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SOMATOFORM DISORDERS

Somatoform disorders are psychological disorders characterized by complaints about physical well-being that cannot be entirely explained by a medical condition, substance use, or another psychological disorder. Somatoform disorders are relatively rare in the general population but are the most common type of psychological disorder in medical settings. A third of patients visiting their primary care physician have symptoms that are not adequately explained by a medical condition. Somatoform disorders must be distinguished from factitious disorder, in which people intentionally induce symptoms or falsely report symptoms that they do not have to receive attention from others. Those with a somatoform disorder neither pretend to have symptoms nor intentionally induce physical symptoms for any type of gain. By their very nature, however, somatoform disorders are "rule out" diagnoses, meaning that the clinician must make sure that there aren't medical conditions or other psychological disorders that can better explain the patients' physical symptoms.

Somatoform disorders share two common features:

1. *bodily preoccupation*, which is similar to the heightened awareness of panicrelated
bodily sensations experienced by people with panic disorder, except that with somatoform disorders the patient can be preoccupied with any aspect of bodily functioning; and

2. *Symptom amplification*, or directing attention to bodily symptoms, which in turn intensifies the symptoms. A common example of symptom amplification occurs when someone with a headache pays attention to the headache–and the pain worsens.

SOMATIZATION DISORDER (SD)

Somatization disorder (SD) is characterized by multiple physical symptoms that are medically unexplained and impair an individual's ability to function. The symptoms are chronic; they may fluctuate in location or in intensity (so that the criteria for SD are no longer met), but symptoms usually never completely disappear. In an effort to minimize their bodily symptoms, people with somatization disorder may restrict their activities. However, inactivity can create additional symptoms (such as back pain) or make existing symptoms worse (such as increased heart rate or difficulty breathing). Many laboratory tests and visits to doctors may be required to rule out other medical and psychological diagnoses, which is necessary before a diagnosis of SD can be made.

DSM-IV-TR DIAGNOSTIC CRITERIA

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: a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)
(2) two gastrointestinal symptoms: a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhoea, or intolerance of several different foods)
(3) one sexual symptom: a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory.

dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)
(4) one pseudo neurological symptom: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia [loss of voice], urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)

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 [as] 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 feigned or produced (as in Factitious Disorder or Malingering).

Factors that contribute to SD include genes, catastrophic thinking about illness (along with symptom amplification and bodily preoccupation), other people's responses to illness, and the way symptoms function as a means of expressing helplessness.

PAIN DISORDER

Pain disorder occurs when psychological factors significantly affect the onset, severity, or maintenance of significant pain. For a clinician to arrive at a diagnosis of pain disorder, the pain must cause significant distress or impair functioning, and malingering or factitious disorder must be ruled out. In some cases of pain disorder, examiners cannot identify a medical cause for the pain; in other cases, a medical cause may underlie the pain, but psychological factors contribute significantly to the patient's experience of it. When the pain can be diagnosed as arising predominantly from a medical condition, pain disorder will not be diagnosed on Axis I, but the medical condition will be noted on Axis III, along with the specific location of the pain, such as the lower back.

DSM-IV-TR DIAGNOSTIC CRITERIA

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.

Both pain disorder and somatization disorder involve genuine—as opposed to feigned—pain to which psychological factors are thought to contribute. However, SD requires that the individual have a history of four

different locations of significant pain (as well as other types of bodily symptoms), whereas pain disorder requires only one location of significant pain.

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laboratory tests and visits to doctors may be required to rule out other medical and psychological diagnoses, which is necessary before a diagnosis of SD can be made.

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B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:
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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 [as] 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 feigned or produced (as in Factitious Disorder or Malingering).

Factors that contribute to SD include genes, catastrophic thinking about

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DSM-IV-TR DIAGNOSTIC CRITERIA

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.

Both pain disorder and somatization disorder involve genuine—as opposed to feigned—pain to which psychological factors are thought to contribute. However, SD requires that the individual have a history of four different locations of significant pain (as well as other types of bodily symptoms), whereas pain disorder requires only one location of significant pain.

DSM-IV-TR DIAGNOSTIC CRITERIA

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).

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 behaviour 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.

TREATMENT FOR SOMATOFORM DISORDERS

CBT is generally the treatment of choice for somatoform disorders; the foci of the cognitive and behavioural methods used in treating each of the disorders vary because each disorder has different symptoms. Cognitive methods focus on identifying and then modifying irrational thoughts and shifting attention away from the body and bodily symptoms. Behavioural methods focus on decreasing compulsive behaviours and avoidance.

Medications, such as SSRI when used, target anxiety-related symptoms. Biofeedback to decrease bodily tension or Electro convulsive therapy (ECT) may be used for somatisation disorder and conversion disorder.
Group and family therapy are generally used as supplementary treatments.

For SD and conversion disorder, the therapist strives to understand the context of the symptoms and of their emergence and the way the symptoms affect the patient's interactions with others (Holder-Perkins & Wise, 2001); with these two disorders, treatment may focus on helping the patient communicate more assertively—which can help to relieve the social stressors that contribute to the disorders.

Treatment may also focus on the family—
educating family members about the disorder and the ways they may have contributed to or reinforced the patient's symptoms. The therapist may teach family members how to reinforce positive change and to extinguish behaviour related to the symptoms.

DISSOCIATIVE DISORDERS

The central feature of dissociative disorders is **dissociation**, the separation of mental processes—such as perception, memory and selfawareness—that are normally integrated. Generally, each individual mental process is not disturbed, but their normal integrated functioning is disturbed. In contrast, with schizophrenia, it is the mental processes themselves, such as the form or pattern of thoughts that are disturbed. Dissociation may arise suddenly or gradually, and it can be brief or chronic.

Four types of dissociative symptoms are noted in DSM-IV-TR.

- **Amnesia,** or memory loss, which is usually temporary but, in rare cases, may be permanent;

- **Identity problems,** in which an individual isn't sure who he or she is or may assume a new identity;

- **Derealization**, in which the external world is perceived or experienced as strange or unreal, and the individual feels "detached from the environment" or as if viewing the world through "invisible filters" or "a big pane of glass".

- **Depersonalization**, in which the perception or experience of self—either one's body or one's mental processes—is altered to the point of feeling like an observer, as though seeing oneself from the "outside".

Occasional dissociating is a part of everyday life. For instance, you may find yourself in a class, but not remember walking to the classroom. In some cases, periods of dissociation are part of religious or cultural rituals, as in possession trance. DSM-IV-TR reserves the category of **dissociative disorders** for cases in which perception, consciousness, memory, or identity are dissociated to the point where the symptoms are pervasive, cause significant distress, and interfere with daily functioning. DSM-IV-TR defines the following types of dissociative disorders.

DISSOCIATIVE AMNESIA

Dissociative amnesia is a dissociative disorder in which the sufferer has significantly impaired memory for important experiences or personal

information that cannot be explained by ordinary forgetfulness. The experiences or information typically involve traumatic or stressful events, and the amnesia can come on suddenly. The memory problems in dissociative amnesia can take any of several forms:

- Generalized amnesia, in which the individual can't remember his or her entire life.

- Selective amnesia, in which the individual can remember some of what happened in an otherwise forgotten period of time.

- Localized amnesia, in which the individual has a memory gap for a specific period of time, often a period of time just before the stressful event.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

B. The disturbance does not occur exclusively during the course of another psychological disorder and is not due to the direct physiological effects of a substance or a neurological or other general medical condition

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Researchers have focused on two theories of how cognitive disturbances—especially amnesia—arise with dissociative disorders: dissociation theory and neodissociation theory. Both theories focus on how dissociation can arise in response to traumatic experiences—specifically, how the normal processes of memory and its relation to other cognitive processes might be disrupted. Although neither theory can completely explain the phenomenon of dissociative amnesia, both offer some insight.

Dissociation theory posits that very strong emotions (as occur in response to a traumatic stressor) narrow the focus of attention and also disorganize cognitive processes, which prevent them from being integrated normally.

According to this theory, the poorly integrated cognitive processes allow memory to be dissociated from other aspects of cognitive functioning, leading

to dissociative amnesia.

In contrast, neodissociation theory proposes that an "executive monitoring system" normally coordinates various cognitive systems, much like a chief executive officer coordinates the various departments of a large company.

However, in some circumstances (such as while a person is experiencing a traumatic event) the various cognitive systems can operate independently of the executive monitoring system. When this occurs, the executive system no longer has access to the information stored or processed by the separate cognitive systems.

Memory thus operates as an independent cognitive system, and an "amnestic barrier" arises between memory and the executive system. This barrier causes the information in memory to be cut off from conscious awareness—that is, dissociated.

DISSOCIATIVE FUGUE

The key features of **dissociative fugue** are sudden, unplanned travel and difficulty remembering the past. This combination can lead sufferers to be confused about who they are and sometimes to take on a new identity. A person with dissociative fugue can have an episode that lasts from a few hours to weeks or even months.

During a fugue state, an individual generally seems to function normally. Once the fugue state has subsided, however, the individual may not be able to remember what occurred during it. The fugue state begins after a traumatic or overwhelming event, although it is not known how much time typically passes between the event and the onset of the fugue state. Patients usually experience only a single episode, in response to high levels of stress, and recover quickly; however, some people may continue to have amnesia for events that transpired during the fugue state.

Very little is known about the process by which people recover from dissociative fugue. An important fact about dissociative fugue is that it does not arise in all cultures. Syndromes that are similar occur in some cultures. This simple observation implies a larger role for social factors than occurs for many other psychological disorders.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. The predominant disturbance is sudden, unexpected travel away from home or one's
customary place of work, with inability to recall one's past.

B. Confusion about personal identity or assumption of a new identity (partial

or complete).

B. The disturbance does not occur exclusively during the course of another psychological disorder and is not due to the direct physiological effects of a substance or a neurological or other general medical condition

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DISSOCIATIVE IDENTITY DISORDER

The central feature of **dissociative identity disorder (DID)** is the presence of two or more distinct alters (personality states or identities), each with its own characteristics and history. These alters take turns controlling the person's behaviour. For example, a person with this disorder might have an "adult" alter that is very responsible, thoughtful and considerate and a "child" alter that is irresponsible, impulsive and obnoxious.

Each alter can have its own name, mannerisms, speaking style, and vocal pitch that distinguish it from other alters. Some alters report being unaware of the existence of other alters, and thus they experience amnesia due to the memory gaps. The most compelling characteristic of alters is that, for a given patient, each alter can have unique medical problems and histories:

One alter might have allergies, medical conditions, or even EEG patterns that the other alters do not have. Stressful events can cause a switch of alters, whereby the alter that was the dominant personality at one moment recedes and another alter becomes the dominant personality.

Although the number of alters that have been reported ranges from 2 to 100, most people diagnosed with DID have 10 or fewer alters

DSM-IV-TR DIAGNOSTIC CRITERIA

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behaviour.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance or a general medical condition.

People with DID may also be diagnosed with a mood disorder, a substance-related disorder, PTSD, or a personality disorder. DID may be difficult to distinguish from schizophrenia or bipolar disorder. It can take years to make the diagnosis of DID from the time that symptoms first emerge. Because of this long lag time and the rarity of the disorder, there is no accurate information about the usual age of onset. DID—which is easy to role-play—can be difficult to distinguish from malingering also.

CAUSAL FACTORS OF DISSOCIATIVE DISORDERS

- Neurological factors include damage to the hippocampus causing amnesia, and reduced activation in the frontal lobes implicated in fugue, resulting from increased level of stress hormones. Although neuroimaging studies of patients with DID find that their brains function differently when different alters are dominant, no definite understanding is present.

- Suggestive of psychological factors, people with dissociative disorders are more hypnotizable and dissociate more readily than others. DID is caused by severe, chronic physical abuse during childhood, which leads to dissociation during the abuse; these dissociated states become alters, with their own memories and personality traits.

- Dissociative disorders generally occur in response to significant stressors that involve social factors, such as combat and abuse. For instance, someone experiencing a dissociative fugue probably experienced a traumatic event beforehand.

Although there are clues as to possible factors that contribute to dissociative disorders, the specific roles these factors may play and how they might influence each other are not known.

TREATMENT FOR DISSOCIATIVE DISORDERS

The goal of treatment for dissociative disorders ultimately is to reduce the symptoms themselves and lower the stress they induce. Treatments that target the psychological factors underlying dissociative disorders focus on three elements: (1) reinterpreting the symptoms so that they don’t create stress or lead the patient to avoid certain situations; (2) learning additional coping strategies to manage stress; and (3) for DID patients, addressing the presence of alters and dissociated aspects of their memories or identities. Hypnosis may be used, depending on the therapist’s theoretical orientation.

In general, medication is not used to treat the symptoms of dissociative disorders because research suggests that it is not helpful for dissociative symptoms. However, patients may receive medication for comorbid disorders or for anxiety or mood symptoms that arise in response to the dissociative symptoms.

Treatment may also focus on reducing the traumatic stress that can induce dissociative disorders