● NCLEX 2026 · PSYCHOSOCIAL INTEGRITY

Somatic Symptom *Disorder*

A psychiatric condition where physical symptoms — real or unexplained — provoke disproportionate thoughts, feelings, and behaviors that disrupt daily functioning. The body speaks the language the mind cannot.

SYSTEM: MENTAL HEALTH | DSM-5 · F45.1 | DURATION ≥ 6 MONTHS

SECTION 01

1 Definition & Overview

- **One or more somatic (physical) symptoms** that are distressing or significantly disrupt daily life — symptoms may or may not have a medical explanation, but the *response* is disproportionate.
- **Excessive thoughts, feelings, and behaviors** related to the symptoms: persistent rumination, high health anxiety, excessive time and energy devoted to symptoms.
- **Persistent** — typically more than 6 months. The patient is not "faking"; the suffering is real and the somatic experience is genuine.

SECTION 02

2 Pathophysiology (Simplified)

1. **Psychological distress** (trauma, anxiety, depression, alexithymia — difficulty identifying emotions) goes unprocessed.

↓

2. **Brain–body axis activation:** heightened amygdala & insula sensitivity amplifies normal bodily sensations.

↓

3. **HPA axis dysregulation** → elevated cortisol → real GI, musculoskeletal, and autonomic symptoms.

↓

4. **Catastrophic thinking** about symptoms → hypervigilance → symptoms feel worse → cycle reinforces itself.

↓

5. **Secondary gain** (attention, role relief, avoidance) reinforces the somatic pattern; doctor shopping ensues.

SECTION 03

3 Signs & Symptoms

MILD · EARLY

- Vague physical complaints (pain, fatigue, GI distress)
- Frequent provider visits
- Symptom monitoring & body checking
- Mild functional disruption

SEVERE · LATE

- Multiple unexplained symptoms
- Doctor shopping; invasive workups
- Opioid / benzo misuse risk
- Disability, isolation, depression

RED FLAGS

- Suicidal ideation or hopelessness
- Escalating opioid / benzo use
- Repeated invasive procedures
- Severe functional decline

SECTION 04

4 Priority Nursing Interventions

ASSESS · SAFETY FIRST

- **Rule out medical cause** — assess before assuming psychogenic origin
- **Acknowledge** the symptoms are real to the patient
- Screen for **suicidal ideation** & substance misuse
- Assess coping, stressors, trauma history

THERAPEUTIC PLAN

- **One primary provider** — prevents doctor shopping
- **Regular, scheduled** brief visits — NOT symptom-contingent
- Limit **secondary gain** (attention, role relief)
- Refer to **CBT**; teach relaxation & mindfulness
- Encourage **verbal** emotional expression over somatic
- Treat comorbid depression / anxiety

SECTION 05

5 Pharmacology

SSRIS · SERTRALINE, FLUOXETINE
First-line for comorbid depression/anxiety. Monitor suicidality (black box), serotonin syndrome. Onset 4–6 weeks.

SNRIS · DULOXETINE, VENLAFAXINE
Useful when chronic pain coexists. Monitor BP (venlafaxine), liver labs (duloxetine).

TCAS · AMITRIPTYLINE (LOW DOSE)
Adjunct for neuropathic/chronic pain. Watch anticholinergic effects, cardiac toxicity, fall risk in elderly.

⚠ AVOID · BENZODIAZEPINES & OPIOIDS
High dependence and abuse risk. Reinforce somatic preoccupation. Use non-pharm strategies first.

SECTION 06

6 NCLEX Test Traps

- ✗ **Don't say "It's all in your head."** The pain & suffering are REAL to the patient — invalidation breaks trust.
- ✗ **Don't order repeated diagnostic tests** to "reassure" — reinforces illness behavior and secondary gain.
- ✓ **Best response:** "Tell me more about how you've been feeling lately." Open-ended, non-symptom-focused.
- ✓ **Schedule visits by time, not symptoms** — every 2 weeks regardless of how the patient feels.

SSD	Focus on the **symptoms themselves** + excessive thoughts/behaviors about them.
ILLNESS ANXIETY	Fear of **having a disease**; few or no actual somatic symptoms.
CONVERSION / FNSD	**Neurological deficit** (paralysis, blindness) with no medical cause.
FACTITIOUS	**Intentionally produced** for INTERNAL gain (sick role, attention).
MALINGERING	**Intentionally faked** for EXTERNAL gain (money, drugs, avoiding work).

SECTION 07

7 Patient Education

- 💬 **Your symptoms are real.** The mind–body link doesn't make them less valid — it explains why they happen.
- 👤 **Stay with one primary provider** — coordinated care prevents redundant testing.
- 📔 **Keep a symptom journal** — track triggers, stressors, and emotional patterns.
- 🧘 **Practice relaxation** — deep breathing, progressive muscle relaxation, mindfulness, yoga.
- 🏃 **Move daily.** Regular physical activity reduces somatic sensitivity and improves mood.
- 💊 **Take meds as prescribed.** Don't stop SSRIs/SNRIs abruptly — risk of discontinuation syndrome.
- 📅 **Attend CBT regularly** — therapy is the cornerstone of treatment, not medication alone.

SECTION 08

8 Memory Boosters & Mnemonics

"SOMATIC"

- **S** Symptoms are real — never invalidate.
- **O** One provider — stop doctor shopping.
- **M** Mind-body link education.
- **A** Acknowledge feelings & emotions.
- **T** Therapy — CBT is first-line.
- **I** Identify triggers & stressors.
- **C** Coping skills & relaxation.

The 4 D's

- **D** istress · symptoms cause genuine suffering
- **D** isproportionate · excessive thoughts/behaviors
- **D** uration · ≥ 6 months
- **D** isruption · daily function impaired

Quick Differential

- SSD focus on symptoms
- IAD focus on having a disease
- CD neurological deficit
- FD intentional → internal gain
- Malintentional → external gain

Pattern: If a question describes a patient with multiple physical complaints + excessive worry about them + many doctor visits → think **SSD**.