anxiety disorder

Answer Key: 1) B, 2) A, 3) D, 4) A, 5) C

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