

Somatization Disorders: A Clinical Overview

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ABSTRACT:

Real symptoms frequently appear even when there is no actual illness. Somatization is the term for when psychic factors are to blame for the symptoms. Real symptoms frequently appear even when there is no actual illness. Somatization is the term for when psychic factors are to blame for the symptoms. Real symptoms frequently appear even when there is no actual illness. Somatization is the term for when psychic factors are to blame for the symptoms. An assessment by a psychiatrist is required to rule out concurrent psychiatric condition. Unaware doctors or surgeons may conduct investigations or diagnostic procedures that could have iatrogenic effects as a result of their ignorance of this sickness. It also puts a significant financial strain on the healthcare system. Many studies have been conducted to identify the best way to treat the condition. Treatment options include psychological and pharmaceutical therapies. In around half of these individuals, MUS resolve on their own within a year. Pharmaceutical therapy includes the use of sedative drugs such benzodiazepines, hypnotics, and antidepressants.

INTRODUCTION:

Actual symptoms frequently manifest even when no physical sickness is present. When psychic elements are to blame for the symptoms, this is referred to as somatization. A psychological condition may be in play when several symptoms impair functional ability, result in subjective harm, and prompt the need for medical attention (1).

Recurrent pain (location and quality vary), conversion symptoms, anxiety or sadness (or both), marital and sexual problems, and frequently menstrual issues are the most common complaints among SD patients. These individuals typically have a history of frequent hospital stays or surgeries (2). They frequently abuse medical resources. The limits of the syndromes in which they manifest are hazy, and their clinical manifestations frequently fluctuate. There are commonly underlying psychiatric conditions like mood disorders, anxiety disorders (including obsessive compulsive disorder), and personality disorders (3).

To rule out concomitant psychiatric disorder, a psychiatric evaluation is necessary. Lack of awareness of this illness could prompt an unsuspecting doctor or surgeon to pursue

investigations or diagnostic techniques that could result in iatrogenic effects. Additionally, it places a heavy financial burden on the healthcare system (4). Teaching papers on somatoform disorders frequently suggest patient treatment options that apply to the entire category. For this heterogeneous patient population, accurate diagnosis of somatoform diseases is both possible and essential for providing the best possible therapy. Diagnoses and patient-centred management are contrasted with recommendations for more universal treatments (5).

The presence of a somatic symptom disorder can be detected using screening tools. Regular check-ups, a solid therapeutic alliance, acknowledging and validating the patient's symptoms, and limiting diagnostic procedures or referrals to subspecialists are crucial for the primary care physician. Pharmacotherapy, cognitive behaviour therapy, and mindfulness-based therapy are examples of effective treatments. The symptoms can be reduced with the help of tricyclic antidepressants or selective serotonin reuptake inhibitors. When primary care physician treatment is unsuccessful, referral to a mental health professional may be required (6).

EPIDEMIOLOGY:

The prevalence of somatization disorder and was too low in population-based research to accurately assess related aspects. A significant female predominance in either disease was not discovered in research utilising condensed criteria, yet there was a continuous correlation between little educational attainment and both disorders (7).

The prevalence of MUS and somatoform disorders declines after the age of 65, according to the data that are currently available (8). A higher number of somatic symptoms is significantly associated with urban residence, increasing age (to 65+), female sex, marital status (especially separated and divorced), lower educational level. Lower socioeconomic status, and greater health-care utilization. No significant association with race emerges. In comparison to urban areas, rural areas differ more in terms of education, whereas urban areas differ more in terms of sex (9).

ASSOCIATION WITH OTHER PSYCHIATRIC DISORDERS:

Somatization shows a weaker association with symptoms of substance use and antisocial personality, but a strong association with symptoms of depression and anxiety, as well as an intermediate association with symptoms of schizophrenia and mania. The most typical co-occurring condition with somatization in primary care is depression. 69% of people who are sad had somatic symptoms, according to a large-scale research of primary care patients; the presence of more somatization symptoms is linked to a higher risk of depression (10). In comparison to the general population, persons with bipolar disorder have a 10–20 years shorter life expectancy due primarily to somatic illnesses, such as cancer, cardiovascular, and respiratory disorders. The fact that somatic treatments for bipolar disorder have not

significantly improved over time, especially in nations where everyone has equal and free access to healthcare services, is surprising and quite concerning (11).

SOMATIZATION DISORDERS IN CHILDREN AND ADOLESCENTS:

A somatoform disorder's diagnosis encompasses a continuum of symptoms, from ordinary aches and pains to incapacitating functional impairments. Children and teenagers cannot be classified using the diagnostic categorization systems now in use. The clinician requires enough time to assess the child and learn about his or her entire living situation whenever somatization is suspected (12).

In the paediatric age group, recurrent, medically unexplained physical complaints are typical, frequently accompanied by various psychiatric symptoms, and may be a common presentation of a psychiatric disorder in the primary care setting. There are still gaps in our knowledge of paediatric somatization and its effects. Collaboration between primary healthcare doctors and mental health specialists is crucial (13).

In order to predict somatization based on PTSD symptoms, IQ, age, and the type of sexual abuse, correlation and regression analyses were conducted. The goal was to determine whether the type of abuse had a moderating influence on the relationship between PTSD symptoms and somatization. Somatization in sexually abused children was influenced by the severity of PTSD symptoms and IQ, and the effect of the PTSD symptoms on somatization was moderated by kind of abuse (14).

RISK OF SUICIDE IN PATIENTS WITH SOMATIZATION DISORDER:

Suicide risk in psychiatric outpatients with and without somatization illness was measured. The findings showed that somatization disorder was strongly linked to suicidal ideation, even after statistical adjustments were made for the impact of concomitant major depressive disorder and comorbid personality disorder (15).

Numerous studies have found that psychiatric comorbidity raises the risk of suicide: people who have two or more psychiatric conditions are more likely to attempt suicide. The spectrum of anxious and affective illnesses appears to share a considerable mental comorbidity with somatization disease (16). Suicidal ideation and suicide attempts are associated with somatic symptoms and related disorders. Suicide deaths have not been adequately studied. The risk seems unrelated to co-occurring mental illnesses (17).

FAMILY HISTORY OF PATIENTS WITH SOMATIZATION:

Depression and alcoholism are the two illnesses that affects patients' family the most frequently. Relatives of somatization patients who were or were not themselves depressed had similar rates of depression (18). The diagnostic of Briquet's condition based on Guze's

original criteria and the diagnosis of somatization disorder based on DSM-III criteria in women were remarkably similar. Compared to women, somatization disorder diagnoses in men were less frequent and less reliable. The results demonstrate that somatization typically presents differently in men and women in terms of both the clinical presentation and the family antecedents (19).

DIAGNOSIS:

Typically, somatizing patients exhibit atypical sickness behaviour (e.g., do not respond to treatment, use excessive amounts of care) and experience psychological discomfort (eg, depressive symptoms, psychosocial stressors). A keen eye for distinguishing characteristics and an effective interviewing style are necessary for recognition. The first step in effective management is to validate symptoms. When conducting investigations and giving somatizing patients diagnoses, restraint should be utilised (20).

A new diagnostic category called physical symptom disorder (PSD) is being suggested to take the place of somatization disorder, undifferentiated somatoform disorder, and pain disorder. PSD would be characterised by one or more physical symptoms that are currently present, producing functional impairment, and which are not entirely explained by another medical or mental disease (with the exception of functional somatic syndromes). Using a 15-symptom checklist, duration must last at least six months, and severity can be classified as mild, moderate, or severe (21).

PROGNOSIS:

In this article, we provide a summary of recent findings regarding the prognosis of MUS. Comprehensive somatic testing in patients with MUS diagnosed by a doctor rarely yields a somatic diagnosis. In roughly half of these patients, MUS resolve on their own within a year. Symptom-related traits, such as having several physical symptoms at once, and psychological traits, such as negative thoughts, are indicators of an unfavourable prognosis (22).

Subsyndromal depression may be the prognostic marker of the high risk and quick manifestation of somatic disorders, and precise and useful diagnostic techniques may be able to identify it. Patients with depressive disorders could therefore be thought of as having a greater risk of developing a variety of somatic pathologies (23).

Patients with "small," "substantial," and "pronounced" somatization had a markedly reduced quality of life in terms of physical and mental health. Aside from the degree of somatization, older age, the length of hospital stays related to pain, and the subjective level of occupational impairment were found to be significant factors in the regression analysis that explained 48% of the variance in the body-related quality of life and 35% of the variance in the psychological quality of life (24).

EFFECTS OF COVID-19 PANDEMIC:

Clinicians observed that in addition to respiratory symptoms, a sizable portion of people with COVID-19 infection also experienced loss of appetite, nausea, vomiting, and diarrhoea. The public's attention may be diverted from the psychosocial effects of this outbreak in the general population due to the current emphasis on the physical features of COVID-19 infection. Stress plays a significant role in the emergence and persistence of functional gastrointestinal disorders (FGIDs). Since growing mental health concerns related to this global crisis may develop into long-lasting FGIDs, clinicians can manage FGIDs effectively with greater understanding of this urgent situation and can avoid diagnostic mistakes and costs (25).

MANAGEMENT:

To determine the ideal method of treating the illness, numerous investigations have been carried out. Pharmacological therapy and psychosocial therapies are included in treatments. Pharmacological therapy involves taking various sedatives such as benzodiazepines, hypnotics, and antidepressants. Mirtazapine is a safe and effective antidepressant for therapy. Adinazolam, a triazolobenzodiazepine, was another medication that proved particularly effective in treating patients. Alprazolam considerably outperformed amitriptyline in certain randomised studies in terms of alleviating the symptoms. Cognitive behavioural therapy (CBT), mindfulness-based cognitive therapy, relaxation training, and meditation are a few examples of psychosocial interventions. Other psychological interventions include enhancing multidimensional social support, altering cognitive assessment, directing positive coping, and invoking positive emotions (26). ECT may be a useful therapeutic option for somatization disorder symptoms that are severe and resistant. However, more investigation is needed to determine the effectiveness, safety, and tolerability of ECT in treating somatization disorder (27).

CONCLUSION:

Urban residency, growing age (to 65+), female sex, marital status (particularly separated and divorced), and lower educational level are all strongly linked to a larger number of somatic complaints. Somatization exhibits a weaker correlation with the signs of substance abuse and antisocial behaviour, but a significant correlation with the signs of depression and anxiety, as well as a middle correlation with the signs of schizophrenia and mania. Suicidal thoughts are more likely to occur in people who have two or more psychiatric illnesses, which increases the risk of suicide. Both the clinical manifestation and the familial antecedents of somatization often differ between men and women. Using a 15-symptom checklist, physical symptom disorder (PSD) can be categorised as having mild, moderate, or severe severity and a minimum period of six months. Within a year, MUS resolve on their own in about half of

these people. Taking sedative medications including benzodiazepines, hypnotics, and antidepressants is a part of pharmaceutical therapy.

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