# SOMATIC COMPLAINTS IN PSYCHIATRY

Acknowledgements: Most of the information included in this chapter was obtained from the Handbook of Psychiatry, 2005, Mental Health Information Centre of SA, Department of Psychiatry, University of Stellenbosch.

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## SOMATOFORM DISORDERS

These patients present to the clinician with physical symptoms suggestive of a medical illness, but there is either no demonstrable organic cause, or the severity of the symptoms exceeds the bounds of identifiable pathology. These physical symptoms are an unconscious expression of emotional or other distress (i.e., feelings are communicated by means of physical symptoms). The patients do not consciously "fabricate" the symptoms, but experience the symptoms as being authentic; the symptoms are therefore not under voluntary control. The patients do not understand the origin of the symptoms, and cannot link the physical symptoms to the subjective psychological distress.

### Somatization disorder:

These patients characteristically present with frequent and multiple somatic complaints that have required attention over the course of years, and for which no cause has been found. The condition starts before the age of 30 and follows a chronic, fluctuating course.

Complaints are usually presented in a dramatic, vague and exaggerated way, and often form part of a prolonged and complicated medical history with multiple diagnoses. At any point in time the patient would usually already have been treated by a number of doctors, often simultaneously.

The following symptoms occur frequently: paralyses, blindness, abdominal pain, dysmenorrhoea, frigidity and dizziness. Anxiety and depression are frequent concomitants. Patients with somatization disorder often display interpersonal problems in the areas of marriage, occupation and social adjustment.

**i) Complications:**

Repeated medical examinations, special investigations, unnecessary surgery and other forms of treatment. There is a risk of alcohol and other substance abuse.

**ii) Incidence:**

It is found more commonly, but not exclusively, in women.

**iii) Treatment:**

- A good therapeutic relationship.
- Examine your stressors, perhaps with the help of a therapist.
- At each visit to your therapist / clinician a thorough history taking will take palce and a complete examination will be performed.
- Get all the information you need (i.e. psycho-education): Attempt linking your symptoms with specific stressors.
- Ask the therapist / clinicain to explain the physiological connection between the causes and symptoms.
- Avoid habit-forming medication.
- Avoid unnecessary special investigations and interventions.
- Psychotherapy: Pursue individual therapy with a clinical psychologist.
- Ask your therapist / clinician to assist with skills for coping with stress.
- Get support on a regular basis.
- Try to stay involved with one principal doctor.

- Avoid too much emphasis on the ailments; rather attempt focussing on the underlying psychosocial factors requiring attention.[3]

**Conversion disorder:**

The clinical picture of a patient with conversion disorder typically consists of one or more symptoms suggestive of neurological disease, but which are in fact a consequence of psychic conflict/need. The disorder is not under voluntary control, and after a complete examination cannot be explained by known pathophysiological mechanisms.

The most classical conversion symptoms are those suggesting neurological disease (such as paralysis, aphonia, convulsions, coordination problems, blindness, tunnel vision, anaesthesia or paraesthesiae), vomiting and pregnancy. It is accepted that the conversion symptoms produce primary or secondary gain in the sufferer.

**Pain disorder:**

This usually starts at a later age (40's and 50's) and occurs especially in women. There is no proven pathological reason for the pain. The degree of pain is out of proportion to that which would be expected from any existing pathology. Comorbid diagnoses which often occur are (a) substance abuse or dependence, (b) major depressive episode, and (c) dysthymic disorder.

Patients with psychogenic pain disorder are common in medical practice, frequently have a long medical history, and are usually suffering from longstanding psychological distress and conflict. The disorder often develops into a chronic problem.

**Hypochondriasis:**

Hypochondriasis commences before the age of 30. Its course is chronic. The disorder is characterised by disproportionate or unwarranted interpretation of physical or physiological symptoms. Such a patient suffers from excessive fear of illness, and imagines that the most trivial symptoms signify the presence of a serious disease. This disorder severely impairs the patient's social and occupational functioning.

**Body dysmorphic disorder:**

A person suffering from this condition is typically preoccupied with a "deformity" of a body part, for example the nose. Though there is in fact no - or virtually no -noticeable abnormality, the person perceives the specific part as being abnormal. Such a patient is often (incorrectly) referred to a plastic surgeon or dermatologist. Comorbid conditions include depressive and anxiety disorders.

Body dysmorphic disorder commences between the ages of 15 and 20 years, and is more common in women.

**PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION**

(Also known as "Psychosomatic illness".)

Man's functioning is determined by the sum of interrelated and inseparable biological, psychological and social factors. Consequently, psychosocial factors are frequently involved in the causation, progression and duration of physical illness.

The widespread biochemical changes that accompany psychological stress can influence people's physical functioning by producing and maintaining disease, interfering with treatment and exacerbating the condition. Disease can indeed be regarded as the end product of all of man's bio-psycho-social problems.

**Example:**

In a vulnerable person, psychological distress originating outside the body (e.g., in the marital relationship) produces a great deal of emotional distress (limbic system) which is followed by a neurophysiological response (hypothalamus) and thereafter an immuno-endocrinological-autonomic nervous response. This immuno-endocrinological-autonomic nervous response can initiate disease, maintain it, exacerbate it and influence its response to treatment.