Somatoform disorder

Somatoform Disorders

- A broad group of illnesses that have bodily signs and symptoms as a major component.
- Encompass **mind-body interactions.**

CLASSIFICATION OF SOMATOFORM DISORDER

(1)Somatization disorder

(2)Conversion disorder

(3) Hypochondriasis

(4) Body dysmorphic disorder

(5) Undifferentiated somatoform disorder.

(6) Somatoform disorder not otherwise specified

Somatization Disorder

- multiple somatic complaints in multiple organ **significant psychological distress**,
- **impaired**
- **Excessive medical-help-seeking behavior.**
- Suicide threats are common, but actual suicide is rare. (suicide common with substance abuse)
- Patients classically (but not always) describe their complaints in a dramatic, emotional, and exaggerated fashion, with **vivid** and colorful language; they may confuse temporal sequences.

Etiology

Psychosocial Factors

- **Suppression or repression** of anger towards others; turned to self can account for symptom
- Punitive personality organization with strong superego
- A behavioral perspective on somatization disorder emphasizes on identification with parent who **model sick role**
- In addition, some patients with somatization disorder come from **unstable homes** and have been physically abused.

Biological Factors

- Genetics:-tends to run in families and occurs in 10 to 20 percent of mothers & sisters of affected pts.
- One study also reported a concordance rate of 29 percent in monozygotic twins and10 percent in dizygotic twins, an indication of a genetic effect.

Diagnostic Criteria for Somatization Disorder

A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.

B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:

1 **four pain symptoms:** at least four different sites (e.g., head, abdomen, back, joints, extremities, chest, rectum) or functions (e.g. during menstruation, during sexual intercourse, or during urination)

2 **two gastrointestinal symptoms**: e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods

3 **one sexual symptom**: at least one sexual or reproductive symptom other than pain (e.g., both sex (sexual indifference), males (erectile or ejaculatory dysfunction), females (irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)

4 **one pseudo neurological symptom:** at least one symptom or deficit suggesting a neurological condition not limited to pain

eg. impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures;

C Either (1) or (2):

1 after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

2 when there is a related general medical condition, the physical complaints or not resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

3 The symptoms are not intentionally produced or feigned (as in factitious disorder or malingering).

Differential Diagnosis

- The three features that most suggest a diagnosis of somatization disorder instead of another medical disorder are:

(1) The involvement of multiple organ systems,

(2) Early onset and chronic course without development of physical signs or structural abnormalities, and

(3)Absence of laboratory abnormalities that is characteristic of the suggested medical condition.

- In the process of diagnosis, the astute (**smart**) clinician considers other medical disorders that are characterized by ***vague, multiple***, and ***confusing somatic symptoms***,
- such as thyroid disease, hyperparathyroidism, multiple sclerosis (MS), and systemic lupus erythematosus.

Course and Prognosis

Course and Prognosis

- Somatization disorder is a chronic, undulating (rising & falling), and relapsing disorder that rarely remits completely. It is unusual for the individual with somatization disorder to be free of symptoms for greater than 1 year, during which time they may see a doctor several times.

Treatment

Pharmacological:

- avoid psychotropic except under periods of acute anxiety & depression, b/c pts tend to be psychologically dependent
- Antidepressants or anxiolytics are indicated in case of co-morbid depressive &anxiety disorders.
- Psychological:-long term insight oriented & supportive psychotherapy is required to provide understanding of the dynamic, support through distressing life events & also to follow the pt to prevent substance abuse, doctor shopping, unnecessary procedures or diagnostic tests

Conversion Disorder

- **affect voluntary motor or sensory functions,** which suggest another medical condition, but that is judged to be caused by psychological factors because the illness is preceded by conflicts or other stressors.

- **Motor symptoms**:-Abnormal gait (ataxia), Astasia-abasia, Paralysis, Weakness, Aphonia
  Sensory Deficits:-Anesthesia, especially of extremities, analgesia, Blindness, Deafness
- **Pseudoseizure**
- **Visceral Symptoms**:-Psychogenic vomiting, Swooning or syncope, Urinary retention, Diarrhea

Epidemiology

- One third of general population
- The ratio of women to men among adult patients is at least 2 to 1 and as much as 10 to 1; among children.

Etiology

- **Psychoanalytic Factors**:-conversion of anxiety into a physical symptom.
- **Biological Factors:-**hypo metabolism of the dominant hemisphere and hyper metabolism of the non-dominant hemisphere and have implicated impaired hemispheric communication in the cause of conversion disorder.

Diagnostic Criteria for Conversion Disorder

- One or more symptoms or deficits affecting voluntary motor or sensory function
- Psychological factors are judged to be associated with the symptom
- The symptom or deficit is not intentionally produced
- The symptom or deficit cannot, after appropriate investigation.
- The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of somatization disorder, and is not better accounted for by another mental disorder.

- *Specify* type of symptom or deficit:
  With motor symptom or deficit
  With sensory symptom or deficit
  With seizures or convulsions
  With mixed presentation

Psychological symptoms that have been associated with conversion disorder.

- **Primary Gain**
- Patients achieve primary gain by **keeping internal conflicts outside their awareness**.
- **Secondary Gain**
- Patients ensue tangible advantages and benefits as a result of being sick;.
- **La Belle Indifference**
- La belle indifference is a patient's inappropriately careless attitude toward serious symptoms; that is, the patient seems to be unconcerned about what appears to be a major impairment.

Course and Prognosis

- The onset of conversion disorder is usually acute, but a crescendo of symptomatology may also occur. Symptoms or deficits are usually of short duration, and approximately 95 percent of acute cases remit spontaneously, usually within 2 weeks in hospitalized patients.

Treatment

- ***insight-oriented supportive or behavior therapy.***
- **Hypnosis, anxiolytics, and behavioral relaxation exercises** are effective in some cases.
- Parenteral **amobarbital or lorazepam** may be helpful in obtaining additional historic information, especially when a patient has recently experienced a traumatic event.

Hypochondriasis

- Hypochondriasis is characterized by ***preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.***
- The term hypochondriasis is derived from the old medical term hypochondrium, (below the ribs) and reflects the common abdominal complaints of many patients with the disorder, but they may occur in any part of the body.

Epidemiology

- One recent study reported a 6-month prevalence of hypochondriasis of ***4 to 6 percent*** in a general medical clinic population, but it may be as high as 15 percent. Men and women are ***equally*** affected by hypochondriasis.

Etiology

- Much data indicate that persons with hypochondriasis ***augment and amplify their somatic sensations***; they **have low thresholds for, and low tolerance of, physical discomfort**. ***faulty cognitive scheme.***
- A second theory is that hypochondriasis is understandable in terms of a ***social learning model.***
- According to psychodynamic theory, ***aggressive and hostile wishe***s toward others are transferred (through repression and displacement) into physical complaints.

Diagnostic Criteria for Hypochondriasis

- 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 belief in Criterion A is not of delusional intensity (as in delusional disorder, somatic type) and is not restricted to a circumscribed concern about appearance (as in body dysmorphic disorder).
- The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The duration of the disturbance is at least 6 months.
- The preoccupation is not better accounted by another problem.

Course and Prognosis

- The course of hypochondriasis is usually **episodic;** the episodes last from months to years and are separated by equally long quiescent periods. There may be an obvious association between exacerbations of hypochondriacal symptoms and psychosocial stressors.

Treatment

- Patients with hypochondriasis usually resist psychiatric treatment
- **Group psychotherapy**
- Other forms of psychotherapy, such as **individual insight-oriented psychotherapy, behavior therapy, cognitive therapy, and hypnosis** may be useful.
- Frequent, regularly scheduled physical examinations
- Pharmacotherapy alleviates hypochondriacal symptoms only when a patient has an underlying drug-responsive condition.

Body Dysmorphic Disorder

Body dysmorphic disorder is characterized by a preoccupation with an imagined defect in appearance that causes clinically significant distress or impairment in important areas of functioning. If a slight physical anomaly is actually present, the person's concern with the anomaly is excessive and bothersome.

- Epidemiology
- Body dysmorphic disorder is a poorly studied condition, partly because patients are more likely to go to dermatologists, internists, or plastic surgeons than to psychiatrists

Diagnostic Criteria for Body Dysmorphic Disorder

- 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 social, occupational, or other important areas of functioning.
- The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa)

Treatment

tricyclic drugs,

monoamine oxidase inhibitors (MAOIs), and pimozide (Orap)

Dissociative Disorders

- is a disruption or alteration in the usually integrated functions of **consciousness, memory, identity,** or **perception** of the environment.
- Dissociative response occurs when **anxiety is overwhelming (irresistible).**
- Certain **mental contents** are removed from consciousness to protect the ego from experiencing painful anxiety.

Classification

- DSM-IV-TR classifies dissociative disorders in to:
- Dissociative amnesia,
- Dissociative identity disorder,
- Depersonalization disorder,
- Dissociative fugue, and
- Dissociative disorder not otherwise specified (NOS).

Dissociative Amnesia

dissociative amnesia is an inability to recall important personal information, usually of a **traumatic or stressful nature**, that is too extensive to be explained by normal forgetfulness.

- The capacity to learn **new material is preserved**.

Epidemiology

- **<u>6 percent</u>** of the general population.
- No known difference is seen in incidence between men and women.
- Cases generally begin to be reported in **late adolescence and adulthood.**

Etiology

- Emotional trauma e.g. *domestic violence*
- It is common following wars, disasters

Treatment

Cognitive therapy

Somatic therapy

Hypnosis

Group therapy

Depersonalization Disorder

- is the persistent or recurrent feeling of detachment or estrangement from one's self. The individual may report **feeling like an automaton or as if in a dream or watching himself or herself in a movie**
- But the experience of **reality testing remains intact**.

Epidemiology

- Transient experiences of **depersonalization and derealization** are extremely common in normal and clinical populations. They are the third most commonly reported psychiatric symptoms, after **depression and anxiety**.
- Depersonalization is found **two to four times** more in women than in men.

Treatment

- SSRI antidepressants, such as fluoxetine (Prozac),
- Psychodynamic, cognitive, cognitive-behavioral, hypnotherapeutic, and supportive

Dissociative Fugue

- sudden, unexpected travel away from home or one's customary place of daily activities, with inability to recall some or all of one's past.
- This is accompanied by confusion about personal identity or even the **assumption of a new identity.**

Ethiology

- Traumatic circumstances (, rape, recurrent childhood sexual abuse, massive social dislocations, natural disasters)
- extreme emotions or impulses (i.e., overwhelming fear, guilt, shame, or intense incestuous, sexual, suicidal, or violent urges

Treatment

- Dissociative fugue is usually treated with psycho dynamically oriented psychotherapy that focuses on helping the patient recover memory for identity and recent experience.
- Hypnotherapy and pharmacologically **facilitated interviews** are frequently necessary adjunctive techniques to assist with memory recovery.

Dissociative Identity Disorder

- Dissociative identity disorder, previously called multiple personality disorder, characterized by the **presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior** accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

Epidemiology

- Clinical studies report female to male ratios between 5 to 1 and 9 to 1 for diagnosed cases.

Etiology

- Is strongly linked to severe experiences of **early childhood trauma**, usually maltreatment. The rates of reported severe childhood trauma for child and adult patients with dissociative identity disorder range from **85 to 97** percent of cases. **Physical and sexual abuse** are the most frequently reported sources of childhood trauma.

Treatment

Psychotherapy

Hypnosis

- Hypnotherapeutic interventions can often alleviate self-destructive impulses or reduce symptoms, such as flashbacks & dissociative hallucinations.
- **Psychopharmacological Interventions**
- Clinicians report some success with SSRI, tricyclic, and monamine oxidase (MAO) antidepressants

Adjunctive Treatments

- **Group Therapy**
- Therapy groups composed only of patients with dissociative identity disorder are reported to be more successful, although the groups must be carefully structured, must provide firm limits, and should generally focus only on here-and-now issues of coping and adaptation.

Family Therapy

- Family or couples therapy is often important for long-term stabilization and to address pathological family and marital processes that are common in patients with dissociative identity disorder and their family members.

Dissociative Disorder not Otherwise Specified

- This category is included for disorders in which the predominant feature is a dissociative symptom (i.e., a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment) that does not meet the criteria for any specific dissociative disorder.

Example

- Loss of consciousness, stupor, or coma not attributable to a general medical condition.
- **Ganser syndrome**: the giving of approximate answers to questions (e.g., 2 + 2 = 5) when not associated with dissociative amnesia or dissociative fugue.

THANK YOU!