Somatoform Disorders

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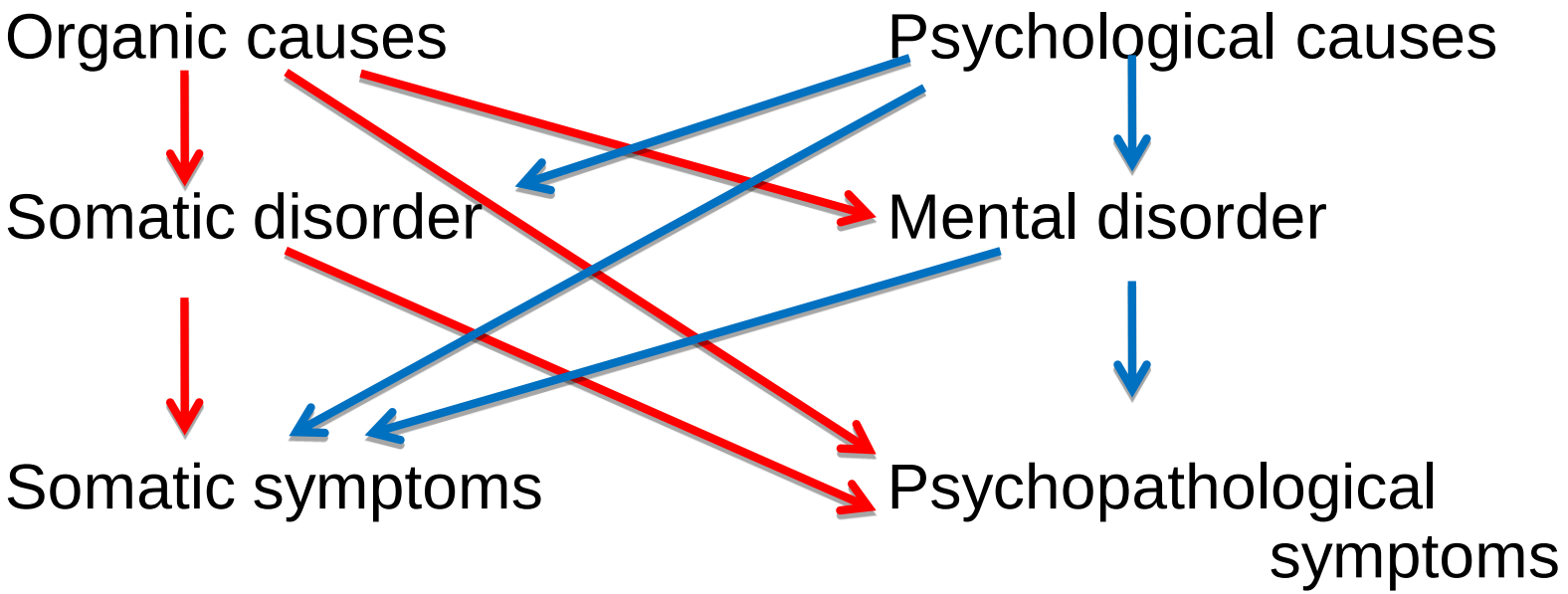
Etiology – symptoms - disorders

- Etiological complexity (ekvi- and multifinality)
  - Most of chronic medical disorders have komplex psychological and pathophysiological background
  - SYMPTOMS ≠ DISORDER



The spectrum of illness in the clinical practise

	Soma-tic d.	Psycho-somatic d.	Somato-form d.	Organic mental d.	Mental d.
Main symp-toms	Somatic	Somatic	Somatic	Psychic	Psychic
Physio-logical abnor-malities	√	√	–	√	–
Psycho-logical factors	–	√	√	–	√

Introduction – what about neurosis?

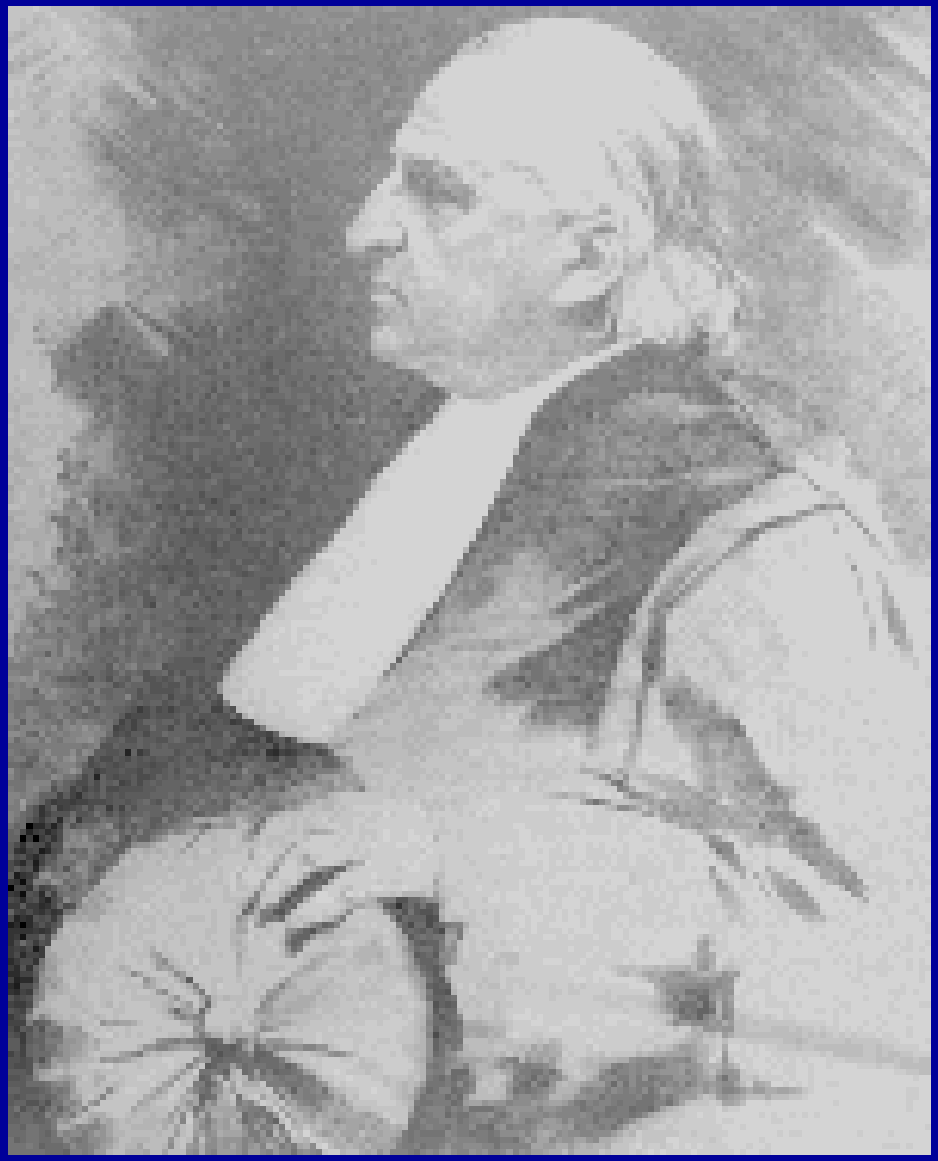
- Big changes in the modern diagnostic classification systems – not included the terms of neurosis and hysteria
- These terms are existing in everyday usage (mostly negative)
- Many neurotic people can be found in the clinical practise – it cause many problems in the doctor-patient relationship (crux medicorum)
- Mostly it has a chronic course - great burden for patients and health care system as well
- It is necessary changing of the medical paradigm
  - real symptoms and suffering without clinical abnormalities
  - not a somatic-organic, but psychological background

Historical aspects

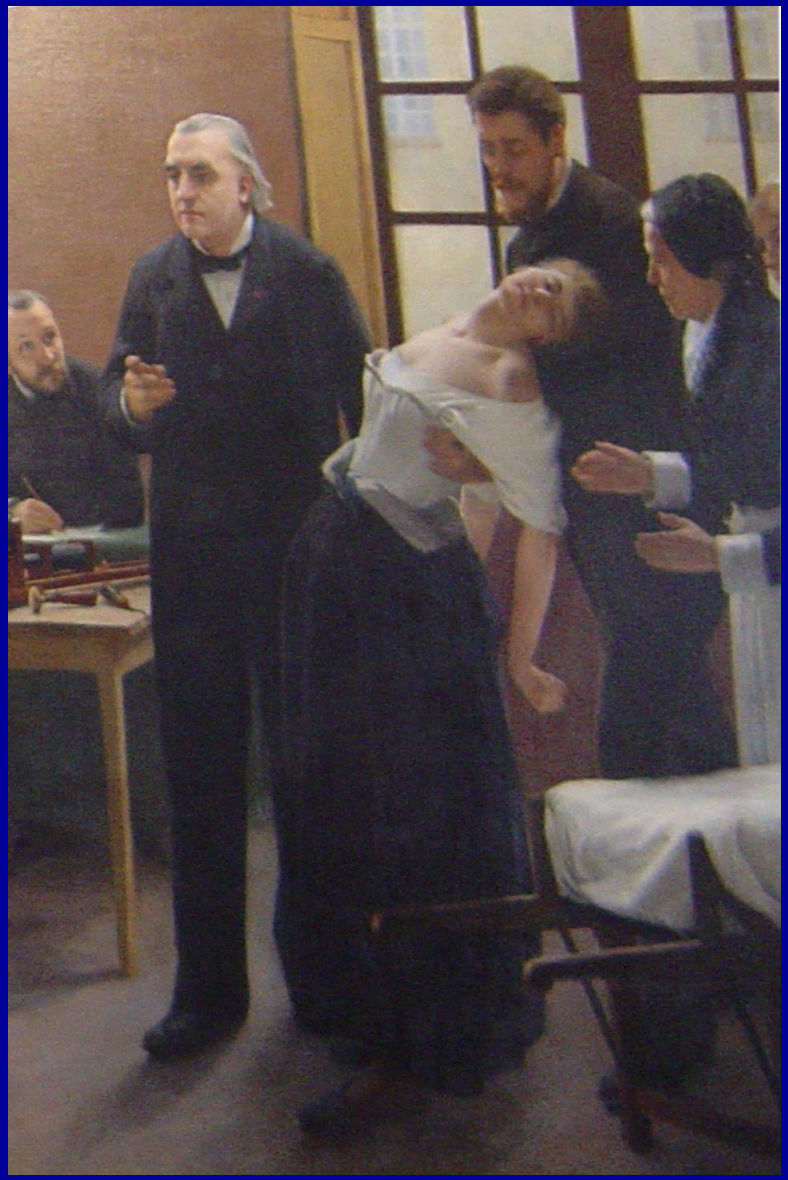
- Moving of „Hystera” to different parts of the body
- B.C. 1900 – Egypt
- The moving of uterus was seen as the cause of hysteria

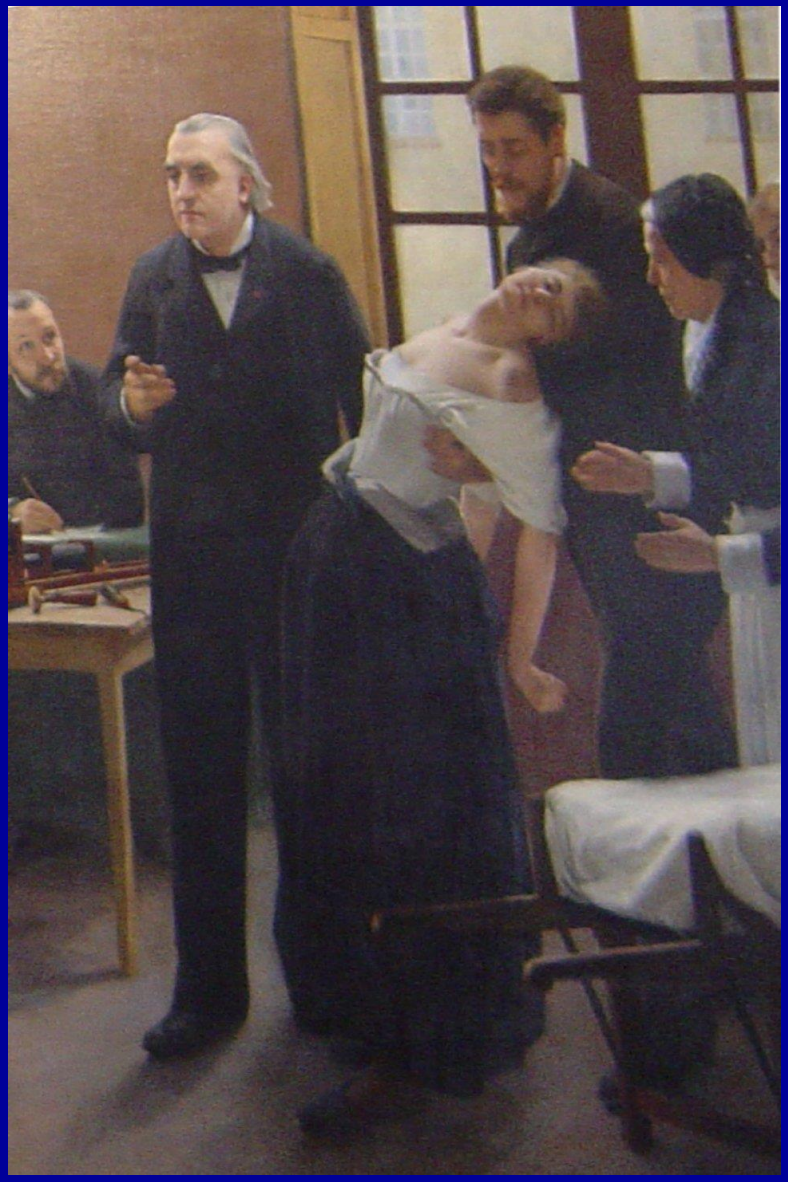
History of neurosis

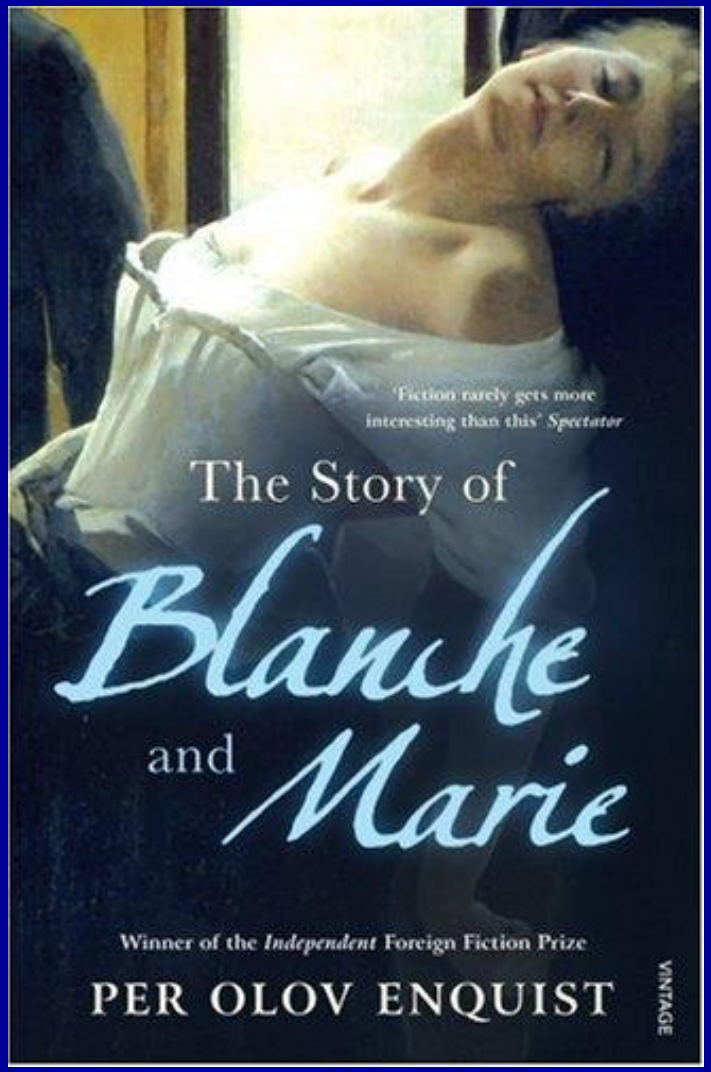
- Ancient age – hysteria - hypochondria
- XVIII.c.: neurosis — McCullen
- XIX. c.: NEURASTHENIA (irritability – fatigue) — Beard
- PSZICHASTHENIA (anxiety, obsession, depression) — P. Janet
- HYSTHERIA (hyperexpressivity – suggestibility) — Briquet
- HIPOCHONDRIA — Sydenham
- Freud: actuall neurosis psychoneurosis
- DSM- III (1980), DSM-IV (1995): neurosis és hysteria excluded – classification based on main symptomps
- ICD-10.: phobias, panic, OCD, dissociative (conversion), somatoform d.



Jean-Martin Charcot






'Fiction rarely gets more interesting than this' *Spectator*
The Story of
Blanche
and
Marie
Winner of the *Independent* Foreign Fiction Prize
PER OLOV ENQUIST
VINTAGE

In Andrè Brouillet's famous painting of neurologist **Jean-Martin Charcot's lecture on female hysteria**, a woman is draped over Charcot's assistant's arm. She is placid and completely sensual in the cold room; her dress has fallen from her shoulders and a nurse reaches out to help her as she swoons. This woman is **Blanche Wittman**, the favorite hysteria patient of Charcot, the head of the women's psychiatric hospital. Brouillet's painting was the only existing image of Blanche Wittman until Per Olov Enquist's new novel, *The Book About Blanche and Marie*.

The Book About Blanche and Marie.

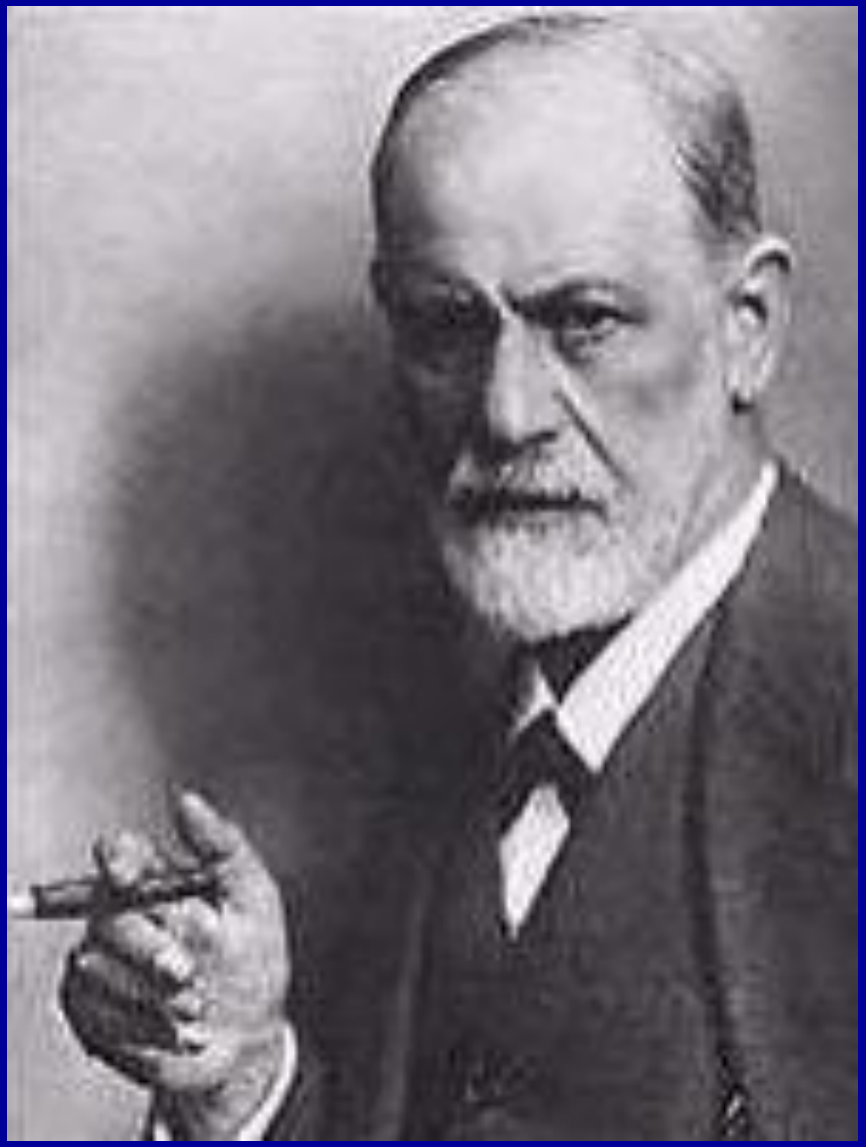
Marie Curie, the two-time Nobel Prize winner and scientist who hired Blanche to work in her laboratory, supplies the other half of the title.

The Marie in this book, a blend of historical fact and outright fiction, is Marie Skłodowska Curie, a scientist who, with her husband Pierre, discovered the elements polonium and radium, and twice won the Nobel Prize. Blanche refers to Blanche Wittman, who came to be Marie's assistant, after having spent a number of years **in Salpêtrière Hospital in Paris for her "hysteria," in the care of Dr. Jean-Martin Charcot**.

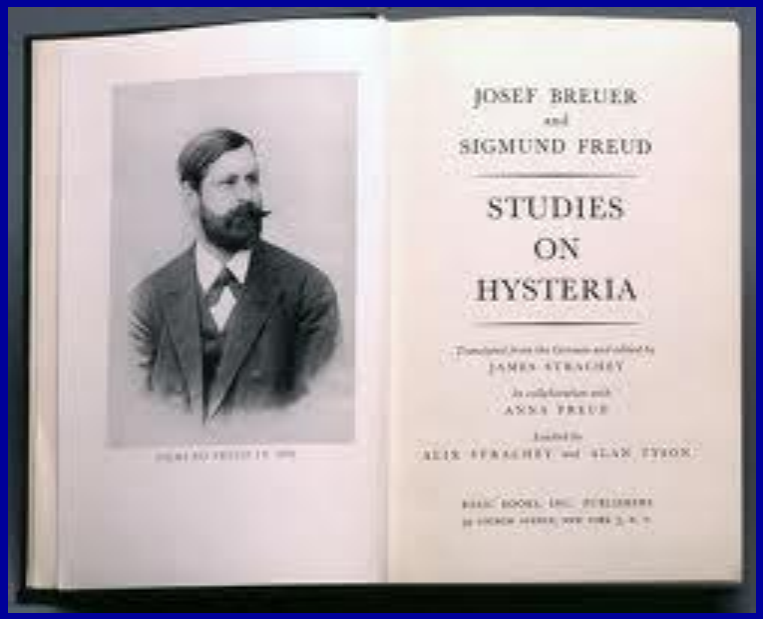
Blanche's "cure" was based on the rather odd belief at the time in stimulating/manipulating women's ovaries and other lady parts. Blanche was Charcot's favorite "performer," and the cover of this novel is a piece of a famous painting by André Brouillet that shows Blanche during one of her public "treatments."

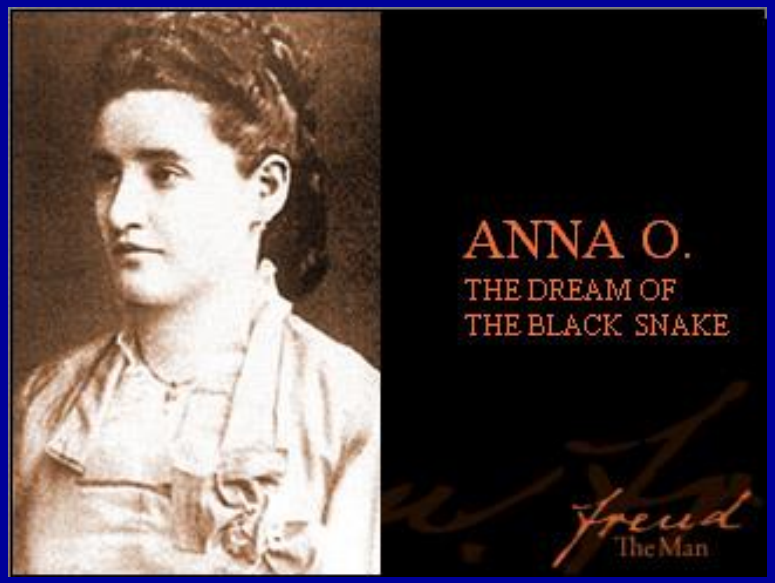
Neurotic symptoms

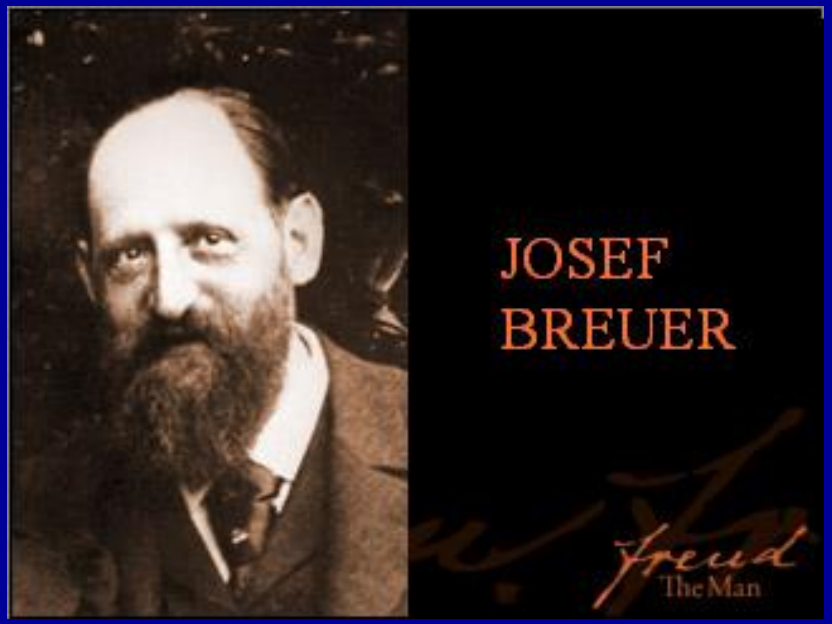
- Symptoms cause worrying and suffering for the patients
- Could not explained by organic abnormalities
- Chronic and recurrent (may be in other form)
- Not limited only external stresses
- Reality testing is intact
- Symptoms are not under intentional control
- The origin of symptoms is in the past history of personality
- The patient awares the illness – behaves like other patients, who suffers in somatic disorder

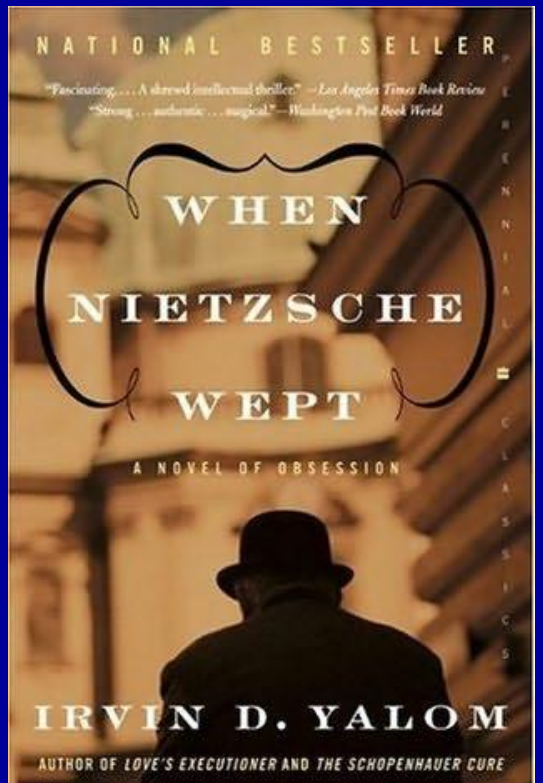


Sigmund Freud

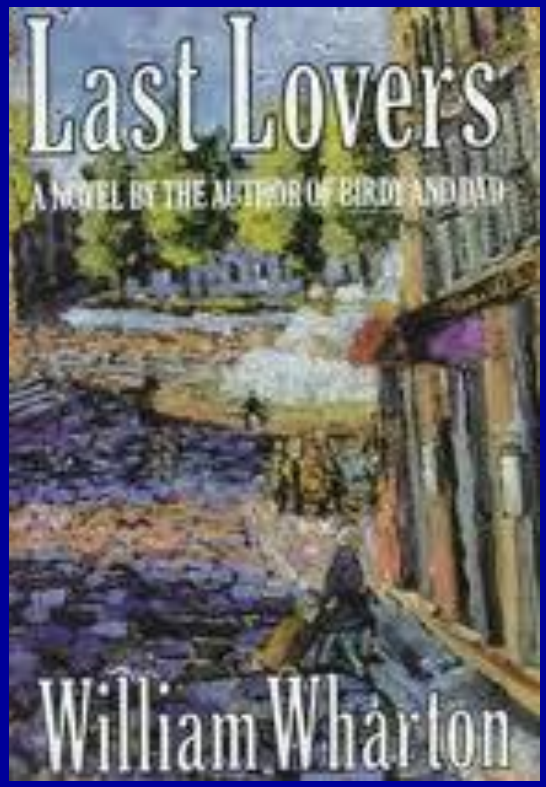

JOSEF BREUER
and
SIGMUND FREUD
STUDIES
ON
HYSTERIA
JAMES STRACHEY
ANNA FREUD
ALIX STRACHEY and ALAN TYSON


ANNA O.
THE DREAM OF
THE BLACK SNAKE
Freud
The Man


JOSEF
BREUER
Freud
The Man

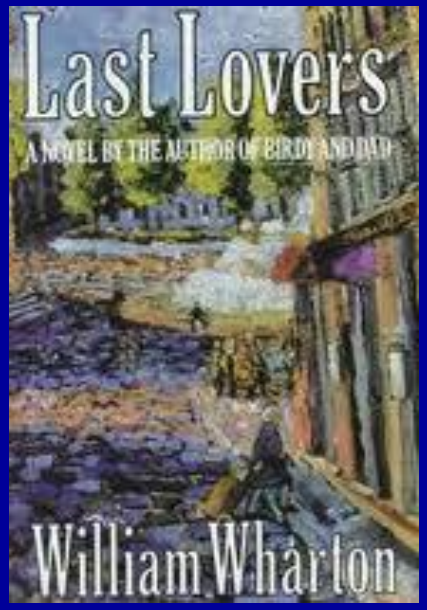

NATIONAL BESTSELLER
"Fascinating. . . . A shrewd intellectual thriller." —Los Angeles Times Book Review
"Strong . . . authentic . . . magical." —Washington Post Book World
WHEN
NIETZSCHE
WEPT
A NOVEL OF OBSESSION
IRVIN D. YALOM
AUTHOR OF LOVE'S EXECUTIONER AND THE SCHOPENHAUER CURE

A middle-aged man abandons his corporate life to follow his dream to become a painter. On the way, he develops an unlikely but beautiful relationship with an older woman.



Jack is a middle-aged American living as a squatter in a Paris attic. He paints in a public square and sells his work to survive. There he meets Mirabelle, a blind, 71-year-old, self-appointed pigeon lady who cares for the birds who flutter about his easel. Between Jack and Mirabelle springs a friendship that deepens into an improbable but impassioned love affair.

This love story, by the author of Birdy and Dad, is set in Paris in 1975. Jack, 49, and American, has walked out on his fast-lane corporate career and troubled marriage to return to his first love, painting. He lives a hand-to-mouth existence in Paris, struggling to express his long-suppressed feelings through his art. While painting in the park (and blocking the sidewalk), an elderly blind woman walks into him, knocking him off his feet and getting herself smeared with paint. Mirabelle, 71, is small, elegant, and radiant.



They fall slowly, carefully, and improbably in love, and into a tender physically passionate affair. While Mirabelle's tremendous sense of life inspires Jack to paint with new vision and freedom, he shares with her the mysteries of passion, and **frees her from the traumatic event that blinded her in childhood**.

Psychological background of neurosis I.

- Social learning theory – parents are (bad) models
- Familiar and cultural background – beliefs and misconceptions
- Cognitive distortion – the symptoms is life-threatening (i.e. pain in heart, tachicardia – anxiety – mortal fear – vegetative hyperactivity – anxiety, etc.)
- Parental maltreatment – reinforcing the sick role
- Secondary and tertiary gains – avoiding extreme expectations
- Hypersensitivity for normal somatic sensations
- Symptoms = illness = worrying → take medical advice
- Refusing the psychological origin of symptoms

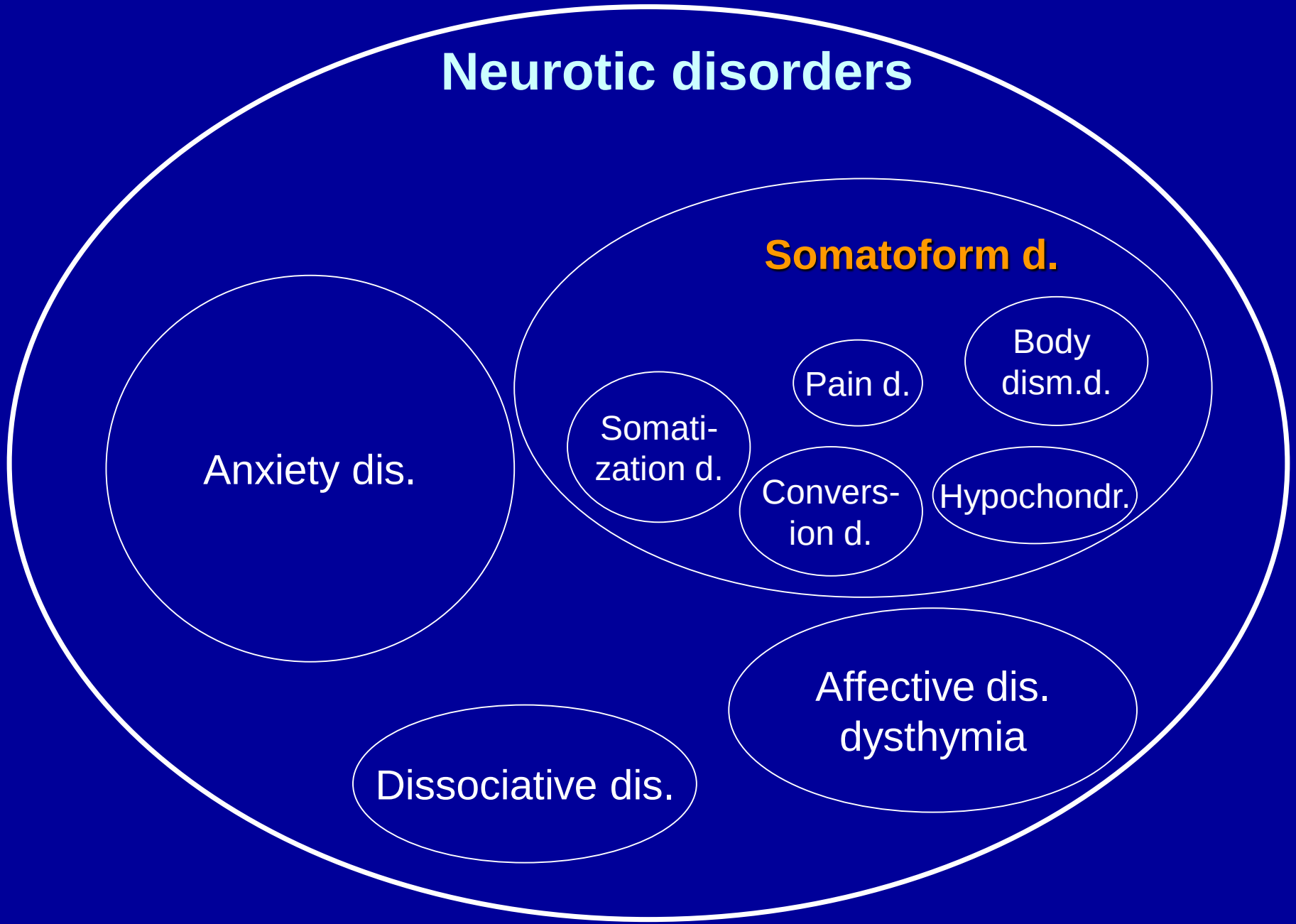
Psychological background of neurosis II.

- Psychoanalitic approach – repressing of unconcious intrapsychic conflict and conversion of anxiety into a physical symptom (Freud, Breuer – Case of Anna O.)
  - bad compromise between the instictual impulse (e.g. aggression or sexuality) and prohibitions againts its expression
  - the patient can avoid consciously confronting their unacceptable impulses (primary gain)

- „le belle indifférence” – inappropriate passive attitude toward serious symptoms
- Conversion – „ the symptom as symbol” (of conflict)
- Somatization – „the symptomatology has not got symbolic meaning”

Main conclusion

- **Basic feature – alexithymia – inability to or difficulty in describing or being aware of emotions**
- **No connection between feelings and somatic sensations**
- **Anxiety, panic phobia, obsession, somatisation are consequence of psychological - emotional problems**
- **Neurotic behavior is learned from parents**
- **The inappropriate, inadequate behavior can be corrected by cognitive-behavior therapy**


Neurotic disorders
Somatoform d.
Anxiety dis.
Somati-
zation d.
Pain d.
Body
dism.d.
Convers-
ion d.
Hypochondr.
Affective dis.
dysthymia
Dissociative dis.

Definition of somatoform disorder

- Psychological-psychiatric disorder
- The basic mechanism is the somatisation
- The main symptoms are somatic
- Organic abnormalities could not diagnose
- No intentional control of symptoms
- Some psychological factors are in connection with complaints
- Patients mostly refused the psychological origin
- Not simple to refer to psychiatrist

Classification – DSM IV.-TR

- Somatization disorder
- Undifferentiated somatoform disorder
- Conversion disorder
- Pain disorder
- Hypochondriasis
- Body dysmorphic disorder
- Somatoform disorder not elsewhere classified

- Factitious disorder
- Malingering

Main differences of classification I.

Table 1 – Diagnostic categories regarding somatoform disorders in DSM-5 and DSM-IV

DSM-5	DSM-IV
Somatic symptom disorder	Somatization disorder Undifferentiated somatoform disorder Pain disorder Hypochondriasis
Illness anxiety disorder	Hypochondriasis
Conversion disorder (functional neurological symptom disorder[a])	Conversion disorder
Psychological factors affecting other medical conditions	Psychological factors affecting other medical conditions
Body dysmorphic disorder[b]	Body dysmorphic disorder
Factitious disorder[c]	Factitious disorder
Other specified/unspecified somatic symptom and related disorder	Somatoform disorder not otherwise specified

[a] Not part of the somatoform disorders in DSM-IV.

Main differences of classification II.

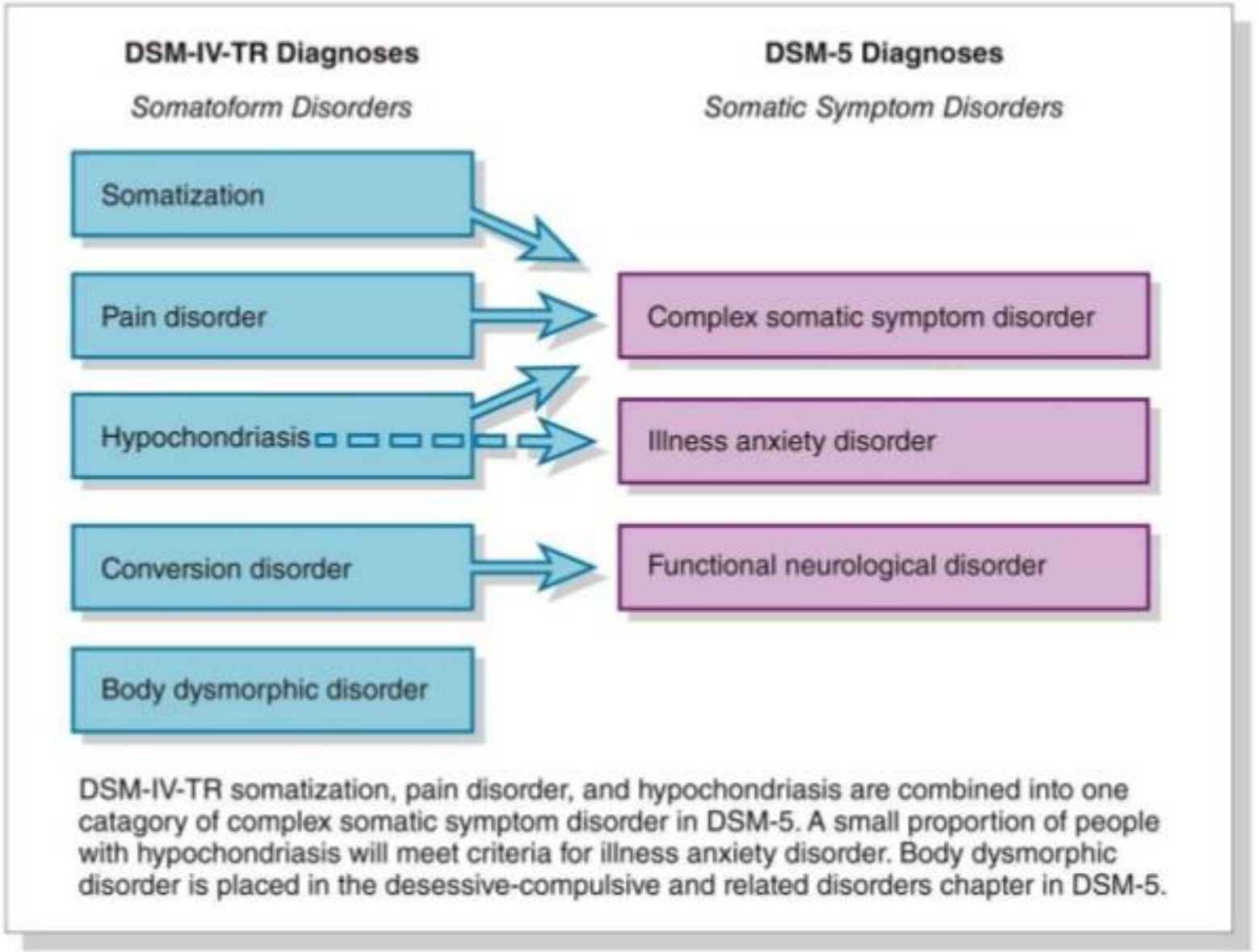


Figure 8.3

TABLE 1.

DSM-5 Somatic Symptom and Related Disorders

Somatic symptom disorder

Preoccupation and/or anxiety/worry related to having one or more somatic symptoms, with or without a concurrent medical condition

Illness anxiety disorder

Preoccupation with having a serious illness with mild to no somatic symptoms or excessive concern in the presence of an illness

Conversion disorder

Unexplained and potentially incompatible physical symptoms that mimic a neurological or general medical condition unexplained by an actual medical or other mental health condition

Psychological factors affecting other medical conditions

Factors adversely impacting the course, impact, or presentation of an established medical condition

Factitious disorder

An attempt to deceptively present the self or another with physical or mental symptoms in the absence of apparent external motivation

Other specified somatic symptom and related disorder

Somatic symptoms not meeting criteria for any of the previous diagnoses

Unspecified somatic symptom and related disorder

Somatic symptoms not meeting criteria for any of the previous diagnoses, used in rare situations when there is insufficient information to establish a more explicit diagnosis

Abbreviation: DSM-5, The Diagnostic and Statistical Manual of Mental Disorders, *fifth edition.*
Adapted from DSM-5.[1]

Table 8.2 Diagnoses of Somatic Symptom and Related Disorders

Proposed DSM-5 Diagnosis	Description	Likely Key Changes in DSM-5
Complex somatic symptom disorder	Somatic symptom(s) Excessive thoughts, feelings, and behaviors related to somatic symptoms	• Symptoms do not have to be medically unexplained • Pain is now a specifier, not a separate diagnosis
Illness anxiety disorder	Unwarranted fears about a serious illness despite absence of any significant somatic symptoms	• New diagnosis
Functional neurological disorder	Neurological symptom(s) that cannot be explained by medical disease or culturally sanctioned behavior	• Name of disorder changed from conversion disorder • Removed criterion that the clinician establish that the patient is not feigning symptoms • Removed criterion that psychological risk factors be apparent • Emphasized the importance of neurological testing
Malingering	Intentionally faking psychological or somatic symptoms to gain from those symptoms	
Factitious disorder	Falsification of psychological or physical symptoms, without evidence of gains from those symptoms	

Table 8.2

DSM 5 Criteria for Somatic Symptom Disorder

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

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

1) Disproportionate and persistent thoughts about the seriousness of one's symptoms.

2) Persistently high level of anxiety about health or symptoms.

3) Excessive time and energy devoted to these symptoms or health concerns.

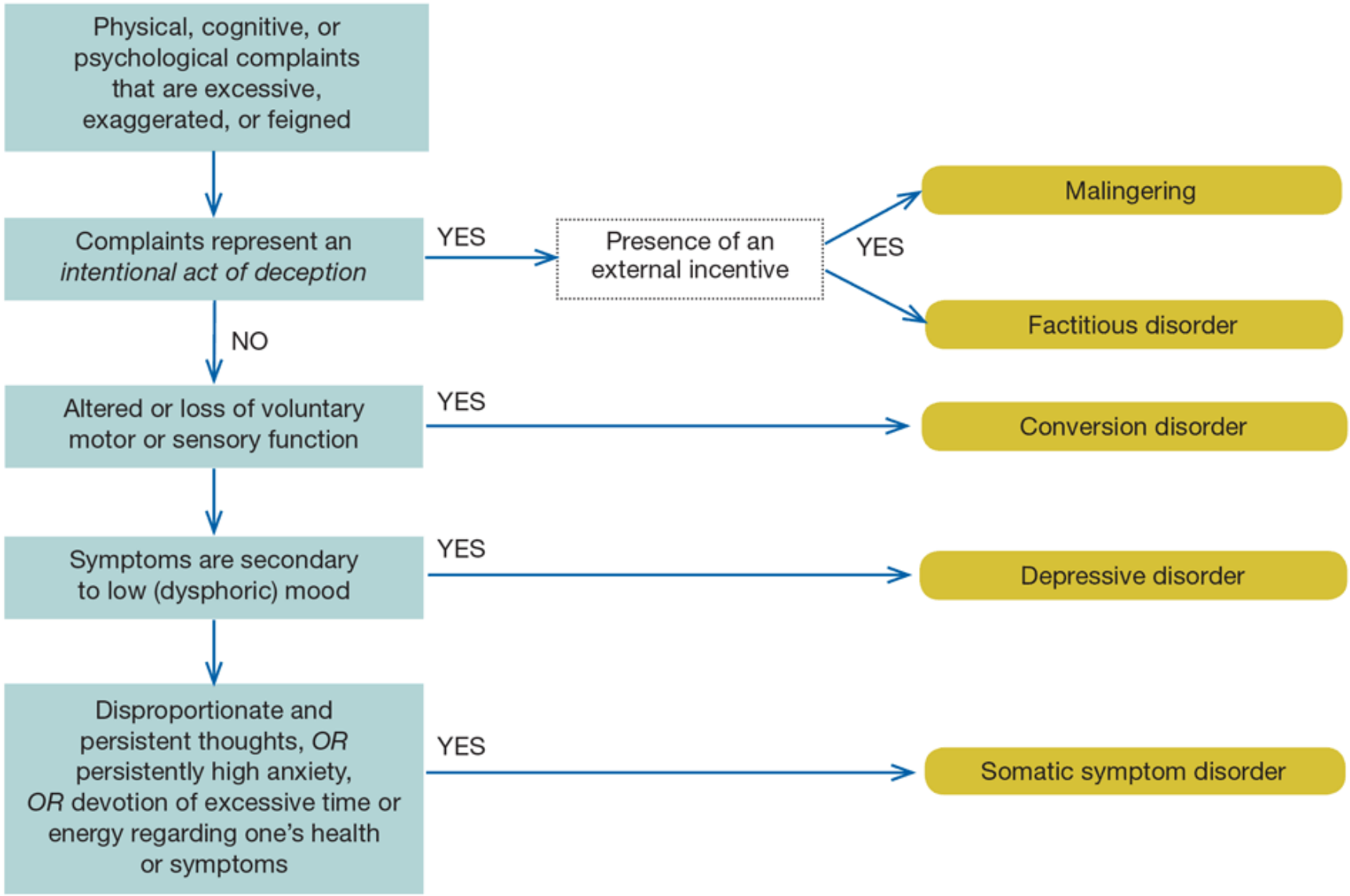
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent - more than 6 months.

American Psychiatric Association ((APA) (2013). *Diagnostic and Statistical Manual of Mental Disorders*. (5th ed.) Washington, DC: American Psychiatric Association Press. p. 309–27.

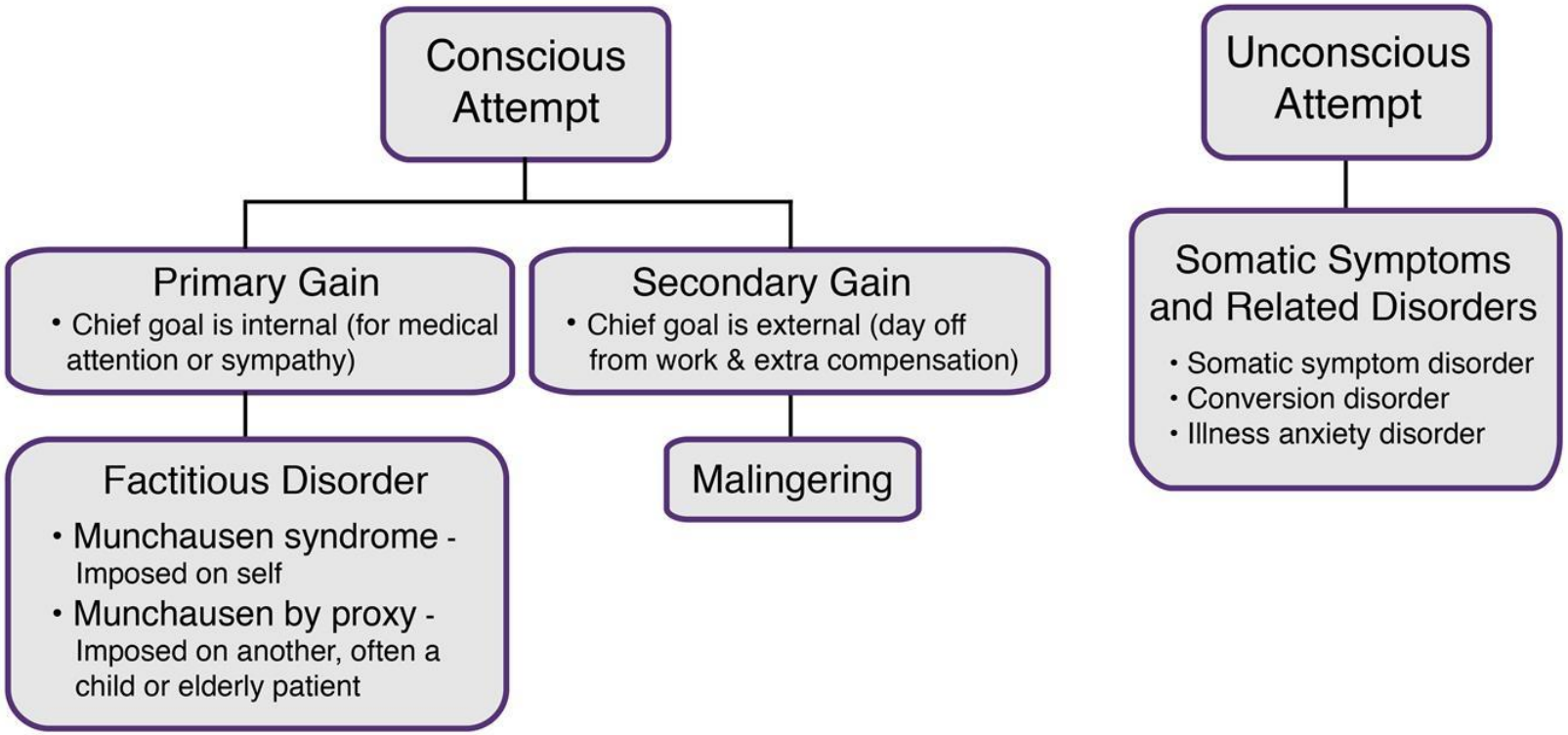
Table 2 – Andrew's symptoms as they relate to DSM-5 criteria for somatic symptom disorder

Criteria	Symptoms
A: ≥ 1 somatic distressing symptoms	Somatization disorder Undifferentiated somatoform disorder Pain disorder Hypochondriasis
B1: Disproportionate and persistent symptom-related thoughts	• "This will never end; I cannot trust my body anymore" • "How can I continue living with this burden?" • "I know that my doctor says that everything is alright with me, but what if he has overlooked something?" • "There has to be a reason for my symptoms—I need to find a doctor who can help me" • "This pain is ruining my quality of life—how much longer can I bear it?"
B2: Persistent high level of health-/symptom-related anxiety	• Patient experiences anxiety, hopelessness, and despair • Anxiety that doctors have overlooked a severe cardiac disorder
B3: Excessive time/energy spent on symptoms/health	The following illness behaviors cost the patient a lot of time: • Every time pain intensifies, patient looks for a calm place, rests, and focuses his attention on his body; measures blood pressure and heart rate several times a day • Several medical consultations every month • Ruminations about symptoms: distraction and concentration deficits
C: Duration ≥ 6 months	Symptoms have lasted 8 years

Figure. Differential diagnosis of malingering, factitious disorder, and selected related disorders



Differential Diagnosis for Suspicious Symptoms



Lucy Liu

Most important differences

Disorder	Symptom production	Motivation
Somatoform disorders	Non-intentional	Unconscious
Factitious disorders (Münchausen syn.)	Intentional	Unconscious motivation to sick role
Malingering	Intentional	Obvious, recognizable enviromental goal

The most important viewpoints of diff.dg.

	Symptoms without Identifiable Cause			
	Gain	Deliberate	Psychiatric Disorder	Agrees to Procedures
Malingering	External	✓		
Factitious Disorder	Sick Role	✓	✓	✓
Somatization			✓	✓

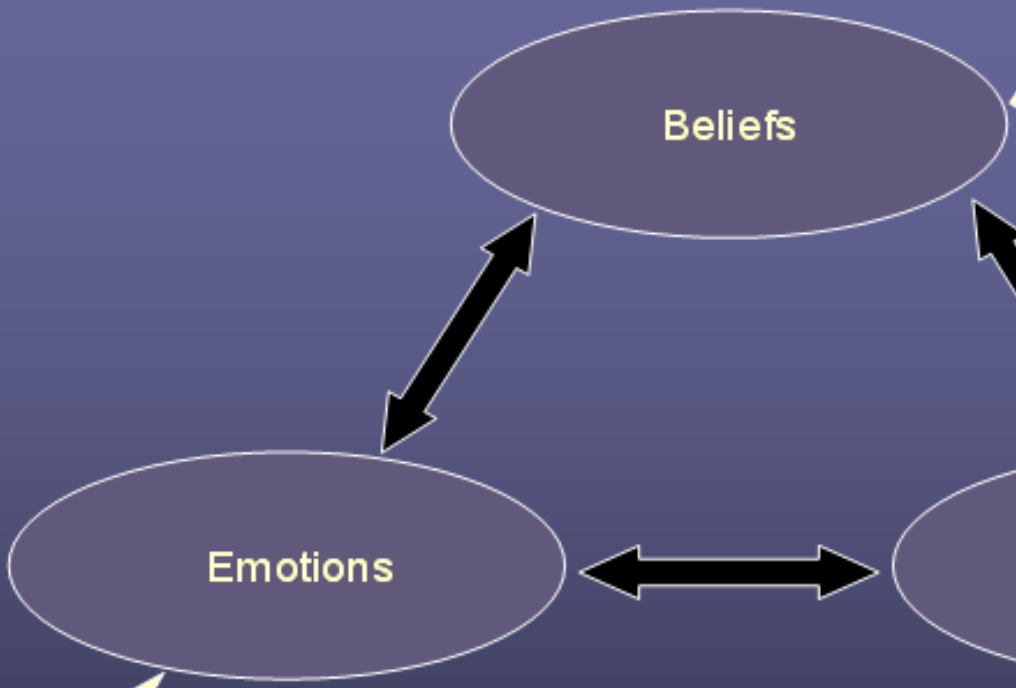
1.com

Malingering

HYR 1

- Psychiatrically healthy
- **External/secondary gain**
- **Deliberate**
- Get what they want → symptoms disappear
- **Unwilling to undergo painful test**

Diagram Showing How Beliefs May Interact With Emotions & Behaviours in Somatoform Disorders



Example beliefs:

"Activity makes my symptoms worse"

"I'm always going to be unwell"

"This illness is untreatable"

"People must think I'm disabled"

"I feel useless having all these problems"

Example emotions:

Sad

Angry

Overwhelmed

Hopeless

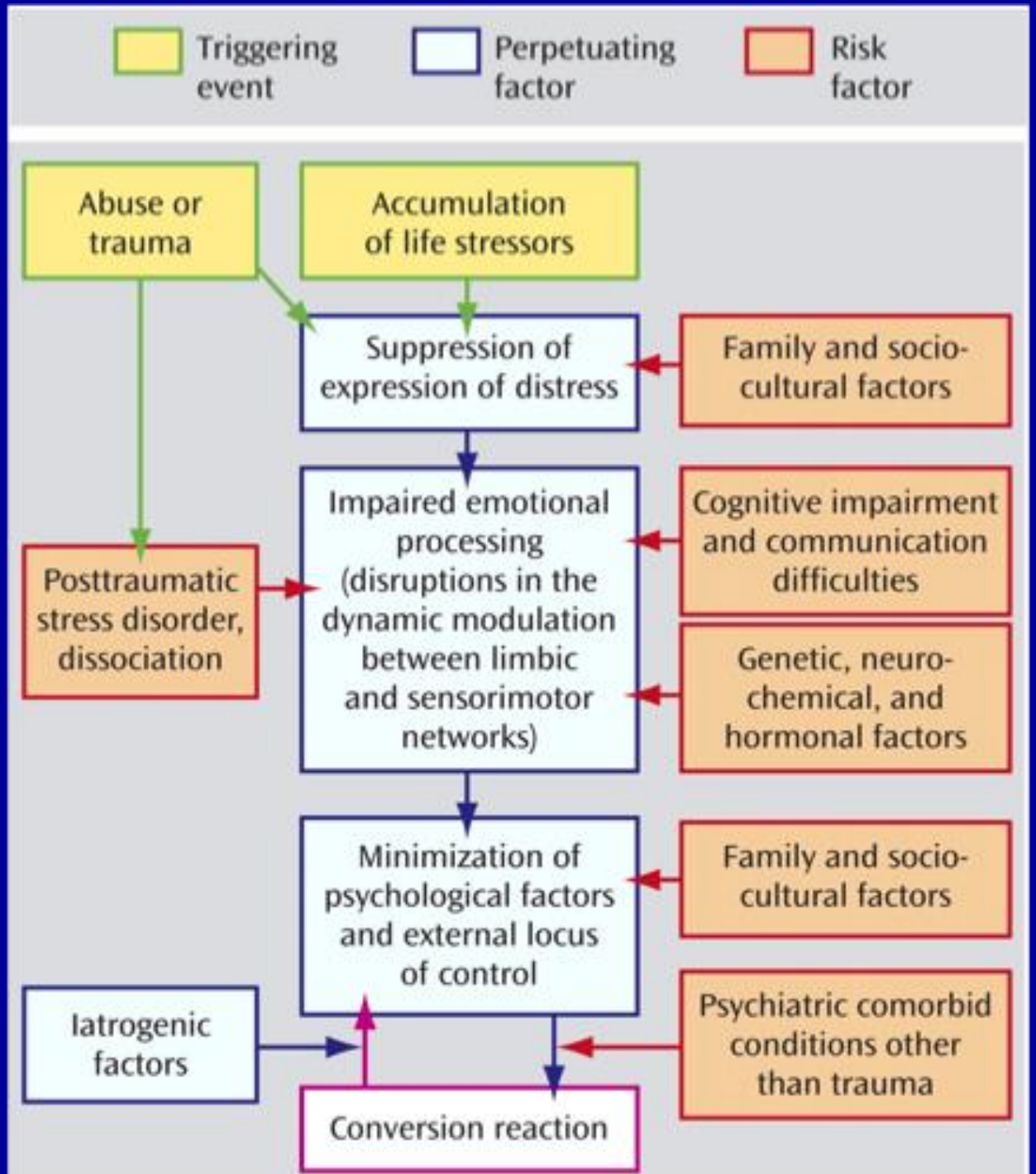
Example behaviours:

Avoids all exercise

Avoids social events

Repeatedly checks self for new symptoms

Asks family if they agree she/he looks ill


Triggering event
Perpetuating factor
Risk factor
Abuse or trauma
Accumulation of life stressors
Suppression of expression of distress
Family and socio-cultural factors
Posttraumatic stress disorder, dissociation
Impaired emotional processing (disruptions in the dynamic modulation between limbic and sensorimotor networks)
Cognitive impairment and communication difficulties
Genetic, neuro-chemical, and hormonal factors
Minimization of psychological factors and external locus of control
Family and socio-cultural factors
Iatrogenic factors
Psychiatric comorbid conditions other than trauma
Conversion reaction

Main clinical features I.

Table 17–1
Clinical Features of Somatoform Disorders

Diagnosis	Clinical Presentation	Demographic and Epidemiological Features	Diagnostic Features	Management Strategy	Prognosis	Associated Disturbances	Primary Differential Presentation	Psychological Processes Contributing to Symptoms	Motivation for Symptom Production
Somatization disorder	Polysymptomatic Recurrent and chronic Sickly by history	Young age Female predominance 20 to 1 Familial pattern 5–10% incidence in primary care populations	Review of systems profusely positive Multiple clinical contacts Polysurgical	Therapeutic alliance Regular appointments Crisis intervention	Poor to fair	Histrionic personality disorder Antisocial personality disorder Alcohol and other substance abuse Many life problems Conversion disorder	Physical disease Depression	Unconscious Cultural and developmental	Unconscious psychological factors
Conversion disorder	Monosymptomatic Mostly acute Simulates disease	Highly prevalent Female predominance Young age Rural and low social class Little-educated and psychologically unsophisticated	Simulation incompatible with known physiological mechanisms or anatomy	Suggestion and persuasion Multiple techniques	Excellent except in chronic conversion disorder	Alcohol and other substance dependence Antisocial personality disorder Somatization disorder Histrionic personality disorder	Depression Schizophrenia Neurological disease	Unconscious Psychological stress or conflict may be present	Unconscious psychological factors
Hypochondriasis	Disease concern *or* preoccupation	Previous physical disease Middle or old age Male-female ratio equal	Disease conviction amplifies symptoms Obsessional	Document symptoms Psychosocial review Psychotherapeutic	Fair to good Waxes and wanes	Obsessive-compulsive personality disorder Depressive and anxiety disorders	Depression Physical disease Personality disorder Delusional disorder	Unconscious Stress—bereavement Developmental factors	Unconscious psychological factors

Main clinical features II.

Table 17–1
Clinical Features of Somatoform Disorders

Diagnosis	Clinical Presentation	Demographic and Epidemiological Features	Diagnostic Features	Management Strategy	Prognosis	Associated Disturbances	Primary Differential Presentation	Psychological Processes Contributing to Symptoms	Motivation for Symptom Production
Body dysmorphic disorder	Subjective feelings of ugliness or concern with body defect	Adolescence or young adult ? Female predominance Largely unknown	Pervasive bodily concerns	Therapeutic alliance Stress management Psychotherapies Antidepressant medications	Unknown	Anorexia nervosa Psychosocial distress Avoidant or obsessive-compulsive personality disorder	Delusional disorder Depressive disorders Somatization disorder	Unconscious Self-esteem factors	Unconscious psychological factors
Pain disorder	Pain syndrome simulated	Female predominance 2 to 1 Older: 4th or 5th decade Familial pattern Up to 40% of pain populations	Simulation or intensity incompatible with known physiological mechanisms or anatomy	Therapeutic alliance Redefine goals of treatment Antidepressant medications	Guarded, variable	Depressive disorders Alcohol and other substance abuse Dependent or histrionic personality disorder	Depression Psychophysiological Physical disease Malingering and disability syndrome	Unconscious Acute stressor and developmental Physical trauma may predispose	Unconscious psychological factors

Adapted from Folks DG, Ford CV, Houck CA. Somatoform disorders, factitious disorders, and malingering. In: Stoudemire A, ed. *Clinical Psychiatry for Medical Students*. Philadelphia: JB Lippincott; 1990:233.

Diagnostic Criteria for Somatization Disorder I.

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

(2)two gastrointestinal symptoms

(3)one sexual symptom

(4)one pseudoneurological symptom

Diagnostic Criteria for Somatization Disorder II.

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 resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

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

Somatization dis.– dg. and course

- Chronic, recurrent, diffuse and inconsistent complaints
- Adeloscent age – under 30 ys.
- Long, complicated medical history („big and heavy binder”)
- Circumstantial, imprecise communication
- The main topic – the illnesses (sickness identitity)
- Emotional and interpersonal problems, psychosocial distress
- Difficult therapy – aims:
  - strong relationship with one doctor
  - to avoid additional examines and decreasing hospitalisation
  - to increase awareness of psychological factors
  - to facilitate the expression of emotions
  - careful psychopharmacological treatment – comorbid depr. etc

Somatization dis.– diff.dg.

- Anxiety/depression: 1-2 somatic sympt., acut beginning, short duration
- Panic: somatic symptoms during attacks
- Hypochondriasis: fear of (fatal) illness, misinterpretation of bodily functions, older age
- Conversion: 1-2 main symptoms
- Pain dis.: 1-2 pain symptoms

Diagnostic Criteria for Conversion Disorder I.

A. One or more symptoms 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 symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.

C. The symptom or deficit is not intentionally produced or feigned (as in factitious disorder or malingering).

Diagnostic Criteria for Conversion Disorder II.

D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behavior or experience.

E. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

F. 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.

Table 17–3
Common Symptoms of Conversion Disorder

Motor symptoms	Sensory deficits
Involuntary movements	Anesthesia, especially of extremities
Tics	Midline anesthesia
Blepharospasm	Blindness
Torticollis	Tunnel vision
Opisthotonos	Deafness
Seizures	**Visceral symptoms**
Abnormal gait	Psychogenic vomiting
Falling	Pseudocyesis
Astasia-abasia	*Globus hystericus*
Paralysis	Swooning or syncope
Weakness	Urinary retention
Aphonia	Diarrhea

Courtesy of Frederick G. Guggenheim, M.D.

Conversion dis.– symptomatology

General:

• Sudden, acute onset

• Lack of concern about the symptoms

• Unexplainable motor or sensory function impairment

Motor:

•Impaired coordination or balance and/or bizarre gait pattern

•Paralysis or localized weakness

•Loss of voice, difficulty swallowing, or sensation of a lump in the throat

•Urinary retention

Sensory:

•Altered touch or pain sensation (paresthesia or dysesthesia)

•Visual changes (double vision, blindness, black spots in visual field)

•Hearing loss (mild-to-profound deafness) – OR hallucinations

•Seizures or convulsions

•Absence of significant laboratory findings

•Electrodiagnostic testing within normal limits

•Deep tendon reflexes within normal limits

Conversion dis.– dg. and therapy

- The problems does not conform to current concepts of the anatomy or physiology of the central and peripherial nervous system
- The association between the cause of the neurological symptoms and psychological factors
- Frequent comorbid medical diseases
- Thorough medical and neurological examination!
- Treatment: psychotherapy
  - psychodynamic approach – explore intapsychic conflict

Diagnostic Criteria for Pain Disorder

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in factitious disorder or malingering).

E. The pain is not better accounted for by a mood, anxiety, or psychotic disorder and does not meet criteria for dyspareunia.

Pain dis.– psychodynamic factors

- **May be symbolically expressing an psychiatric conflict through the body**
- **Legitimate claim to the fulfillment of dependency needs**
- **Perceived sin, expiation of guilt, supressed aggression**
- **Pain as a method to obtain love**
- **Heterogeneous symptomatology**

  - low back pain, headache, atypical facial pain, chronic pelvic pain, others

Pain dis.– features

- **Long history of medical and surgical care - many type of medication (abuse!)**
- **Focus on pain - deny emotional problems**
- **Generally begins abruptly and gradual increase the severity**
- **Treatment – long term - rather rehabilitation**
- **Doctor must fully understand that the patient’s experiences of pain are real**
- **Discuss the role of psychological factors**

Pain dis.– treatment

- **Psychoeducation – the mechanism of pain and emotions – focus on the connection!**
- **Pharmacoth.: - avoiding analgesics (abuse!)**
  - **TCA, SSRI**
- **Psychotherapy**
  - **develop a solid th. alliance – empathy with the suffering, accept the reality of the pain**
  - **Interpersonal th.: - pain and relational problems**
  - **Cognitive th: alter negative thoughts, to foster positive attitude**
  - **Biofeedback, hypnosis, relaxation**
- **Pain Control Program – multidisciplinar approach**

Pain dis.– diff.dg. I.

Physical pain – may be difficult to distinguish

- fluctuates in intensity
- highly sensitive to emotional, cognitive, attentional and situational influences

Depression

- Pain symptoms is common (masked depression!)
- Anamnesis – recurrent depressive episodes
- Depression in the family
- Other smyptoms:
  - Vegetative: sleep, appetite
  - Cognitive: decreased activity and interest
- Antidepressant treatment is effective

Diagnostic Criteria for Hypochondriasis

A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.

B. The preoccupation persists despite appropriate medical evaluation and reassurance.

C. 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).

D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The duration of the disturbance is at least six months.

F. The preoccupation is not better accounted for by generalized anxiety disorder, obsessivecompulsive disorder, panic disorder, a major depressive episode, separation anxiety, or another somatoform disorder.

Hypochondriasis - features

- Preoccupation with the fear of contracting or the belief of having, a serious disease
- Unrealistic or inaccurate interpretations of physical symptoms or sensations
- The convictions persist despite negative results of examinations and appropriate reassurances from physicians
- But the beliefs are not fixed enough to be delusions
- Childhood maltreatment in the anamnesis
- Th.: focus on stress reduction and education in coping with the illness, anxiety reduction
  - Group pth. – social support, social interaction
  - Supportive th. – reassurance patients that their physicians are not abandoning them and their complaints

Diagnostic Criteria for Body Dysmorphic Disorder

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in anorexia nervosa)

Table 17–8
Location of Imagined Defects in 30 Patients with Body Dysmorphic Disorder[a]

Location	*N*	%
Hair[b]	19	63
Nose	15	50
Skin[c]	15	50
Eyes	8	27
Head, face[d]	6	20
Overall body build, bone structure	6	20
Lips	5	17
Chin	5	17
Stomach, waist	5	17
Teeth	4	13
Legs, knees	4	13
Breasts, pectoral muscles	3	10
Ugly face (general)	3	10
Ears	2	7
Cheeks	2	7
Buttocks	2	7
Penis	2	7
Arms, wrists	2	7
Neck	1	3
Forehead	1	3
Facial muscles	1	3
Shoulders	1	3
Hips	1	3

Body dysmorphic dis. - features

- Gradual onset
- Increasingly concerned about a particular body part – abnormal functioning
- Attempts to hide the presumed deformity
- Avoid social and occupational exposure
- Comorbid anxiety and depression
- Medical-surgical help-seeking – try to solve the problem – mostly unsuccesful
- Unrealistic expectations of correction
- Chronic course without treatment
- Th.: TCAs, MAOI, SSRI
- - psychotherapy

Conditions Commonly Confused With Somatoform Disorder

- Multiple sclerosis
- Acute intermittent porphyria
- Central nervous system syphilis
- Lupus erythematosus
- Brain tumor
- Hyperthyroidism
- Hyperparathyroidism
- Myasthenia gravis

Therapy of som. dis. – general remarks

- Main individual differences in the outcome
- Importance of doctor-patient relationship
- Long therapy with one doctor
- Explorative and supportive psychotherapy
- Psychopharmacology – based on comorbid conditions (anxiety, depression)

Table 3 – Communication strategies for clinicians who work with patients who have a somatic symptom or related disorder recommended by the Royal College of General Practitioners[21]

Strategies that should be avoided	Recommended strategies
Focus exclusively on a diagnosis	Focus on the symptoms and their effect on functioning
Always make a diagnosis	Focus on how to manage symptoms; talk about functional conditions
Dismiss the symptoms as normal without addressing the patient's concerns	Address the patient's concerns using terminology that the patient will understand
Require excessive tests without explaining the likelihoood of false-positives	Share your uncertainty; discuss the possible test result and its implications
Rely on drugs to treat symptoms	Discuss results of therapeutic trials and adverse effects of drugs
Assume you know what the patient wants	Share decision making and carefully listen to what the patient wants
Be judgmental and critical; attribute the patient's behavior to a single life event	Acknowledge the patient's concerns—they are important
Ignore or miss psychological cues	Sensitively accept psychological cues and let the patient expand on them
Assert psychosocial explanations, which leads to defensiveness	Allow time and encourage the patient to make the connections; it may take several sessions
Let your anxiety or uncertainty take over	Encourage shared decision making; be open about your uncertainty yet be reassuring; keep an open mind

Elements of psychotherapy of som.dis.

- Insight to psychological aspect of symptoms
- Motivation to the psychotherapy
- Psychoeducation
- Monitoring symptoms
- Relaxation and cognitive coping strategies
- Behaviour techniques (modifying the reinforcements)