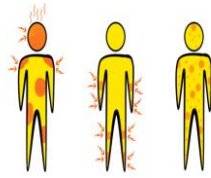


Somatic Symptom Disorders



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Characteristics of SSD

Defined by the **presence** of physical symptoms suggestive of a medical problem

Symptoms cannot usually be attributed to any underlying medical problem

Individuals genuinely believe they have a medical problem

Symptoms cause significant distress or impairment of social or occupational functioning

Important to differentiate true disorders from “malingering”

2

The diagnosis & characteristics of somatic symptom disorders

Somatic symptom disorder

Illness anxiety disorder

Conversion disorder

Factitious disorder

3

DSM-5 criteria for somatic symptom disorder

One or more somatic symptoms that are distressing or result in significant disruption of daily life.

Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

- Disproportionate and persistent thoughts about the seriousness of one's symptoms.
- Persistently high levels of anxiety about health or symptoms.
- Excessive time and energy devoted to these symptoms or health concerns.

Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

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Characteristics of somatic symptom disorder

Multiple, current, somatic symptoms that are distressing or result in significant disruption to daily life

Symptoms can either be specific (e.g. localizable pain) or nonspecific (e.g. general fatigue)

Sufferers often seek medical attention for their symptoms, but are particularly unresponsive to medical interventions

Somatic symptom disorder is also closely associated with other psychiatric diagnoses such as anxiety disorders and major depression

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Main DSM-5 criteria for illness anxiety disorder

Preoccupation with having or acquiring a serious illness

Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g. strong family history is present), the preoccupation is clearly excessive or disproportionate

There is a high level of anxiety about health, and the individual is easily alarmed about personal health status

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Characteristics
of illness
anxiety disorder

Preoccupation with having or acquiring a serious, undiagnosed illness –especially when somatic symptoms are either not present or only mild

The distress is largely generated by beliefs about the meaning, significance or cause of a symptom

Seeking medical reassurance about health status

Sufferers are also prone to intrusive thoughts about illness, death and dying and usually catastrophise their symptoms

Illness anxiety disorder differs from its diagnostic predecessor hypochondriasis significantly

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DSM-5
criteria for
conversion
disorder

One or more symptoms of altered voluntary motor or sensory function.

Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

The symptoms or deficit is not better explained by another medical or mental disorder.

The symptom or deficit causes clinical significant distress or impairment in social, occupational, or other important areas of functioning.

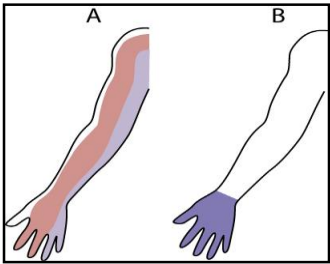
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Characteristics
of conversion
disorder

- Common symptoms are paralysis, impaired balance, localized motor function weaknesses
- Common sensory symptoms are loss of touch or pain, double vision, blindness, deafness
- Sufferers do not appear to intentionally produce these symptoms
- Sufferers seem to be largely philosophical about their symptoms (*la belle indifférence*)
- Symptoms usually develop in adolescence or early adulthood
- Lifetime prevalence rate is around 1% and is more common in women than in men (Maldonado & Spiegel, 2003)

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Glove anaesthesia



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DSM-5
criteria
for
factitious
disorder

Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.

The individual presents himself or herself to others as ill, impaired or injured.

The deceptive behaviour is evident even in the absence of obvious external rewards.

The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

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DSM-5
criteria for
factitious
disorder
imposed
by
another

Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.

The individual presents another individual (victim) to others as ill, impaired or injured.

The deceptive behaviour is evident even in the absence of obvious external rewards.

The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

Note: The perpetrator, not the victim, receives the diagnosis

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The aetiology of SSD

- Psychodynamic interpretations
- Consciousness & behaviour
- Life stress, childhood abuse & anxiety
- Learning approaches
- Cognitive factors
- Sociocultural approaches
- Biological factors

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Key questions

- Are physical symptoms a manifestation of underlying psychological conflict and stress?
- Are physical symptoms generated in an involuntary fashion?
- What is the role of life stress and childhood abuse in the development of somatoform disorders?
- How do sufferers acquire the biased thinking and dysfunctional beliefs typical of somatoform disorders?

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Psychodynamic interpretations

- Basic psychodynamic view of somatoform disorders is one of conflict resolution
- Distressing memories, inner conflict, anxiety etc. is repressed in consciousness and expressed as somatic symptoms
- Psychodynamic theorists also view those suffering from somatoform disorders as regressing to the state of the sick child (e.g., Kuechenoff, 2002)
- The psychodynamic *conflict-resolution model* is that physical symptoms provide relief from distressing psychological symptoms (Temple, 2002)

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Consciousness & behaviour

- In conversion disorder and somatic symptom disorder, sufferers appear to generate symptoms in an involuntary fashion
- Experimental studies suggest that individuals with conversion disorder are not performing in exactly the same way as individuals with genuine disabilities (e.g. Theodor & Mandelcorn, 1973)
- Individuals with conversion disorder are similar to the effects of disability caused by *hypnosis* (Oakley, 1999)
- Some somatoform disorders may result from a form of *self-hypnosis*

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Life stress, childhood abuse & anxiety

- A history of trauma or abuse or significant periods of stress and anxiety are found in the history of individuals with somatoform disorders
- However, such a history is not a *necessary* condition for the development of a somatoform disorder
- The psychodynamic conflict-resolution model is one that views early negative experiences as central to the development of somatoform disorders

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Learning approaches

- Some sufferers may have learnt to express negative feelings in terms of physical symptoms (Tezzi et al., 2001)
- Expressing symptoms of physical illness may be reinforced by parents (e.g., Latimer, 1981)
- Many individuals may learn to adopt a sick role which enables them to opt out of dealing directly with life stressors

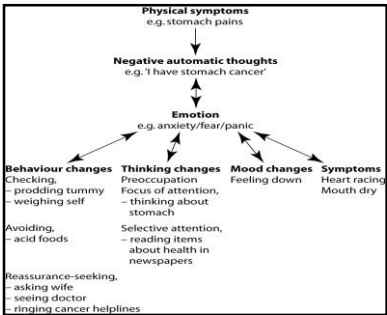
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Cognitive factors

- Sufferers often develop *thinking and information processing biases* that lead them to believe they have medical problems
- Individuals with illness anxiety disorder also have a *reasoning bias* that leads them to seek information to support their views (Smeets et al., 2000)
- Individuals with somatic symptom disorders may also have a memory bias towards remembering and retrieving illness relevant material

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A cognitive model of illness anxiety disorder



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Dysfunctional beliefs

Dysfunctional beliefs in SSD (*rogue representations*) can be created by experiences that include:

- A history of physical illness that leads to interpreting any bodily sensation as a symptom of illness
- A history of experiencing emotional states that have strong physical manifestations
- Exposure to physical illness in others

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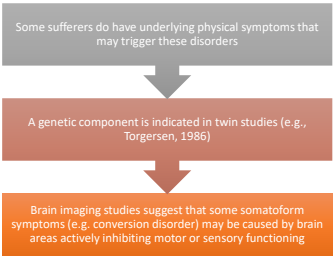
Sociocultural approaches

Cultural differences will affect the nature and prevalence of somatoform disorders (e.g. whether physical illness is seen as an acceptable way of expressing distress)
Socioeconomic standards affect prevalence rates
Some symptoms (e.g. conversion disorder) can be 'contagious' and affect a number of people in a single social setting (e.g. Cassidy et al., 2005)

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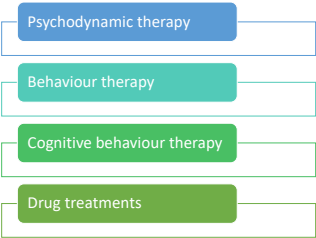


Biological factors



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Treatments & Approaches



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Treating SSD

Many sufferers believe they have medical problems rather than psychological ones and so are often resistant to psychological treatment

SSD are highly comorbid with other psychiatric disorders, making treatment complex

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Behaviour therapy

Some somatoform disorders are developed through processes of learning

Learning principles address:

- The reinforcing function of attention given to individuals
- Continuous checking for physical signs of illness or deformity, which are prominent in illness anxiety disorder and somatic symptom disorder

Behavioural stress management (to reduce worrying and catastrophizing about symptoms)

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Psychodynamic therapy

Psychodynamic approaches take the view that somatoform disorders result from the repression of anxiety and distressing memories

Psychodynamic therapy adopts procedures designed to bring these repressed memories into consciousness

Meta-analyses have shown that psychodynamic therapy for somatoform disorders is more effective than no treatment (Leichsenring, 2005)

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Behaviour therapy

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Cognitive behavioural therapy

Sufferers often develop reasoning biases, negative thought patterns, dysfunctional beliefs that maintain symptoms and can be treated with CBT

CBT is an important treatment for illness anxiety disorder

Randomised control trials (RCTs) indicate that CBT for somatic symptom disorders is significantly more effective at treating symptoms than normal medical care

Initial results of studies using mindfulness-based cognitive therapy (MCBT) indicate the effects of mindfulness may be favourably comparable to those of CBT

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Drug treatments

Because SSD are often comorbid with anxiety and depression, anxiolytic and antidepressant drugs can be used to reduce symptoms

Use of SSRIs to treat comorbid depression does have a positive effect on somatoform symptoms (Hollander et al., 1999)

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SSD are all characterized by psychological problems manifesting as physical symptoms

Causes of SSD appear to be related to life stress, anxiety and a history of conflict or abuse

In many cases somatic symptoms are maintained by cognitive biases and dysfunctional beliefs which can be treated with CBT
