



Somatoform Disorders

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1. Somatisation Disorder

Introduction

In this chronic disorder, the person reports physical symptoms in various parts of the body, but medical examinations can reveal no physical cause. The person might also have endless psychological complaints, including psychotic symptoms, in addition to physical complaints. The symptoms experienced by the person feel very real, and are not intentionally faked or under the person's conscious control. Because of the pain and discomfort, the person experiences distress and impairment in functioning. Since much of their lives revolve around their symptoms, in some cases, people's identities become inseparable from their symptoms, making them more difficult to treat.

People with somatisation disorder may also exhibit anxious and depressive symptoms. For example, they may find it difficult to cope with various life stressors and even feel suicidal. It is also not uncommon for people with this disorder to abuse drugs or alcohol. The age of onset occurs during adolescence. Those most likely to have this condition are female, unmarried, and of lower socioeconomic status.

Symptoms

According to DSM-IV-TR, somatisation disorder is characterised by the following symptoms:

- A history of many physical complaints beginning before age 30 that occur over a period of several years and result in treatment being sought or significant impairment of functioning
- Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance
 - 4 pain symptoms: a history of pain related to at least 4 different sites or functions

- 2 gastrointestinal symptoms: a history of at least 2 gastrointestinal symptoms other than pain
- 1 sexual symptoms: a history of at least 1 sexual or reproductive symptom other than pain
- 1 pseudoneurological symptom: a history of at least 1 symptom or deficit suggesting a neurological condition not limited to pain
- Either:
 - After appropriate investigation, each of the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance OR
 - When there is a related medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings
- The symptoms are not intentionally produced or feigned

Causes and risk factors

The exact cause of somatisation disorder is as yet unclear, but a genetic vulnerability appears to be implicated in this condition since it runs in families. A history of family illness or injury during childhood, parental somatisation, or sexual or physical abuse has also been found to be associated with the development of somatisation disorder. Other hypotheses suggest that this disorder may be related to oversensitivity to pain or other bodily sensations.

Treatment

Cognitive-behavioural therapy is one form of treatment used with somatisation disorder. As part of treatment, the clinician tries to provide patients with reassurance and helps them reduce stress in order to improve their ability to cope with their pain or discomfort. Patients may also be asked to identify and modify thoughts related to bodily sensations so that they will be able to develop more adaptive cognitions and responses. The aim of CBT is to decrease the frequency of help-seeking behaviours as well as the positive consequences of relating to significant others on the basis of physical symptoms alone. At the same time, patients are encouraged to use more appropriate methods to interact with others. CBT also promotes healthy social and personal adjustment without relying on being “sick”. In addition, patients are advised to find at least part-time employment as a first step to discontinuing their disability. Working on family, employment, and social issues that have arisen due to the disorder are an important aspect of treatment.

In terms of pharmacological treatment, antidepressants have been used to alleviate symptoms. They are especially helpful if the patient has a comorbid anxiety or mood disorder. However, the somatic side effects of such drugs are often frightening to patients and difficult to tolerate.

2. Conversion Disorder

Introduction

Conversion disorder is defined by a physical malfunctioning (e.g., paralysis, blindness, or aphonia) without any organic pathology that can explain the malfunction. The dysfunction in conversion disorder commonly manifests as pseudoneurological symptoms, which means that it affects sensory-motor functioning and suggests a neurological deficit. In most cases, the symptoms are precipitated by significant stress, which often occurs in the form of physical injury.

The age of onset for this disorder is adolescence or slightly later, and it is found primarily in females. Conversion disorder was formerly known as hysteria, which was thought to only affect women. This disorder often co-occurs with somatisation disorder, and anxiety and mood disorders. Generally, children and adolescents with the disorder have a better prognosis than adults.

Symptoms

According to DSM-IV-TR, conversion disorder is characterised by the following symptoms:

- 1 or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition
- Psychosocial factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors
- The symptom or deficit is not intentionally produced or feigned
- The symptom or deficit cannot, after appropriate investigation, be fully explained by a known general medical condition or the direct effects of a substance, or as a culturally sanctioned behaviour or experience
- The symptom or deficit causes clinically significant distress or impairment in functioning, or warrants medical evaluation

Causes and risk factors

Genetic vulnerability is implicated in the development of conversion disorder, especially under conditions of stress. External factors, such as experiencing a traumatic event, may trigger the onset of conversion disorder by providing the person with a socially acceptable way to escape from the situation and this true motivation may be unknown to him or her. Environmental factors can also reinforce conversion behaviour, contributing to the maintenance of the disorder. For example, if the individual receives greatly increased attention and sympathy from the people around him or her, and may

even be permitted to avoid difficult tasks or situations, there is great incentive to continue displaying such sympathy-inducing behaviour.

People who are less educated and in lower socioeconomic groups who may be less informed about disease and medical illness are more likely to develop this disorder. Prior experience with real physical problems (e.g., a family member who was injured) can affect the person's presentation of the disorder, particularly which specific conversion symptoms the person will exhibit.

Treatment

The primary treatment for conversion disorder is cognitive-behavioural therapy. Part of therapy involves identifying and attending to the traumatic or stressful life event that appears to be related to the patient's symptoms if it is still present (either in real life or in memory). Stress management may also be useful in alleviating symptoms and any associated distress. It is important for the patient to attain some form of catharsis, which can be done with therapeutic assistance in re-experiencing or even reliving the event. Any reinforcing consequences of the person's conversion symptoms must also be reduced or eliminated so that there is no motivation for the patient to continue to exhibit symptoms. At the same time, the patient's help-seeking behaviours should be minimised.

Physical or occupational therapy may also be needed to prevent the affected body part from simply wasting away or losing function until the patient's symptoms disappear. For example, if the patient reports paralysis in his or her limbs, they must still be exercised to prevent muscle atrophy.

3. Body Dysmorphic Disorder

Introduction

Body dysmorphic disorder (BDD) is similar to OCD in the sense that the person displays obsession-like symptoms. However, this preoccupation is strictly related to appearance and a fear that others will notice any physical defects or deformities. The features the person worries about are typically in but not limited to the face or head region. Similar to OCD and the eating disorders, an excessive level of perfectionism is implicated in BDD. Usually, the person has poor insight and is convinced that his or her imagined bodily defect is real and a reasonable source of concern. Though this disorder appears to affect males and females equally, the focus of the disorder differs between men and women.

Suicidal ideation, suicide attempts, and suicide are common, and the suicide rate for BDD is high, at 17%. The age of onset ranges from early adolescence through the person's 20s, with a peak age between 16 and 17 years old. BDD is a chronic condition if left untreated, though the severity of symptoms may wax and wane over time. BDD can co-occur with depression, substance abuse, social phobia, and OCD. It is not uncommon for people with BDD to display a variety of checking or compensating rituals in attempts to alleviate their concerns. In some cases, people can become socially isolated, with their condition rendering themselves housebound for fear of showing themselves to other people.

Symptoms

According to DSM-IV-TR, body dysmorphic disorder is characterised by the following symptoms:

- Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.
- The preoccupation causes clinically significant distress or impairment in functioning

Causes and risk factors

The development of BDD is influenced by genetic factors. Relatives of a person with BDD are more likely to have the disorder. The personality traits implicated in BDD include neuroticism, perfectionism, and aesthetic sensitivity. Thus, they might have the inclination to place more emphasis on physical appearance when forming their self-identity. People with BDD tend to show catastrophic reactions to perceived or slight defects that most people do not even notice. In many cases, even though the defect is not imagined, their reaction is clearly excessive. In addition, because their avoidance

and checking behaviour, as well as attempts to improve their physical appearance, help them to reduce or even eliminate any appearance-related distress, such behaviour is negatively reinforced and they continue believing that they have serious flaws in their appearance. Furthermore, this sort of avoidance prevents people with BDD from correcting their maladaptive cognitions regarding their perceived or slight defect as they do not give others the opportunity to notice it without trying to hide it or cover it up in some way. Environmental factors such as childhood neglect, low parental warmth, childhood abuse, and teasing appear to be associated with this disorder.

Treatment

Psychologically based treatments for BDD primarily involve cognitive-behavioural techniques. Cognitive restructuring can be used to identify and modify the various dysfunctional cognitions patients have associated with their appearance. Exposure and response prevention, similar to what is used in OCD treatment, helps to reduce appearance-related rituals and avoidance behaviours, as well as the distress associated with these actions. In ERP therapy, the therapist and client come up with a hierarchy of anxiety-provoking situations and work through the hierarchy, increasing the patient's exposure to his or her feared stimuli while preventing any safety behaviours or rituals so that the patient can habituate to the aversive stimuli. In addition, such exposure works as an experiment, where the patient is able to test the validity of his or her beliefs and related predictions. Habit reversal training aims to encourage new, more adaptive behaviours that are designed to interfere with ritualistic behaviours that may have become habitual. Increasing other adaptive behaviour, such as greater participation in social activities, can also be helpful in improving symptoms. Mirror retraining procedures address any appearance-related cognitions, avoidance, and distress while patients are exposed to their reflection in a full-length mirror. The aim is to help them see and describe their appearance objectively, without concentrating on their perceived flaws. During this exercise, safety behaviours are prevented.

Selective-serotonin reuptake inhibitors have been used in the treatment of BDD. However, high relapse rates are observed when the drug is discontinued. Sometimes, people with BDD go to medical doctors like plastic surgeons or dermatologists in attempts to correct their supposed defects. However, they are almost always dissatisfied with the result and usually return for additional surgery on the same problem or begin to focus on another flaw. In most cases, the severity of the disorder and any accompanying distress either remain the same or worsen after surgery.

4. Hypochondriasis

Introduction

Hypochondriasis involves a preoccupation with the possibility of having a serious disease due to a misinterpretation of somatic symptoms. Typically, people with hypochondriasis go from doctor to doctor, until they find one who provides a diagnosis that is consistent with their beliefs. Reassurances from many doctors that their health is in order rarely provide anything more than short-term relief. These people erroneously think that they have a disease, a difficult to shake belief that is sometimes referred to as “disease conviction”. Often, there is comorbidity with depression and the anxiety disorders. Most of the time, people with hypochondriasis are able to function fairly well, which might make this disorder difficult to diagnose, since there are no observable symptoms.

Hypochondriasis affects about the same number of men as women and has three peak ages of onset – adolescence, middle age, and after the age of 60. There are more people with hypochondriasis in the above 50 age group, perhaps accountable by the higher frequency of minor aches and pains in this bracket. Hypochondriasis follows a chronic course, and so does not spontaneously disappear.

Symptoms

According to DSM-IV-TR, hypochondriasis is characterised by the following symptoms:

- Preoccupation with fears of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms
- The preoccupation persists despite appropriate medical evaluation and reassurance
- The preoccupation is not of delusional intensity and is not restricted to a circumscribed concern about appearance
- The preoccupation causes clinically significant distress or impairment in functioning
- The duration of the disturbance is at least 6 months

Causes and risk factors

A genetic vulnerability appears to be implicated in the development of hypochondriasis as the disorder runs in families. However, rather than a specific predisposition to the disorder itself, what is inherited could instead be the tendency to overreact to stress. Those with the disorder might also have developed the tendency to view the world around them as unpredictable and uncontrollable, and to be guarded against it at all times. Furthermore, they might have learnt early on from family members to focus their

anxiety on specific physical conditions and illnesses. Typically, they have a restrictive concept of health as being completely free of any physical symptoms.

There also appears to be a link between a greater incidence of disease in the family during childhood and the later emergence of hypochondriasis. It could be that people with a history of family disease carry strong memories of illness with them that later become the focus of their anxiety. If not managed appropriately, illness within the family could cause physical illness to become a prominent theme in a person's life, contributing to the development of hypochondriasis. They might also have learned that an ill person often enjoys many benefits, such as positive attention and permission to avoid work or other responsibilities, which could be an encouraging factor.

Treatment

Often, treatment involves psychotherapy and medication. Cognitive-behavioural therapy focuses on identifying and modifying patients' illness-related misinterpretations of bodily sensations. As part of therapy, the clinician can show patients how to create physical symptoms by concentrating on certain parts of their body. Recognising that they are able to create their symptoms in this manner teaches patients that such occurrences are under their control. Patients also learn to seek less reassurance regarding their somatic concerns. At the same time, clinicians try to offer reassurance in an effective and sensitive manner, properly address patients' concerns, and focus on the meaning of their symptoms, perhaps in relation to life stressors. Patients can also participate in support groups where they may find some reassurance and meet others who have similar concerns.

Antidepressants, such as selective serotonin reuptake inhibitors, have been used in the treatment of hypochondriasis as well.

5. Somatoform Pain Disorder

Introduction

The predominant feature of pain disorder is the experience of pain. However, even if there may be clear physical reasons for the pain (at least initially), psychological factors are judged to play a major role in the maintenance of the pain, particularly anxiety that is focused on the experience of pain. Even if no medical source of the pain can be found and regardless of the presumed cause, the pain is real and severe enough to cause distress or impair functioning. This disorder appears to affect men and women equally.

Symptoms

According to DSM-IV-TR, somatoform pain disorder is characterised by the following symptoms:

- Pain in one or more anatomical sites is predominant focus of clinical presentation and is of sufficient severity to warrant clinical attention
- Pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of pain
- Symptom or deficit is not intentionally produced or feigned

Causes and risk factors

A familial pattern of chronic pain appears to be implicated in this disorder. Chronic pain may be more common in first-degree relatives of individuals with chronic pain disorder. In addition, people with pain disorder might be oversensitive to painful sensations, exacerbating their experience of pain. Those with a history of physical or sexual abuse are also more likely to develop this disorder. Research suggests that emotional wellbeing can affect how pain is perceived in an individual, thus stress may play a role in the development of this disorder.

Once the pain behaviour is established, positive reinforcement in the form of supportive responses from others and increased attention can work to perpetuate such behaviour. Being able to avoid certain responsibilities may also function as extra incentive for patients to persist with their behaviour. If patients become less active as a result of the pain, they might become more sensitive to pain signals, worsening their symptoms.

Treatment

Cognitive-behavioural therapy can be used in the treatment of pain disorder. In CBT, patients learn to recognise factors that exacerbate their pain and how to use coping methods to ameliorate their experience of pain. They are also encouraged to keep themselves active in spite of their pain. In addition, patients are taught to identify and modify maladaptive cognitions, especially those centred on helplessness and hopelessness. Operant conditioning has also been found to be effective in improving symptoms. Operant treatment involves identification of pain behaviours and the factors that reinforce the behaviours, as well as working to eliminate such reinforcers and promote positive reinforcement of non-pain behaviours. Ultimately, the aim is to terminate all pain-related behaviours. Other psychological treatment options include teaching relaxation techniques, supportive therapy to help patients cope with stress, hypnotherapy, and group therapy.

Antidepressants, including tricyclic antidepressants and selective serotonin reuptake inhibitors, can be used to alleviate pain, improve sleep, augment the benefits of opioids (e.g., codeine), and reduce depressive symptoms. The effect on pain can be seen in a few days, though observable results for depressive symptoms may take several weeks. Pain medications typically are not effective in dealing with symptoms of pain disorder.