Somatoform Disorders

Cornelia Pinnell, Ph.D.
Argosy University/Phoenix
Lecture Outline

- Hysteria & hysteria-like symptoms
- Somatic symptoms & somatization
- Somatoform disorders
Hysteria-like syndromes

- In premodern societies, hysteria-like syndromes are most likely to manifest in trance or spirit possession syndromes that include *somatic symptoms* & symptoms of:
  - Anxiety
  - Depression
  - Dissociation
Hysteria

- **South Asia:**
  - **Urban India** – emotional distress (e.g., following a social stressor such as a family argument) is likely to be experienced as an illness – convulsions, tremors, crying, shouts of abuse, amnesia; ‘fits’ of 30-60 minutes duration likely to occur 2x/month
  - **Rural India** - emotional distress is likely to be experienced as *spirit possession*; exorcism rituals would be performed with good outcome
Somatic symptoms

- The *somatization of anxiety* is very common among North American and British patients in primary care settings.

- Cross-cultural studies indicate that somatic symptoms are the most common clinical manifestations of anxiety disorders worldwide.
Somatization

- A tendency to seek medical attention out of proportion to evident physiological signs and symptoms (Fink et al., 1999)
- Transduction of unrecognized negative affect into somatic symptoms (e.g., unexplained pain) (Wickramasekera, 1988)
Somatoform Disorders

- **Common feature:**
  - Presence of physical symptoms that suggest a general medical condition but are not fully explained by a general medical condition, the direct effects of a substance, or by another mental disorder – *grouping based on clinical utility*
  - Symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning
Somatoform Disorders

- 300.81 Somatization Disorder
- 300.82 Undifferentiated Somatoform Disorder
- 300.11 Conversion Disorder
- 307.80 Pain Disorder Associated With Psychological Factors
- 307.89 Pain Disorder Associated With Both Psychological Factors & a General Medical Condition
- 300.7 Hypochondriasis
- 300.7 Body Dysmorphic Disorder
- 300.82 Somatoform Disorder NOS
Briquet’s Syndrome

- 1859 - Paul Briquet - first systematic description of hysteria
- 1962 - Perley & Guze systematized the diagnostic criteria for hysteria: 25 symptoms (anxiety, somatic, depressive and dissociative type symptoms) without medical explanation
- 1970 - Guze proposed the use of the term Briquet’s syndrome instead of ‘hysteria’
300.81 Somatization Disorder (aka ‘Hysteria’ or ‘Briquet’s Syndrome’)

- History of multiple physical/somatic complaints beginning before age 30; sx occur over a period of several years & result in seeking treatment or significant impairment

- *Each criterion must be met:*
  - 4 pain symptoms (different sites)
  - 2 gastrointestinal symptoms
  - 1 sexual symptom
  - 1 pseudoneurological symptom (e.g., conversion)
300.81 Somatization Disorder

- Patients describe their symptoms in exaggerated terms – specific factual information is absent; inconsistent historians
- Treatment sought for several conditions simultaneously – resulting in complicated treatment regimens (often hazardous)
- Comorbid anxiety & mood disorders (GAD Panic Disorder, Major Depressive Disorder)
300.81 Somatization Disorder

- **Prevalence:**
  - Variable lifetime prevalence rates: less than 0.2% in men & rates ranging between 0.2% and 2% in women (non-physician interviewers - lower rates)
  - Cultural factors may influence the sex ratio – higher prevalence rates in Greek and Puerto Rican men
300.81 Somatization Disorder

- **Course & Prognosis:**
  - Onset: first symptoms emerge in adolescence; full criteria met in young adulthood, before age 25
  - Chronic & fluctuating course
300.82 Undifferentiated Somatoform Disorder

Diagnostic criteria:

– A. One or more physical complaints (fatigue, loss of appetite, gastrointestinal, urinary)

– B. Either (1) or (2):
  • (1) No physical findings
  • (2) When there is a medical condition, physical complaints or impairment exceed expectations

– C. Sxs cause significant distress or impairment

– D. Duration of disturbance of at least 6 months
300.11 Conversion Disorder

- **Common symptoms:**
  - Amnesia
  - Paralysis
  - Impaired coordination or balance
  - Localized Anesthesia
  - Blindness, deafness, double vision
  - Hallucinations
  - Tremors
  - Seizures without medical explanations
300.11 Conversion Disorder

- **Diagnostic criteria:**
  - A. One or more sx or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition
  - B. Psychological factors are judged to be associated with the sx
  - C. Sx or deficit is not intentionally produced
  - D. Sx or deficit cannot be fully explained by a general medical condition
300.11 Conversion Disorder

- **Type of symptom or deficit:**
  - With Motor Symptom or Deficit
  - With Sensory Symptom or Deficit
  - With Seizures of Convulsions
  - With Mixed Presentation
300.11 Conversion Disorder

- **Differential diagnosis:**
  - Exclude occult neurological, other general medical conditions & substance-induced etiologies
  - *Pain Disorder* or *Sexual Dysfunction* are diagnosed if sxs are limited to pain/sexual dysfunction
  - Sxs may be due to another mental disorder (e.g., *Schizophrenia*, other *Psychotic Disorders*, *Mood Disorder*)
  - Hallucinations occur with intact insight; absence of other psychotic sxs; more sensory modalities
300.11 Conversion Disorder

• **Differential diagnosis:**
  - *Hypochondriasis* – preoccupation with a ‘serious disease’ underlying the sxs
  - In *Body Dysmorphic Disorder* the patient is preoccupied with an imagined or slight defect in appearance
  - Shared features with *Dissociative Disorder* – if both are present, both should be diagnosed
  - *Factitious Disorders & Malingering* – sxs are intentionally produced
Conversion Disorder symptoms typically result from:

- Emotional stress
- Exposure to traumatic events
Chronic pain

- Affects 34 million Americans
- Accounts for more than $40 billion in annual health care costs
Pain Disorder

- **Diagnostic criteria:**
  - A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation & is of sufficient severity to warrant clinical attention.
  - B. The pain causes clinically significant distress or impairment.
  - C. Psychological factors are judged to play an important role in the onset, severity, exacerbation, or maintenance of the pain.
  - Sxs or deficits are not intentionally produced.
Pain Disorder

- **Subtypes:**
  - 307.80 Pain Disorder Associated With Psychological Factors
  - 307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
    - code on Axis III

- **Specifiers:**
  - *Acute* – if the duration of pain is < 6 months
  - *Chronic* – if the duration of pain is > 6 months
Pain Disorder

• **Associated features:**
  – Severe disruption of aspects of daily life: unemployment, disability, family problems
  – Iatrogenic Opioid/Benzodiazepines Dependence or Abuse
  – Inactivity, social isolation
  – Severe depression & increased risk for suicide – in chronic pain
  – Anxiety – in acute pain
Etiology of Pain Disorder

- Wickramasekera, 1995 – Physiological activation in response to perceived threat places the individual at risk for development of somatic symptoms and illness.
  - High Risk Model of Threat Perception (HRMTP)
  - 9 predisposing, triggering, and buffering factors
High Risk Model of Threat Perception (HRMTP)

- **Predisposing factors**
  - High & low hypnotic ability
  - Repression
  - Catastrophizing
  - Negative affect

- **Triggering factors**
  - Real/perceived stressors (major life changes, daily hassles)

- **Buffering factors**
  - Social support & coping skills
Pain Disorder

- **Prevalence**: Relatively common – 10%-15% of adults in US have some form of work disability due to back pain

- **Course**:
  - Most acute pain resolves in relatively short periods of time
  - Recovery from Pain Disorder is influenced by participation in regularly scheduled activities despite the pain & change in lifestyle
Differential diagnosis in Pain Disorder

- If pain sx occur exclusively during the course of Somatization Disorder, Pain Disorder is not diagnosed.
- If presentation meets criteria for Dyspareunia, Pain Disorder is not diagnosed.
- In Conversion Disorder, sx are not limited to pain.
- Pain sx are intentionally produced or feigned in Factitious Disorder and Malingering.
International Association for the Study of Pain

- **Five-axis system** for categorizing chronic pain according to:
  1. Anatomical region
  2. Organ system
  3. Temporal characteristics of pain & pattern of occurrence
  4. Patient’s statement of intensity and time since onset of pain
  5. Etiology (*psychological* or *psychophysiological*)
300.7 Hypochondriasis

- **Diagnostic criteria:**
  - A. Preoccupation with fears of having a serious disease based on the person’s misinterpretation of bodily symptoms
  - B. Preoccupation persists despite appropriate medical evaluation & reassurance
  - C. The Belief in Criterion A is not of delusional intensity & not restricted to appearance
  - D. Causes clinically significant distress/impairment
  - E. Duration of disturbance of at least 6 months
300.7 Hypochondriasis

- **Specifier:**
  - *With Poor Insight* – if the person does not recognize during the current episode that the concern about having a serious illness is excessive or unreasonable
300.7 Body Dysmorphic Disorder

- **Diagnostic criteria:**
  - A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive
  - B. Causes clinically significant distress/impairment
  - C. The preoccupation is not better accounted for by another mental disorder
Phenomenology of Body Dysmorphic Disorder

- Intense preoccupation with an imagined or real, but minor defect of the physical appearance - focus is usually on one aspect of the body, but can shift during the course of the illness.
- Any part of the body can be the focus of concern, but most complaints are concerning aspects of the face or head (e.g. nose, hair thinning, acne, wrinkles, scars, facial asymmetry or disproportion, or excessive facial hair).
300.7 Body Dysmorphic Disorder

- **Differential diagnosis:**
  - Normal concerns about appearance
  - Body Dysmorphic Disorder *may be underrecognized in cosmetic surgery settings*
  - Body Dysmorphic Disorder is not diagnosed if the excessive preoccupation is restricted to concerns about fatness in Anorexia Nervosa or primary or secondary sex characteristics as in Gender Identity Disorder
300.7 Body Dysmorphic Disorder

**Differential diagnosis:**

- Healthy exercise vs. excessive exercise
- Major Depressive Episode - preoccupation that occurs exclusively during the episode
- Trichotillomania - does not occur in response to appearance concerns
300.7 Body Dysmorphic Disorder

Differential diagnosis:

- Avoidant Personality Disorder or Social Phobia-may worry about being embarrassed about real defects but it is not prominent, time consuming, impairing, or distressing
- Obsessive-Compulsive Disorder-given only when obsessions and compulsions are not restricted to concerns about appearance
Differential diagnosis:

- Persons with BDD can receive additional diagnosis of Delusional Disorder, Somatic Type, if preoccupation with “defect” is held with delusional intensity.

- *Koro* - culture related syndrome, preoccupation that the penis (or labia, nipples, or breast in women) is shrinking or retracting and will disappear in abdomen.
Behaviors Associated with Body Dysmorphic Disorder

- Comparing with others
- Checking the defect directly or in mirrors
- Excessive grooming (e.g., hair cutting, makeup application, shaving, hair styling)
- Seeking reassurance or attempting to convince others of the "defect's" ugliness
- Skin picking, dieting, excessive exercising, steroid abuse
- Camouflaging (e.g., with a hat, clothes, or makeup)
Etiology of BDD

- The cause of BDD is unknown - the pathophysiology of BDD may involve serotonin.
- Cultural concerns about appearance may influence or amplify preoccupations with an imagined "defect".
- Commonly coexists with other mental disorders (e.g. major depressive episode, anxiety disorder, and a psychotic disorder).
Sociocultural Factors

- Family, friends, societal and cultural norms, media, religion
- Culture affects what is considered the ideal of beauty - for example, plumpness or thinness (standards of beauty change over time)
- The value placed on beauty in a culture
Universal beauty (evolutionary)

The “universalist” point of view is that cultures provide nuances to a basically invariant, or universal, standard of beauty

– Unblemished skin and facial symmetry
Cultural Variations in BDD

- BDD affects men and women almost equal cross-culturally
- Similar behaviors present in BDD, such as mirror checking and camouflaging
- Men in the U.S. focus on hair or overall body build
- Asians have more preoccupations with the eyelids
Body Dysmorphic Disorder Examination (BDDE)

- 32 item clinical interview, measures cognitive and behavioral symptoms of BDD
- Looks into the self-consciousness and preoccupation with physical appearance, overvalued ideas about the importance of appearance in self-evaluation, avoidance of social situations or exposure of the appearance defects, and body camouflaging and body checking behavior

Rosen, Reiter, & Orosan, 1995
Treatment

- Pharmacotherapy- serotonin specific drugs have been useful in some cases in reducing symptoms: clomipramine (Anafranil) and fluoxetine (Prozac)
- Cognitive behavioral body image therapy- group and/or individual therapy, useful for persons with various degrees of body image disorder
Somatoform Disorder NOS

- **Pseudocyesis**
  - False belief of being pregnant, associated with objective signs of pregnancy (e.g., abdominal enlargement, reduced menstrual flow, amenorrhea, subjective sensations of fetal movement, nausea, breast engorgement & secretions, labor pains at the expected date of delivery)
  - Endocrine changes may be present
300.82 Somatoform Disorder NOS

- A disorder involving nonpsychotic hypochondriacal symptoms of less that 6 months duration

- A disorder involving unexplained physical complaints (e.g., fatigue or body weakness) of less than 6 months’ duration that are not due to another mental disorder
Neurasthenia

- 1860s, George Miller Beard – ‘nervous exhaustion’

- **Epidemiology**: Cultural differences – It is one of the most commonly diagnosed disorders in China (the Chinese use physical sxs as cultural idioms to express emotional distress)

- **Etiology** – depletion theory (due to stress)
Neurasthenia

- **Clinical features:**
  - Chronic weakness & fatigue
  - Aches and pains
  - General anxiety
  - Nervousness
  - Irritability
Chronic Fatigue Syndrome

- **Epidemiology:** approx. 1/1,000; female to male ratio 2:1; ages 20-40

- **Etiology:** unknown

- **Clinical features:** various physical symptoms
Treatment of Neurasthenia and Chronic Fatigue Syndrome

- Medical workup
- Supportive psychotherapy
- CBT
- Analgesics for symptomatic treatment of pain