29 - Somatoform disorders

Somatoform disorders

© SPMM Course pain disorder are classified along with the somatoform disorder. In other words, all motor/sensory presentations are classed as conversion while memory/personality presentations are retained in dissociation category. Somnambulism is listed as a nonspecific dissociation in DSM-IV.

Seizures vs. pseudoseizures: At times it may be difficult to distinguish epilepsy from pseudoseizures (conversion). The following features are taken to be more suggestive of pseudoseizures:

Seizures vs. pseudoseizures Avoidance behaviour during seizures (to prevent serious injuries) Change in symptomatology of seizure patterns e.g. progression or 'march' that is inconsistent with cortical organization, asynchronous limb movements. Closing eyes during seizures, especially resisting opening of eyelids when attempted Dystonic posturing (this can happen in frontal seizures though rare) Emotional or situational trigger for the seizures and seizures provoked by suggestion Gradual onset and cessation of seizures (true seizures have a rapid crescendo and decrescendo) Tongue biting is rare and if present, usually the tip (not the side) of the tongue is bitten. Pelvic movements (especially forward thrusting) and side-to-side head movements Prolonged seizures (duration of 2 to 3 minutes); High seizure frequency but no history of injury from seizures. Lack of concern or an excessive or exaggerated emotional response Multiple unexplained physical symptoms Non response to antiepileptic drugs or a paradoxical increase in seizures with drug treatment Seizures that occur only in the presence of others or only when the patient is alone

Adapted from Elger RM. Psychogenic nonepileptic seizures: review and update. Epilepsy Behav 2003;4:207. Somatoform disorders Under this chapter in ICD-10, somatization disorder, hypochondriacal disorder, somatoform pain syndromes, autonomic dysfunction and undifferentiated somatoform disorder are included. All somatoform disorders are characterized by the lack of a psychological appraisal on the patient's part along with a resistance to consider presenting problems as one of 'mental' origin. Dissociative trance Possession trance x Altered narrow consciousness x Lost personal identity x No replacement with another identity x Stereotypic movements / utterances x Amnesia seen

x Altered narrow consciousness x Lost personal identity x Replaced with another identity x Stereotypic movements / utterances x Amnesia seen

© SPMM Course Somatization disorder is characterized by (a) at least 2 years of multiple and variable physical symptoms for which no adequate physical explanation has been found; (b) persistent refusal to accept the advice and reassurance of several doctors regarding the absence of

a physical illness; (c) notable impairment of social and family functioning due to the symptoms and the illness behaviour. The term Briquet Syndrome or St. Louis Hysteria is sometimes applied to denote somatisation disorder. Family history of alcohol use and antisocial personality are common in women with somatisation disorder. Hypochondriacal disorder is characterized by 2 conditions (1) persistent belief of harboring atleast one serious physical illness even though repeated investigations and examinations have identified none or a persistent preoccupation with a presumed deformity or disfigurement (body dysmorphic type); (2) persistent refusal to accept the advice and reassurance of several doctors regarding the absence of a physical illness. Both nosophobia and nondelusional dysmorphophobia are classified as hypochondriasis in ICD-10. A 6 months duration criteria is specified in ICD-Diagnostic Criteria for Research (not in the regular diagnostic guidelines). Note that in DSM-IV, body dysmorphic disorder (dysmorphophobia) is considered as a separate diagnostic entity, within the chapter on somatoform disorders. It is described as a 'subjective description of ugliness and physical defect which the patient feels is noticeable to others'. It is an excessive concern (overvalued idea) about trivial or non-existent physical abnormalities, which are perceived to be deformities. Beliefs about deformity that are of delusional intensity are classified under delusional disorders. With delusional intensity, the patient is constantly pre-occupied, convinced and tormented by abnormal belief that some part of his/her body is too large, too small or misshapen, which to other people, the appearance is normal or there is a trivial abnormality. The common complaints are about the nose, ears, eyes, mouth, buttocks, penis, breasts, but any part of the body may be involved. The affected person might think that other people notice and talk about his deformity and, therefore, would get involved in time consuming behaviours such as re-examining, repeated checking, involve in elaborated grooming rituals to hide the perceived defect and avoidance behaviour. This condition usually DSM-5 AND SOMATICSYMPTOMS In DSM-5, somatoform disorders are referred to as Somatic Symptom Disorders (SSD). Diagnosis of Somatization, Hypochondriasis, Pain Disorder and Undifferentiated Somatoform disorders are now eliminated. SSD can be diagnosed even if there is a medical disorder that explains the presenting symptoms. The emphasis is shifted from the actual physical symptoms to the maladaptive thoughts and feelings that surround these symptoms ('positive features'). Individuals with high health anxiety but no somatic symptoms will be diagnosed to have 'illness anxiety disorder' Factitious disorder is placed under somatic symptom and related disorders. Body Dysmorphic Disorder has been moved from somatoform chapter to OCD & related disorders. A "with muscle dysmorphia" specifier has been added the description of body dysmorphic disorder.

Revision #1
Created 2026-01-04 20:04:58 UTC by Omar Ayman
Updated 2026-01-04 20:04:58 UTC by Omar Ayman