SOMATOFORM DISORDERS

Soma means "body". In somatoform disorders psychological problems take a physical form. The physical symptoms of somatoform disorders, which have no known physiological explanations and are not under voluntary control, are thought to be linked to psychological factors, presumably anxiety, and are therefore assumed to be psychologically caused.

Somatoform disorders refer to a group of psychological disorders where the physical symptoms may suggest an organic cause, but there are no demonstrable organic findings or known physiological mechanisms. Instead, there is evidence, or a strong presumption, that these symptoms are linked to psychological factors or conflicts.

Increasingly recognition is being given to "medically unexplained symptoms" in which an individual complains of a condition such as pain or numbness for which no physical counterpart can be observed.

There are five factors to consider when diagnosing a patient suspected of having a somatoform disorder.

- The patient has lost or altered physical functioning, may present with symptoms of blindness, deafness or paralysis.
- The symptom cannot be explained by a known physical or neurological condition; there is no evidence of neurological damage to produce the blindness, deafness or the paralysis.
- There is positive evidence that psychological factors are related to the symptom.
- The patient is often, but not always, indifferent to the physical loss; specifically anxiety is not felt about the symptoms.
- The symptoms are not under voluntary control.

TYPES OF SOMATOFORM DISORDERS

CONVERSION – psychological stress is converted into physical symptoms. Sensory or motor symptoms, such as a sudden loss of vision or paralysis, suggest an illness related to neurological damage of some sort, though the body organs and nervous systems are found to be fine.

PAIN DISORDER – pain in one or more parts of the body causing marked distress or impairment is the central problem.

SOMATIZATION DISORDER

Somatization disorder is a clinical syndrome characterized by recurrent multiple somatic complaints that cannot be explained medically. It begins before the age of 30 and has a chronic and fluctuating course. The patient often describes his/her symptoms in a vague yet dramatic or exaggerated manner with frequent consultations with a number of physicians.

Sometimes known as Briquet's Syndrome, it is rare in men, with a life-time prevalence rate of between 0.2 and 2% in women. Like hypochondriasis, it is inversely related to socio-economic status, occurring more often among the less educated and those of lower occupational status.

A myriad of symptoms in various systems of the body are frequent causes of complaints by the patient. These include gastrointestinal ones such as abdominal pain, vomiting, nausea, bloating sensation, diarrhoea; cardiopulmonary symptoms like shortness of breath, palpitations, chest pain; pain symptoms like back pain, joint pain; psychosexual complaints like dyspareunia, impotence or sexual indifference; and pseudoneurological symptoms like amnesia, difficulty swallowing, loss of voice, blurred or double vision, paralysis, or blindness. In women, menstrual pain, irregular mensus or excessive menstrual bleeding are judged by the person to occur more frequently or severely than in most women.

Psychological distress, especially anxiety, depression and, not infrequently, suicide threats accompany the patients in addition to interpersonal problems. The family is often not emotionally supportive, and there is a poor marital relationship. The patient is also a poor role model as a parent.

Other than physical disorders, which must be ruled out in the first instance, the other differential diagnoses include conversion disorder, factitious disorder, anxiety disorder and depression.

BODY DYSMORPHIC DISORDER

Adeel is a 43 year old man who was referred to the mental health clinic by a local surgeon. For the past 8 years, Adeel has visited plastic surgeons across the country to find one who will perform surgery to reduce the size of his nose, which he perceives as being "too fat." Until he has this surgery, he will not leave his house without wearing glasses. The plastic surgeon concurs Adeel's family members and friends that Adeel's perception of his nose is distorted and that plastic surgery would be in appropriate and irresponsible.

A person with BDD exaggerates a slight bodily defect into the perception of wholesale ugliness, and this concern comes to dominate his or her life. A person is preoccupied with an imagined or exaggerated defect in appearance, frequently in the face – for example, facial wrinkles, excess facial hair, or the shape or size of the nose.

Women tend also to focus on the skin, hips, breasts and legs, whereas men are more inclined to believe they are too short, that their penis are too small, or that they have too much body hair (Perugi et al, 1997). A woman may comb her hair for hours, pick at her skin, or engage in prolonged makeup rituals. A man may try to mask the defect by wearing a beard to cover a small chin, a wig to disguise hair loss, or a sock in his bathing trunks to enhance his "small" penis.

These concerns are distressing and sometimes lead to frequent consultations with plastic surgeons. Unfortunately, plastic surgery does little to relieve patients' concerns (Phillips et al., 1996). At the extreme, he or she may avoid any social contact, dropping out of school or work. Depression, suicide and repeated plastic surgery are all common outcomes.

Body dysmorphic disorder occurs mostly among women, typically begins in late adolescence, and is frequently associated with depression and social phobia (Veale et al., 1996). BDD usually begins in adolescence and may last a lifetime (Wilhelm et al., 1999). It is uncommon in severe form (Hollander and Aronowitz, 1999).

A survey of college students (Fitts et al., 1989) found that 70 percent of the students indicated at least some dissatisfaction with their appearance, with a higher figure for women than for men. Social and cultural factors surely play a role in how a person determines whether he or she is attractive.

HYPOCHONDRIASIS

Gul is a 48 year old mother of two children, both of whom recently moved away from home. Within the past year, her menstrual periods have become much heavier and more irregular. Seeking an explanation Gul began to spend days reading everything she could find on uterine cancer. Although medical books specified menstrual disturbance as a common feature of menopause, one newspaper article mentioned the possibility of uterine cancer. She immediately made an appointment with her gynecologist, who tested her and concluded that her symptoms were almost certainly due to menopause. Convinced that her physician was trying to protect her from knowing the awful "truth", Gul visited one gynecologist after another; in search of someone who would properly diagnose what she was certain was a fatal illness. She decided to give up her job as department store clerk for two reasons. First, she was concerned for long hours of standing at the cash register would aggravate her medical condition. Second, she felt she could not be tied down by a job that was interfering with her medical appointments.

Hypochondriasis is a somatoform disorder in which individuals are preoccupied with fears of having serious disease which persist despite medical reassurance to the contrary. They worry endlessly about minor physical symptoms such as a cough or a little sore. They "doctor shop" and change physicians frequently, believing they are getting inadequate care. Both the patient and physician, usually a family practitioner, feel anger and frustration. Family and social life is also strained, with the patient's complaints about his poor health the central irritant. The patient usually refuses to believe that he is suffering a mental disorder and not a physical one.

The hypochondriacal patient often presents his medical history in great detail and at length. Doctor-hopping and deterioration in doctor-patient relationships often lead to much frustration and anger on both sides. Besides being unduly anxious over his health, he experiences depression during the chronic course of the illness.

It does not involve extreme bodily dysfunction or unexplainable medical symptoms. Instead the person misinterprets or exaggerates normal bodily occurrences.

Hypochondriasis is said to be the male equivalent of hysteria, but occurs in both sexes with only a slight preponderance in men. It is present in about 3 to 13% of patients in general medical practice. The onset is believed to be around the third or fourth decade, although it is not uncommon among the elderly. Most research seems to demonstrate an inverse relationship with socio-economic class and the level of education.

Men and women equally predisposed to hypochondriasis, and around 4 percent of medical patients may display it. It can be found at any stage of life, but particularly in adolescence, in middle ages and after age sixty (Barsky, Wyshak, Klerman 1990; Kellner, 1986). Culture greatly influences what particular physical problems will preoccupy a person who has hypochondriasis.

Making a diagnosis of hypochondriasis involves a process of elimination. First, a medical condition must be ruled out. Then, a series of related mental disorders, such as GAD, OCD, illness phobia, panic disorders and somatization disorders should be eliminated. Further, the patient must not be experiencing the bodily delusions that can occur in psychosis. What is left over is hypochondriasis.

EXPLANATION FOR SOMATOFORM DISORDERS

Psychodynamic explanation points to unconscious gratification of bodily symptoms and physical suffering. Others focus on oral and dependency needs in such patients, viewing the somatic complaints as expressions of their desire for care, nurture, attention and sympathy. Anger is commonly a fundamental emotion in such patients; it could have resulted from past experiences, disappointments, losses or rejection. Somatic symptoms become a non-verbal language used in communicating that anger. And pain is often associated with the need for parental care and affection which may otherwise be minimal or absent without such complaints.

Psychoanalytic theorist relates this defense reaction to the loss of libidinal energy. This deficit stems from unconscious feeling of anxiety and guilt about sexual drives.

Hypochondriac withdraws sexual energy from the objects of the external world and diverts it by concentrating on various internal organs. In this way the actual source of anxiety can be denied. However, the ultimate effect is damaging. The limited libidinal energy of the hypochondriac is reduced even more.

The socio-cultural environment affects the translation of psychological distress into bodily symptoms.

Hypochondriacal symptoms bring secondary gains – positive reinforcement in social learning terms.

Cognitive theory regards somatic symptoms as the person's misinterpretation and wrongful attribution of their normal bodily sensations to serious physical disease. Thus, a non-hypochondriac would attribute the same somatic sensations to non-pathological causes like overwork, insufficient rest, or dietary indiscretion whereas a hypochondriac would be severely alarmed by them. This only leads to greater somatic arousal and self-scrutiny, amplifying their bodily sensations further.

There are a number of explanations for the exaggeration of bodily symptoms seen in people with hypochondrias. One possibility is that these individuals are more sensitive to what is happening inside their bodies, such as their heart rate and other somatic processes.

Once physical sensations are perceived, hypochondriacs interpret the symptoms in terrible terms.

BDD involves a chain of similar cognitive distortions that begins with the belief that one has a significant physical defect. Not surprisingly these cognitive distortions leave people with this disorder, feeling depressed and anxious.

BDD may be associated with positive punishment in social learning terms.

Researchers are beginning to suspect that BDD might be part of a spectrum of disorders including obsessive compulsive disorder, eating disorder, trichotillomania, social phobia and certain personality disorders.

A familial pattern of somatoform disorders is often observed. Somatization disorder occurs in 10 to 20% of female first-degree biological relatives of women with this disorder, while their male relatives show an increased risk for anti-social personality disorders, drug abuse and alcoholism. Similarly, first-degree biological relatives of patients with somatoform pain disorders have higher incidences of painful illness, depression and alcoholism than the general population.

OVERCOMING SOMATOFORM DISORDERS

When working with people with somatoform disorders, clinicians must be mindful that such patients often suffer from anxiety and depression. It should therefore come as no surprise that treating the anxiety or depression often reduces the somatoform concerns (Noyes et al., 1986; Smith, 1992).

Cognitive and behavioral clinicians believe that the high levels of anxiety associated with disorders are linked to specific situations. Techniques such as exposure or any other cognitive therapies could address the fears, the reduction of which would help lessen somatic complaints.

But it is likely that more treatment would be needed, for a person who has been "sick" for a period of time has grown accustomed to weakness and dependency, to avoiding everyday challenges rather than facing them as an adult.

In general cognitive- behavioral approaches have proved effective in reducing hypochondiracal concerns. Aaron Beck's Cognitive Restructuring Therapy focuses on teaching individuals to restructure their maladaptive beliefs about their physical symptoms. Beck sees such beliefs as arising from faulty information-processing and faulty logic.

The aim of Beck's therapy is to identify the implicit and self- defeating assumptions depressed people make about themselves, change their validity and substitute more adaptive assumptions.

Cognitive behavioral group therapy can be used to treat body dysmorphic disorder. In this participants with the disorder give each other feedback about their actual appearance, can also be successful, as can training in behavioral methods, such as exposure therapy and relaxation.

Anxiolytics especially benzodiazepines and antidepressants have been used with varying results. The former lower the hyper-arousal of the autonomic system of these patients while depression may respond to the latter. Because they tend to be vigilant over any possible side effects e.g. constipation and dry mouth due to tricyclic antidepressants, a little explanation when prescribing will ensure better compliance with treatment.

AVERSION THERAPY

Aversion therapy is used with people who want to extinguish the pleasant feelings that are associated with socially undesirable behaviors. Aversion therapy pairs an unpleasant event with a desired but socially undesirable behavior. If this unpleasant event and desired behavior are repeatedly paired, the desired behavior will eventually come to elicit negative responses.

ASSIGNMENT

Mirror, mirror on the wall

90% of people with body dysmorphic disorder excessively check mirrors. Many hope it reflects their greatest wish: that they look normal. But for many it reflects their deepest fear: that some part of their body is defective and that everyone can see it.

(a) Describe what psychologists have found out about somatoform disorders. [8]

(b) Evaluate what psychologists have found out about somatoform disorders. [10]

(c) Giving reasons for your answer, suggest ways in which somatoform disorders may be overcome. [6]