SOMATOFORM DISORDERS

Introduction

Somatoform disorders encompass several mental health disorders in which people report physical symptoms or concerns that suggest but are not explained by a physical disorder or report a perceived defect in appearance. These symptoms or concerns cause significant distress or interfere with daily functioning.

Somatoform disorder is a relatively new term for what many people used to refer to as psychosomatic disorder. In somatoform disorders, the physical symptoms cannot be explained by any underlying physical disease. In some cases of somatoform disorders, a physical disease is present that might explain the occurrence but not the severity or duration of the physical symptoms. People with somatoform disorders are not faking illness; they sincerely believe that they have a serious physical problem.

The most commonly diagnosed somatoform disorders are somatization disorder, conversion disorder, hypochondriasis, body dysmorphic disorder, and pain disorder. The individual people who are diagnosed with a somatoform disorder vary greatly. Treatment approaches also vary according to which somatoform disorder a person has.

Body Dysmorphic Disorder

In body dysmorphic disorder, a preoccupation with a perceived defect in appearance results in significant distress or impaired functioning.

People with body dysmorphic disorder believe they have a defect in appearance that in reality is nonexistent or slight. The disorder usually begins in adolescence and is believed to occur in men and women equally.

Symptoms

Symptoms may develop gradually or abruptly, vary in intensity, and tend to persist without treatment. Concerns commonly involve the face or head but may involve any body part or several parts and may change from one body part to another. A person may be concerned about hair thinning, acne, wrinkles, scars, colour of complexion, or excessive facial hair. Or a person may focus on the shape or size of a body part, such as the nose, eyes, ears, mouth, breasts, or buttocks. Some young men with athletic builds think that they are puny and obsessively try to gain weight and muscle.

Most people with body dysmorphic disorder have difficulty controlling their preoccupation and spend hours each day thinking about their perceived defect. Many people check themselves often in mirrors, others avoid mirrors, and still others alternate between the two behaviours. Most try to camouflage their imagined defect—for example, by growing a beard to hide "scars" or by wearing a hat to cover "thinning" hair. Many undergo medical, dental, or surgical treatment, sometimes repeatedly, to correct their perceived defect, which may intensify their preoccupation.

Because people with body dysmorphic disorder feel self-conscious, they may avoid appearing in public, including going to work and participating in social activities. Some leave their homes only at night; others not at all. This behaviour can result in social isolation. Distress and dysfunction associated with the disorder can lead to repeated hospitalization and suicidal behaviour.

Diagnosis and Treatment

Because people with body dysmorphic disorder are reluctant to reveal their symptoms, the disorder may go undiagnosed for years. It is distinguished from normal concerns about appearance because it is time-consuming and causes significant distress or impairs functioning.

Information regarding effective treatment is limited. Treatment with serotonin reuptake inhibitors, a class of antidepressants, is often effective. Cognitive-behaviour therapy may also diminish symptoms.

Conversion Disorder

In conversion disorder, physical symptoms that are caused by psychological conflict are unconsciously converted to resemble those of a neurological disorder.

Conversion disorder, once referred to as hysteria, is caused by psychological stress and conflict, which people with this disorder unconsciously convert into physical symptoms. Although conversion disorder tends to occur during adolescence or early adulthood, it may first appear at any age. The disorder is generally believed to be somewhat more common in women than in men.

Symptoms and Diagnosis

The symptoms of conversion disorder are limited to those that suggest a nervous system dysfunction—usually paralysis of an arm or leg or loss of sensation in a part of the body. Other symptoms may include simulated seizures and the loss of one of the special senses, such as vision or hearing.

Generally, the onset of symptoms is linked to some distressing social or psychological event. A person may have only a single episode in his lifetime or sporadic episodes, but usually the episodes are brief. If people with conversion symptoms are hospitalized, they generally improve within 2 weeks. However, 20 to 25% of those people who are hospitalized have recurrences within a year, and for some people, symptoms become chronic.

The diagnosis tends to be initially difficult for a doctor to make because the person believes that the symptoms stem from a physical problem and does not want to be seen by a therapist. Also, doctors take great care to be certain no physical disorder is responsible for the symptoms. Thus, the diagnosis is usually considered only after extensive physical examinations and tests fail to reveal a physical disorder that can fully account for the symptoms.

Treatment

A trusting doctor-patient relationship is essential. As the doctor evaluates a possible physical disorder and reassures the person that the symptoms do not indicate a serious underlying disease, the person usually begins to feel better and the symptoms fade. When a psychologically distressing situation has preceded the onset of symptoms, psychotherapy can be particularly effective.

Various treatment methods have been tried. Although some may be helpful, none of them have been uniformly effective. In one method, hypnotherapy, the person is hypnotized, and psychological issues that may be responsible for the symptoms are identified and discussed. Discussion continues after the hypnosis, when the person is fully alert. Another (rarely used) method is narcoanalysis, a procedure similar to hypnosis except that the person is given a sedative to induce a state of semisleep. Behaviour therapy, including relaxation training, has also been effective for some people.

Hypochondriasis

Hypochondriasis is a disorder in which a person is preoccupied with the fear of having a serious disease.

Hypochondriasis occurs most commonly between the ages of 20 and 30 and appears to affect both sexes equally. Some people with hypochondriasis also have depression or anxiety.

In hypochondriasis, the person's concerns about having a serious disease are often based on a misinterpretation of normal bodily functions. Examination and reassurance by a doctor do not relieve their concerns; people with hypochondriasis tend to believe that the doctor has somehow failed to find the underlying disease.

Symptoms and Diagnosis

Hypochondriasis is suspected when a healthy person with minor symptoms is preoccupied with the significance of those symptoms and does not respond to reassurance after thorough evaluation. Personal relationships and work performance often suffer as the person becomes increasingly concerned with health issues. The diagnosis of hypochondriasis is confirmed when the situation persists for at least 6 months and the person's symptoms cannot be attributed to depression or another mental health disorder.

Treatment

Treatment is difficult, because a person with hypochondriasis is convinced that something inside the body is seriously wrong. Reassurance does not relieve these concerns. However, a trusting relationship with a caring doctor is beneficial, especially if regular visits are scheduled. If the person's symptoms are not adequately relieved, the person may benefit from referral to a therapist for further evaluation and treatment, along with continuation of the primary doctor's care. Treatment with serotonin reuptake inhibitors, a class of antidepressants, may be effective. Cognitive-behaviour therapy may also relieve symptoms.

Somatization Disorder

Somatization disorder is a chronic, severe disorder characterized by many recurring physical symptoms, particularly some combination of pain and digestive, sexual, and neurological symptoms, that cannot be explained by a physical disorder.

Somatization disorder often runs in families and occurs predominantly in women. Male relatives of women with the disorder tend to have a high incidence of socially disapproved behaviour (antisocial personality) and substance-related disorders. People with somatization disorder tend to also have personality disorders and exaggerated dependence on others (dependent personality).

The physical symptoms that people with somatization disorder experience appear to be a way of communicating a plea for help and attention. The intensity and persistence of the symptoms reflect the person's intense desire to be cared for in every aspect of life. The symptoms may also serve other purposes, such as allowing the person to avoid the responsibilities of adulthood. The symptoms tend to be uncomfortable and prevent the person from engaging in many enjoyable pursuits, suggesting that the person also suffers feelings of worthlessness and guilt.

Symptoms

Symptoms appear first in adolescence or early adulthood. A person with somatization disorder has many vague physical complaints, often described as "unbearable," "beyond description," or "the worst imaginable." Any part of the body may be affected, and specific symptoms and their frequency vary among different cultures. Typical symptoms include headaches, nausea and vomiting, abdominal pain, diarrhoea or constipation, painful menstrual periods, fatigue, fainting, pain during intercourse, and loss of sexual desire. Men frequently complain of erectile or other sexual dysfunction. Anxiety and depression also occur.

People with somatization disorder increasingly demand help and emotional support and may become enraged when they feel their needs are not being met. In an attempt to manipulate others, they may threaten or attempt suicide. Often dissatisfied with their medical care, they go from doctor to doctor.

Diagnosis

People with somatization disorder are not aware that their basic problem is psychological, so they press their doctors for diagnostic tests and treatments. The doctor usually conducts many physical examinations and tests to determine whether the person has a physical disorder that adequately explains the symptoms. Referrals to specialists for consultations are common, even if the person has developed a reasonably satisfactory relationship with one doctor.

Once a doctor determines that the problem is psychological, somatization disorder can be distinguished from similar mental health disorders by its many symptoms and their tendency to persist over a period of years. Adding to the diagnosis are the dramatic nature of the complaints and the person's dependent and sometimes suicidal behaviour.

Prognosis and Treatment

Somatization disorder tends to fluctuate in severity but persists throughout life. Complete relief of symptoms for an extended period is rare. Some people become more depressed after many years. Suicide is a risk.

Treatment is extremely difficult. People with somatization disorder tend to be frustrated and angered by any suggestion that their symptoms are psychological. Therefore, doctors cannot deal directly with the problem as a psychological one, even when they recognize it. Drug therapy does not help much, and even if the person agrees to a mental health consultation, specific psychotherapeutic techniques are not likely to be beneficial. Usually, a person with this disorder is best helped by a trusting relationship with a doctor, who can offer symptomatic relief and protect the person from very costly and possibly dangerous diagnostic or therapeutic procedures. However, the doctor must remain alert to the possibility that the person may develop an actual physical disorder.