SOMATIZATION DISORDER (HYSTERIA) pdf

1: Somatoform Disorder

What is Hysteria? Hysteria is a somewhat controversial and outdated term, the meaning of which has been adapted and changed over time. While the term Hysteria is seldom used in reference to a medical condition today, the concept still remains and what was once the diagnosable condition Hysteria disorder is now more acceptably know as a somatization disorder or histrionic personality disorder.

For an account of the role played by misdiagnosis in the development of psychoanalysis, see the extract from my Freud Weidenfeld, Freud, Charcot and hysteria. For a recent long but uncompleted essay, see Hysteria revisited The reality was very different. A large proportion of the patients whom Freud treated during his early years in private practice had initially sought medical advice because they were suffering from physical symptoms; they had enlisted the help of a physician for no other reason than that they believed themselves to be ill. Among their symptoms were headaches, muscular pain, neuralgia, gastric pain, tics, vomiting, clonic spasms, petit mal, epileptoid convulsions, and a host of other physical reactions. This consideration is extremely important in any assessment of the early history of psychoanalysis. Freud, indeed, would be unusual among nineteenth-century nerve specialists if he had not misdiagnosed a considerable number of his patients. This is because he practised at a time when medical science had only just begun to emerge from a long period of extreme diagnostic poverty. Many of the most basic diagnostic techniques which are taken for granted by modern physicians had still to be discovered. The lumbar puncture, which is the only way in which Breuer could have tested his momentary hunch that Anna O. X-rays, which would eventually become one of the most useful of all diagnostic aids, were discovered only in â€” the same year in which Studies on Hysteria was published. The electroencephalogram, which would revolutionise neurology and psychiatry and lead to the final definition of temporal lobe epilepsy, was not invented until , and was not in general use until the s. Many other basic techniques of neurological investigation would not be developed until even later. The computed tomography scan, for example, which uses X-ray transmission readings to generate an image of the brain and which can display some lesions, tumours and other signs of pathology directly, began to be generally used only in the late s. Not only were these diagnostic techniques unavailable to Breuer, Freud and their contemporaries, but neurology and psychiatry were relatively young and under-organised branches of medicine whose stores of knowledge were only just beginning to be built up. Both medical historians and modern physicians sometimes underestimate the degree of diagnostic darkness to which their nineteenth-century predecessors had become habituated. This is partly because the direct evidence which might lead to a more realistic assessment is not always available. Doctors tend not to advertise their misdiagnoses any more than they are wont to display the corpses of their patients. Frequently, indeed, they are genuinely unaware of their own mistakes. Indirect evidence usually remains, however, and it is intriguing how often this too tends to be ignored. One of the reasons is that many medical historians are themselves physicians and are interested primarily in a view of medicine which portrays it as a continual progress towards the pinnacle of the present day. The result is that they end up writing a Whig-history of their own profession, concentrating on real medical breakthroughs. The mistakes, misdirections, deceptions and self-deceptions in which the larger part of medical history consists disappear almost completely. Beard, and which would eventually play a significant role in psychoanalysis see below, Chapter 8. The possibility which we must consider, however, is that hysteria itself should be understood as just such a syndrome. In , for example, Steyerthal predicted that: Within a few years the concept of hysteria will belong to history What Charcot called hysteria is a tissue woven of a thousand threads, a cohort of the most varied diseases, with nothing in common but the so-called stigmata, which in fact may accompany any disease. In Britain, and in some parts of continental Europe, hysteria is still referred to as though it were a distinct syndrome in a number of psychiatric textbooks, and some neurologists, psychiatrists and physicians still believe that the concept is a useful one. For it no longer refers to a disorder of the womb. Instead it is used to refer to any symptom or any abnormal pattern of behaviour for which there is no apparent organic pathology and which is therefore believed to be a product of emotional distress, anxiety or some other psychological cause. Those who propose that hysteria

might be an entirely unnecessary concept readily accept that it is sometimes difficult to find an organic pathology behind certain physical symptoms. Hysteria, in effect, ceases to be the very specific disease entity it was always historically considered to be, and becomes merely a negative assertion about the nature of certain symptoms. This in turn means that it is much easier for doctors to miss real but obscure organic illnesses. The point has been well made by the psychiatrist Eliot Slater: This is especially dangerous when there is an underlying organic pathology, not yet recognised. In this penumbra we find patients who know themselves to be ill but, coming up against the blank faces of doctors who refuse to believe in the reality of their illness, proceed by way of emotional lability, overstatement and demands for attention Here is an area where catastrophic errors can be made. In fact it is often possible to recognise the presence though not the nature of the unrecognisable, to know that a man must be ill or in pain when all the tests are negative. But it is only possible to those who come to their task in a spirit of humility. It is evidence of non-communication, of a mutual misunderstanding We are, often, unwilling to tell the full truth or to admit to ignorance During a follow-up period which averaged only nine years, twelve of the eighty-five patients had died, fourteen had become totally disabled and sixteen partially disabled. Among the conditions which had been misdiagnosed either by neurologists or by psychiatrists â€" including Eliot Slater himself â€" were three cases of vascular disease, three of tumour and a number of cases where supposedly hysterical black-outs and fits were subsequently rediagnosed as epileptic. Four of the deaths were due to suicide, but in two of these instances the patient had suffered from organic diseases which had not been diagnosed by doctors at the National Hospital. One was a man suffering from various symptoms, including pain in the legs, unsteadiness of gait and impotence. Two years later she died of a brain tumour. After discussing these and many less serious misdiagnoses and placing them in the context of medical history, Slater comes to the conclusion that the diagnosis of hysteria has no validity whatsoever â€" a conclusion which he states in even more outspoken terms than in the essay cited earlier: Attempts at rehabilitation of the syndrome, such as those by Carter and by Guze, lead to mutually irreconcilable formulations, each of them determined by their terms of reference. The only thing that hysterical patients can be shown to have in common is that they are all patients. The malady of the wandering womb began as a myth, and as a myth it yet survives. But, like all unwarranted beliefs which still attract credence, it is dangerous. It is, in fact, not only a delusion but also a snare. In the United States the diagnosis has, in theory at least, disappeared from mainstream psychiatry. Yet there appears to be a significant gap between theory and practice. If we are to believe the psychiatrist Philip Slavney, writing in , the term still enjoys some currency even in American medical practice: No term so vilified is yet so popular; none so near extinction appears in better health. As early as , W. In Gaupp summarised the reaction which had by then taken place against Charcot: The syndrome has replaced the disease entity. Aubrey Lewis, having anthologised the views quoted above, describes how he conducted his own follow-up inquiry on patients diagnosed as hysterical at the Maudsley Hospital. He notes that a significant divergence between the results of a study based on a neurological hospital, and those of a study made at a psychiatric hospital was only to be expected. It tends to outlive its obituarists. Whatever the kaleidoscope of its manifestations, I submit that its essential difference from somatic disease is that it constitutes a behaviour disorder, a human act, on the psychological level. An hysterical paraplegia is exactly this, but a compression paraplegia is not this at all. Apart from the mimesis of somatic disease hysteria may present, the dramatizations, the exaggerations and the pathological lying are also behavioural disorders, part of the total expression of the abnormal psychical state which is hysteria. One response to such concern has been to attempt to resolve the problem through the adoption of new terminology. The shift away from traditional terminology has been consolidated in later editions. The predominant disturbance is a loss of or alteration in physical functioning suggesting a physical disorder. It is involuntary and medically unexplainable One of the following must also be present: One major problem is that, although it excludes consciously simulated illness, it does not exclude the unconscious simulation of illness. What this means in practice is that patients with imaginary symptoms which have no apparent physiological basis have to be placed in the same category as patients whose symptoms seem real, but are not susceptible to medical explanation. The dangers of this approach should become evident if we consider the subsidiary indicators given for the disorder. Criterion 2 â€" that the symptom allows the

individual to avoid unpleasant activity â€” is, it will be noted, scarcely specific to emotionally based disorders. Most forms of illness, from broken legs to acute appendicitis, create just such opportunities. Criterion 2 is thus rather like saying that a specific name may be given to a plant providing that its leaves are green. Though the restriction may create the illusion of rigour, the field of definition is not very much reduced. Something similar can be said about the next criterion. For since most illnesses provide an opportunity for seeking support â€” if only from a physician â€” criterion 3 is almost as empty as criterion 2. It is difficult not to draw the conclusion that, in formulating its criteria in this particular instance, the American Psychiatric Association did little more than take an old diagnostic error and give it a new name together with a new aura of respectability. To say this is not to rule out the possibility that there can be a direct relationship between prolonged stress or severe emotional trauma and some physical symptoms. Many common disorders do seem to be stress-related. In most cases, however, we do not yet understand the precise physiological mechanism of such a relationship. To allow the resulting syndrome, which has supposedly been carefully delimited, to be equally applicable to real physical symptoms and imaginary or spectral ones providing they are not consciously produced is merely to compound the original confusion. But the underlying concept has remained unaltered. The dangers of this situation feature prominently in one of the most searching contributions to the entire debate, C. No less than 53 It is used as a cloak for ignorance. In addition we can still recognise new neurological diseases. Neurology has never been and is not static. Many neurological diseases are still not widely recognised No doubt there are many other neurological conditions still undiscovered. For, as Marsden writes, It is essential for communication between doctors and other health workers to have some form of shorthand to explain the state of affairs. Consider the paralysed patient who cannot walk, who may or may not have a mild paraparesis, but whose major problem is weakness or even total paralysis not due to organic or functional disease. How are we to convey this concept? But Marsden brusquely, and I believe quite justly, dismisses this usage by referring to the view of Aubrey Lewis. It would be as well at this stage to give it a decent burial, along with some of the fruitless controversies whose fire it has stoked.

SOMATIZATION DISORDER (HYSTERIA) pdf

2: Hysteria - Wikipedia

Somatization Disorder is a psychiatric disorder characterized by persistent complaints of several physical symptoms that have no identifiable physical origin. Their symptoms cannot be related to any medical condition either. It is also known as Briquet's disorder or hysteria. Somatization Disorder.

It is thought that perhaps psychological problems are expressing themselves physically in those affected. Somatization disorder is not an imagined or fictitious disorder as associated with conditions like malingering; rather, the symptoms are very real, and the pain felt by the patient is real as well. We know today that this is an unfair and incorrect assessment of the disorder. Symptoms of Somatization Disorder Complaint of chronic body pain, usually in the digestive, nervous and reproductive systems Symptoms are worsened with stress Gastrointestinal complaints like nausea, bloating and diarrhea at least two gastrointestinal symptoms are required for diagnosis Reproductive problems such as painful intercourse or erectile dysfunction reproductive system symptoms are also required for diagnosis Headaches, body aches, urinary retention At least one symptom must be neurological, like seizing, to be diagnosed as well Coordination and balance problems What Causes Somatization Disorder? Somatization disorder is a much-debated topic, as far as causes go. The first and most commonly suggested possible cause is that somatization disorder is a defense against psychological stress. In other words, the body expresses psychological distress through physical symptoms instead of psychological ones. The next theory is that a person with somatization disorder has a hypersensitive response to changes in the body. The last theory is that the person suffering from somatization disorder has created the symptoms with their own negative, catastrophic way of thinking. Basically, the patient turns a molehill into a mountain a headache into a brain tumor, for example and makes their symptoms seem much worse or more serious than they actually are. Treatment for Somatization Disorder Treatment is usually most effective with the dual support of your regular health care provider and a psychologist. Keeping a supportive and positive relationship with a health care provider that you trust is key to a successful recovery. Normally, a person with somatization disorder is treated effectively when their doctor and psychologist work together. Seeing a psychologist is vital because there could be a lot of suppressed stress or other issues that need to be relieved mentally. This should help with the physical symptoms, as combined with help from your doctor. What Should You Do? People with somatization disorders often make frequent doctor visits, and subsequently have many tests and procedures performed. The best thing to do is to create a relationship that is optimal for you between you, your doctor, and your psychologist. With the combined effort of all three, your symptoms should begin to relieve themselves as you work toward a healthier future mentally, physically, emotionally and psychologically. View Resources Wikipedia â€" Wikipedia page with information about somatization disorder, along with diagnosis criteria and cause theory. Medline Plus â€" Medline plus page for somatization disorder, including symptoms, and treatment information. University of Maryland Medical Center â€" Webpage with info about causes and risk factors for somatization disorder.

SOMATIZATION DISORDER (HYSTERIA) pdf

3: Hysteria (Somatization disorder)- Various methods of treatment. | HubPages

Hysteria colloquially means ungovernable emotional excess. Generally, modern medical professionals have abandoned using the term "hysteria" to denote a diagnostic category, replacing it with more precisely defined categories, such as somatization disorder.

Hysterical blindness is now known as conversion disorder Hysteria - Pain disorder Hysteria - Acupuncture to relieve symptoms and perceived pain. Hysteria - Hypnotherapy Although still commonly referred to as Hysteria, these days the condition is called Somatization disorder or Histrionic personality disorder, which is far more of a contrived mouthful than the original. Hysterical neurosis or hysteria is a psychological state that is caused by extreme emotion, or stress such as overwhelming fear, loss or sorrow. The psychological strain can become so severe that the individual will lose control and start showing physical symptoms even lashing out at those around. The person will be extremely emotional, unaware of their surroundings and will often feel pain associated with the particular event. For centuries, it was conveniently thought that hysteria only affected women. Sadly those suffering from hysteria are completely consumed by fear and anxiety. The person can think of nothing but the event or problem which creates almost blindness to their surroundings. For many of the sufferers the symptoms of hysteria include a heavy feeling in the limbs, severe cramps, an uncontrollably strong feeling of ascending abdominal constriction, difficulty in breathing, constriction in the chest, rapid heartbeat, feeling of choking, swelling of the neck and of the jugular veins, overwhelming suffocation, headache, clenched teeth, and generalized paralysis. There are, however, various other symptoms of hysteria, such as an inexplicable urge to run and run away, that will help to let off steam. Hysteria is not a physical disease where there is some simple treatment and cure. It is a serious psychological disorder which some can be born with or also be brought on by emotional or traumatic experiences such as witnessing a violent crime or the unexpected death of a loved one and the terrifying feeling of being left alone. Hysteria can also develop in children who have lived in an extremely abusive environment and cannot escape. Unfortunately, hysteria can also be a side effect of chemical drugs. The long term use of the anti-anxiety drug, diazepam, for example, has been proven to cause the symptoms of hysteria which is completely contrary to its intended effect. Those suffering from hysteria are often a danger to themselves and to others and because severe depression is a common symptom, thoughts of suicide can occur. Even if a person is able to function socially outwardly, the symptoms of hysteria can be detrimental to interpersonal relationships, creating a hidden but overwhelming barrier. Because of this hysteria sufferers often come across as either distant or intense and have difficulty making friends or forming and maintaining intimate relationships. Hysteria is not always restricted to one person, mass hysteria occurs when a group of people experience paralyzing fear that stems from the same cause. For example, mass hysteria could occur during a bombing, school shooting or a civil disturbance. It is very much thought that mass hysteria was part of the Salem Witch Trials. It is best described as emotional contagion, where groups of people have been known to display the same physical and mental symptoms during or after an incident. Too often this has resulted in mass violence, excitement or even an outbreak of disease-like symptoms with no known cause. Hysterical blindness is now known as conversion disorder which occurs when a person encounters a personal difficulty that they feel unable to cope with by ordinary means. The symptoms of conversion disorder, however, are often alleviated by therapy. Histrionic personality disorder is often diagnosed in people, particularly women, who show behaviour patterns marked by overly emotional, attention seeking or exaggerated dramatic thoughts and actions. These people will often come across as self-centred and embellish stories or claim to be the hero, be extremely egotistical, will continually seek approval from anybody and be visibly hurt when it is not given. In order to attract attention they will often dress and behave in sexually inappropriate ways. Although the person is outwardly able to interact socially, they will often be unable to maintain relationships and may threaten or attempt suicide to get attention. Pain disorder occurs when an affected person suffers from chronic, unexplainable pain, which coincides with a psychologically stressful event such as the unexpected death of a partner, pet or loved one. This pain can last from as little as a few days to as much as several years. The pain disorder experienced is not

the same as fibromyalgia, although many of the symptoms of these two disorders are identical. The person, feeling more and more frustrated, will go from one doctor to another, often adding new complaints at each visit. Until recently somatization disorder was considered a more serious form of hypochondria. In this case a person with somatization disorder is absolutely certain such a physical problem exists, in fact, they will even feel severe pain associated with these supposed illnesses or injuries. Somatization disorder sufferers will also often manifest unexplainable physical disabilities similar to those noted in conversion disorder sufferers Hysterical convulsions fits. This is probably the most serious symptom and the one that most people associate with hysterics. The victim suffers sensory disturbances such as tunnel vision, dulled or heightened senses. They may also be affected by pounding or racing heart, hyperventilation or shortness of breath. They may be racked by trembling or shaking, dizziness or feeling like they are going to faint. Emotionally they may suffer feelings of unreality or detachment and fear of losing control or even dying. In the case of children parents may recognize hysteria symptoms after extreme tantrums or in excessively upset or traumatized children who are very difficult to calm down. In order to eliminate any underlying medical causes a thorough assessment is recommended during which time is spent exploring the hysteria symptoms, feelings and concerns with a physician. It is important not to make a self-diagnosis, as it is a subject that requires specialist interpretation. As hysteria, in the initial stage, should be properly diagnosed by a doctor or medically qualified person we should look at conventional medication first, but these should only be administered to patients with either severe or violent hysteria symptoms. For example, some of the side effects of Xanax are depression and jaundice; while Ativan can cause dizziness and amnesia. Anti-depressants are often prescribed in an attempt to control wild mood swings and thoughts of suicide. Lexapro is one of the most commonly prescribed anti-depressants but although it is effective amazingly it can actually increase thoughts of suicide. Pain killers are often prescribed, with care, for patients suffering from pain disorder and somatization disorder. Extreme caution should be used, as the pain associated with hysteria disorders is mostly psychological and most pharmaceutical pain killers can have unpleasant side effects. When treating painful symptoms of hysteria disorders, it is advisable to use either natural remedies or placebos. Essential oils - Hysteria, is a difficult condition to treat and the use of essential oils is normally better used to prevent a hysterical outburst than to cure one once started. Hysteria is the result, often, of a violent swing of mood and the oils need to be able to calm the emotions. This is a condition where essential oils can work in conjunction with counselling or psychotherapy and obviously the conditions under which the hysteria occurs can be wide and many. When hysteria occurs the oils to use are those normally given for shock bad news, death etc. These can also be used to prevent an attack by using them in a fan, or burner. The blend can also be directly inhaled from the mixing bottle if the person is co-operative or a few drops on their clothes or a tissue. When the person has calmed a massage using Rose and Benzoin in Evening Primrose carrier oil, will help maintain calm and balance. There are many homeopathic remedies that can help relieve the symptoms of hysteria. Each remedy depends on the type and severity of the symptoms and is best selected by a trained Homeopath. As a few examples, Ignatia can be given to help relieve convulsions and perceived pain, Valeriana has a calming effect and can help with mood swings, and Gelsemium can help relieve short temper and irritability. Herbal Remedies - A common herbal remedy is St. The herb can be given in tea, capsule, or tincture form. Sensitivity to sunlight can develop after long term use; otherwise, St. Passion flower, which has practically no side effects, can also be used as a tranquilizer or to help induce sleep. The black berry fruit is an old country remedy for hysteria. Seven pounds of this fruit and a handful of salt should be put in a large jug filled with water. The jug should be covered with muslin and kept in the sun for a week. The patient suffering from hysteria should take 10oz of these fruits on an empty stomach, and drink a cup of water from the jug. On the first day, another 7 pounds of these fruits, mixed with a handful of salt, should be started in another jug filled with water, so that when the contents of the first jug are finished, the contents of the other will be ready for use. This treatment should be continued for two weeks. Honey is regarded as another effective remedy for hysteria. Take one tablespoon of a quality honey daily use Scottish heather or, if you can afford it, Manuka honey. Do not use Chinese honey as they just feed the bees on processed sugar. Honey breaks down the triglycerides that cause blockages in the valves of the heart, thereby avoiding minimizing or helping prevent the occurrence of high blood pressure. Because the

flow of blood through the heart is unrestricted, blood pressure can remain normal and hysteria is less likely to occur. Bottle gourd Calabash has been used as an external application in hysteria. Using a food processor produce a fresh pulp of this vegetable which should be applied onto the head of the patient in the treatment of this disease. It has a reputation for being extremely soothing and cooling, and will help to keep the person calm, it is, however, very messy and difficult to apply to a panicking patient. Do not ingest, particularly if the juice tastes bitter. The herb rauwolfia is very useful for hysteria. One gram of the powdered root should be administered mixed into one cup of milk in the morning as well as in the evening. Treatment should be continued till a complete cure has been obtained. Lettuce is considered valuable in the treatment of this disease. A cup of fresh lettuce juice is mixed with a teaspoon of Indian gooseberry juice and should be given every morning for a month, as a medicine in the treatment of hysteria. While the consumption of lettuce and fresh vegetables may have no direct bearing on the condition itself, consuming lettuce and fresh vegetables can help cleanse the body of any toxins that could be causing health problems further magnifying problems related to hysteria. Asafoetida has also proved beneficial in the treatment of this disease. Inhaling the odour of this gum prevents hysterical attacks. If taken orally, the daily dosage should be from 0. Acupuncture - This Chinese use of fine needles is an affordable way to treat nearly every illness and disorder. In properly qualified hands, acupuncture has little risks or side effects. Acupuncture sessions are quite inexpensive and widely available. Hypnotherapy - Because hysteria is such a serious psychological disorder, hypnotherapy is sometimes necessary to help the person cope. Hypnotherapy can help the person relax, deal with their problems, and begin to develop better habits. Although hypnotherapy does not have any serious risks, it should only be conducted by a trusted fully qualified professional. Hypnotherapy does not, by any means, have a one hundred percent success rate; however, it is a legitimate and, at times, useful treatment option. The severity of the illness or disorder is what determines the cost as well as the number of sessions, which can be significant. Psychotherapy - This is considered a viable treatment option for hysteria. It is often found most useful for treating victims of conversion disorder.

SOMATIZATION DISORDER (HYSTERIA) pdf

4: Somatization disorder | Psychology Wiki | FANDOM powered by Wikia

Although still commonly referred to as Hysteria, these days the condition is called Somatization disorder or Histrionic personality disorder, which is far more of a contrived mouthful than the original.

Abstract Somatization is a clinical and public health problem as it can lead to social dysfunction, occupational difficulties and increased healthcare use. Hence understanding somatoform disorders is of paramount importance, especially so in developing countries like India. This paper discusses the history and evolution of the concept of somatization and somatoform disorders, etiological considerations, classification, assessment, diagnosis and clinical management. Research from India, controversies and criticisms and future perspectives are mentioned. A new model to understand functional somatic symptoms, in Indian setting is also proposed. Conceptual and clinical questions exist about the validity and utility of the concepts. New paradigms might lead to more effective management. In the middle ages, these disorders were believed to be spiritual disorder of evil and demonic possession. In the 19th century, it was Briquet who made the first systematic description of hysteria with cases. Later, hysteria became less popular as a diagnosis. Hysteria has pejorative associations. It might represent misdiagnosis of organic disorders. They had regarded this as a form of hysteria. This new category included traditional psychiatric disorders like hysteria and hypochondriasis, together with newly proposed categories like somatization disorder. These groupings were tentative, lacking substantial evidence base and unsatisfactory. This disorder also produces clinically significant distress or impairment in social, occupational or other important areas of functioning. Symptoms are not intentional, contrasting it with factitious disorder or malingering. Conversion disorder is placed in the somatoform section to consider neurological or medical conditions in differential diagnosis. However, the evidence base for diagnosis and treatment remains sub-optimal. Conceptualizing somatoform disorders Somatization can be conceptualized as a process which appears fundamentally as a way of responding to stress. Another concept is somatosensory amplification, where somatic symptoms are experienced as intense, noxious or disturbing. Somatization is a clinical and pubic health problem as it can lead to social dysfunction, occupational difficulties and increased health care use. Somatization can also be viewed as masked psychiatric disorder eg: Depression or Anxiety or amplified personal perceptual style due to personality trait or abnormal neuro- psychololgical information processing or as seeking care for emotional distress or as a response to health care incentives iatrogenic somatization. Etiological considerations include patho-physiological mechanisms, genetic and developmental factors, cognitive theories, personality characteristics, psychodynamic factors, sexual and physical abuse, socio-cultural factors, gender and iatrogenesis. Patho-physiological mechanisms can be physiological, psychological and inter-personal. Postulated physiological mechanisms are autonomic arousal, muscle tension, hyperventilation, vascular changes, and cerebral information processing and sleep disturbance. Among psychological mechanisms, perceptual factors, beliefs, mood and personality factors are important. Significant interpersonal mechanisms include re-inforcing actions of relatives and friends, health care system and disability benefits. In DSM IV, Somatoform disorders include somatization disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder, undifferentiated and somatoform disorder - NOS. In ICD 10 , body dysmorphic disorder is included under hypochondriasis and also there are categories for somatoform autonomic dysfunction and other neurotic disorders like neurasthenia. The present classification of somatoform disorders has been criticized by many. Important criticisms are i mixture of principles for diagnostic criteria eg: Somatization disorder is chararacterized by multiple somatic symptoms of long duration beginning before the age of 30 years. Understanding functional somatic symptoms in Indian setting - A new model In modern medicine, clinical disciplines traditionally consider only those symptoms which are associated with a physical sign or a laboratory finding as significant. Even when these are absent, a pathophysiology, which is known or at least presumed, may also lend some respectability for the symptoms. For example, complaints like weakness of limbs when associated with changes in deep tendon reflexes or chest pain when ischemic changes in ECG are demonstrated or headache descriptions suggestive of vascular origin or fatigue when investigated shows high TSH values are readily accepted as genuine symptoms. In

training undergraduates and post graduates in clinical sciences, only those cases with demonstrable findings and laboratory evidences are thought to be worthy of any serious diagnostic considerations. Hence it is not surprising that they are never taken up for a bedside discussion or a case conference. But in actual clinical settings, either in general practices or in specialty settings, the situation is quite different. A significantly high proportion of patients present with complaints which are not justified by the presence of a corresponding physical sign or a laboratory finding. As far as the management of these patients is concerned, initially investigations are suggested with enthusiasm and curiosity from the part of the physician to unearth an elusive mysterious diagnosis. Many young doctors are carried away by the medical fairy tales of great clinicians of yesteryears either intuitively or by ordering for an extraordinary investigation making rare diagnoses, which has eluded the less diligent eyes of the lesser mortals! But as the patient continues to present with new set of symptoms in every visit or persist with the same complaints and the investigations continue not to reveal anything significant, the initial interest and enthusiasm gives way to frustration and helplessness. This can lead on to unpleasantness and loss of trust in the doctor-patient relationship. The patient who initially had complied to every suggestion for a new investigation or procedure with a hope of getting a diagnosis may start accusing the doctor of forcing unnecessary investigations with ulterior motives! The physician on the other hand may try to believe and explain the symptoms as resulting from vague constructs like allergy, wear and tear due to ageing, psychosomatic, perimenopausal symptoms etc. He may have ambivalent feelings about the possibility of missing a real problem. A physician is also likely to experience guilt over his inability to help the patient, over his incompetency as a clinician, and over the expenses which the patient had to incur. As a reaction formation to these feelings, she may start seeing the patient as a malingerer who is eating up her valuable time and using up the limited medical resources unnecessarily. He feels betrayed and not cared by his doctor. On the relentless pursuit of finding a meaning to his symptoms he may start believing in equally imprecise constructs like low blood pressure, high ESR, eosinophilia, which may be inadvertently and covertly agreed by the physician who is equally, if not more, at a loss to explain the symptoms. Unfortunately, in India, undergraduate and post graduate medical and psychiatric training is grossly inadequate to understand and effectively deal with these cases which are considered to be functional! This article is written in the background of clinical experience of the authors in a consultation -liaison setting of a general hospital psychiatry unit. The reasons for medically unexplained physical symptoms remaining one of the areas least explored despite their common occurrence may include the following. Traditionally these conditions are not considered part of core psychiatry. The nosology and classification of these conditions are confusing and controversial. Psychiatrists who are trained in mental hospitals are least exposed and not having adequate expertise in this area. Reluctance from the part of patients to seek psychiatric help. Difficulties encountered by general practitioners and specialists in making a referral for psychiatric help. Authors from the West have proposed many models in understanding functional somatic symptoms. For example, Linda Gask[8] described a practical model for the detection, acknowledgement and management of these conditions which can be easily learned and used in primary care. The three stage model emphasizes the importance of shared care between the psychiatrist and the primary health care team. These models are either directed to psychiatrists or primary care physicians. Every centre need to develop and evolve models suiting their needs and limitations as there cannot be a single ideal universal algorithm which may suit a condition as complex and diverse as functional somatic symptoms. We propose a model for understanding functional somatic symptoms, which is expected to be friendly to the non- psychiatrist users. The non- psychiatrist medical professional may consider the following possibilities when he is encountering medically unexplained somatic symptoms. This pattern of excessive complaining and dissatisfaction may baffle and annoy the physician who expects the patient to show a corresponding improvement directly proportional to the physical signs and lab reports. This may be due to the following factors. The neurobiological basis of Anxiety disorders and Depressive disorders points to the involvement of dysfunctional serotonergic, nor-adrenergic or dopaminergic neuronal circuits. Thus he will consider anxiety disorders and depressive disorders higher up in the priority list of differential diagnosis putting them much ahead of rare conditions l No physical or mental disorders to account for the somatic symptoms When the somatic symptoms cannot be explained based on the above

mentioned situations, they become much more difficult to be understood. Even the psychologically minded physicians find it difficult to empathize with this group. Medical professionals not trained in psychiatry may find it very difficult to understand the subtle difference between these disorders and conditions which are of factitious nature. One has to admit that these patients constitute the group which is difficult to tag a diagnosis and manage in the usual way, by virtue of the very nature and chronicity characteristic of these disorders. Naming them as somatoform disorders or sub typing them into somatization disorder or pain disorder may help to differentiate them from malingering or factitious disorders but may not help much in understanding or managing them. But if the physician can understand that these disorders are a result of abnormal processing and perception of signals in the central nervous system, it may help not only them, but also the patients or their worried relatives to make sense out of this baffling presentation. Acute and dramatic presentation of physical symptoms without a medical cause A psychiatrist may label them as a conversion disorder or a dissociative disorder when such disorders are presumed to have a causal relationship to a psychological conflict which may be unconscious. When he makes a referral to a psychiatrist, a medical professional is usually not bothered over these subtleties and is worried whether he is missing an organic cause, is concerned about symptom removal, and is often curious about the psychological stressor identified. One has to admit that these methods are effective at least for symptom removal. The practical difficulties in referring these patients for a psychiatric consultation often cited by physicians are also very valid in the background of our cultural context. Concern and conviction of a disease when none exists For the psychiatrist, this group whose main concern is not the symptoms, but the beliefs about health, disease and diagnosis may be hypochondriasis, a sub type of somatoform disorder. Understanding the relationship between health anxiety and beliefs about diseases and ill health may provide better insight for the physician in empathizing with these patients who are very likely to elicit negative emotional responses from the therapist and other care takers. Deliberate feigning of diseases The subtle difference between factitious disorders and malingering does not bother the non-psychiatrist. The fact that these disorders are relatively rare compared to the more common place conditions described above should be imparted to them rather than heading for the hair splitting arguments over factitious versus malingering. These six situations need not be considered essentially in the exact order given as above. The priority in this article has been assigned depending on the frequency usually encountered in clinical practice in a general hospital setting. The clinician should use his practical wisdom in determining priorities in individual cases. Assessment and diagnosis of somatoform disorders Building an alliance with the patient, collaborating with referral source, reviewing the medical records, gathering collateral information from others, performing psychiatric examination and MSE and physical examination are integral to a proper diagnosis. Management strategies include i Re- attribution approach ii Pychodynamic approach and iii Directive approach. In re-attribution approach the patient is helped to link his physical symptoms with psychological or stressful factors in his life. This is useful in those patients with insight, in short duration illness and for use in PHCs. In the psychotherapeutic approach, the thrust is in forming a close and trusting relationship with the patient. This modality may be useful in persistent somatization. In directive approach, the patient is treated as though he has a physical problem. Interventions are framed in the medical model. This approach is useful in hostile patients and those who deny the relevance of social or psychological factors. Principles of management are fundamentally same for management of all somatoform disorders. Explanations are given to empower the patient, emphasizing good prognosis and ensuring active involvement of the patient and x Specific treatment models like pharmacotherapy, behavior treatments including cognitive therapy and CBT, dynamic psychotherapy, group therapy, marital therapy, family therapy, physical and relaxation therapies. Chandrasekhara R et al.

SOMATIZATION DISORDER (HYSTERIA) pdf

5: Sigmund Freud: hysteria, somatization, medicine and misdiagnosis

But although the concept of 'hysteria' is conspicuously absent from the list of recognised diagnoses, the manual does give criteria for the diagnosis of three disorders which are clearly derived from the traditional concept - 'conversion disorder', 'somatization disorder' and 'histrionic personality disorder'.

Edit Although somatization disorder has been studied and diagnosed for more than a century, there is debate and uncertainty regarding its pathophysiology. Most current explanations focus on the concept of a misconnection between the mind and the body. Widely held theories on this troublesome, often familial disorder fit into three general categories. This theory states that the mind has a finite capacity to cope with stress and strain. Therefore, increasing social or emotional stresses beyond a certain point are experienced as physical symptoms, principally affecting the digestive, nervous, and reproductive systems. In recent years, researchers have found connections between the brain, immune system, and digestive system which may be the reason why somatization affects those systems and that people with irritable bowel syndrome are more likely to get somatization disorder. It is also experienced in very high levels in women with a history of physical, emotional or sexual abuse [3] The second theory for the cause of somatization disorder is that the disorder occurs due to heightened sensitivity to internal physical sensations. Some people have the ability to feel even the slightest amount of discomfort or pain within their body. Somatization disorder would then be very closely related to panic disorder under this theory. However, not much is known about hypersensitivity and its relevance to somatization disorder. The psychological or physiological origins of hypersensitivity are still not well understood by experts. Their catastrophic thinking about even the slightest ailments such as thinking a cramp in their shoulder is a tumor, or shortness of breath is due to asthma, could lead those who have somatization disorder to actually worsen their symptoms. This then causes them to feel more pain for just a simple thing like a headache. Often the patients feel like they have a rare disease. This is because their doctors would not be able to have a medical explanation for their unconsciously exaggerated pain that the patient actually thinks is there. This thinking that the symptom is catastrophic also often reduces the activities they normally do. They fear that doing activities that they would normally do on a regular basis would make the symptoms worse. The patient slowly stops doing activities one by one until they practically shut themselves from a normal life. The relevant brain regions include the dorsolateral prefrontal, insular, rostral anterior cingulate, premotor, and parietal cortices. This may be a central feature of treatment; as well as developing a close collaboration between the GP, the patient and the mental health practitioner [13] See also.

SOMATIZATION DISORDER (HYSTERIA) pdf

6: Somatization - www.enganchecubano.com

www.enganchecubano.com-Symptom ScreeningTestforSomatization Disorder TESTFORSOMATIZATION DISORDER AmJPsychiatry , October www.enganchecubano.comivity,Specificity.

North 1,2 Carol S. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution license http: This article has been cited by other articles in PMC. Abstract This article examines the history of the conceptualization of dissociative, conversion, and somatoform syndromes in relation to one another, chronicles efforts to classify these and other phenomenologically-related psychopathology in the American diagnostic system for mental disorders, and traces the subsequent divergence in opinions of dissenting sectors on classification of these disorders. This article then considers the extensive phenomenological overlap across these disorders in empirical research, and from this foundation presents a new model for the conceptualization of these disorders. The classification of disorders formerly known as hysteria and phenomenologically-related syndromes has long been contentious and unsettled. Examination of the long history of the conceptual difficulties, which remain inherent in existing classification schemes for these disorders, can help to address the continuing controversy. This review clarifies the need for a major conceptual revision of the current classification of these disorders. A new phenomenologically-based classification scheme for these disorders is proposed that is more compatible with the agnostic and atheoretical approach to diagnosis of mental disorders used by the current classification system. Introduction The relationships among dissociative, somatoform, and conversion disorders have long been uncertain and uneasy in the history of efforts to classify and understand them. The current classification of these disorders has evolved over centuries from common historical roots in a syndrome previously known as hysteria that has been interlinked in some periods with spiritual maladies. Uncertainties surrounding the origins and classification of these disorders have generated recurrent, often heated controversies among clinicians and academicians in different eras. The controversies blaze on today. This article will summarize the history of the conceptualization of these phenomena in relation to one another, chronicle efforts to classify these and other phenomenologically-related psychopathology in the American diagnostic system for mental disorders, and trace the subsequent divergence in opinions of dissenting sectors on classification of these disorders. Finally, this article will consider the extensive phenomenological overlap of all these disorders in empirical research, and from this foundation will present a new model for the conceptualization of these disorders. A Long History of Dissociation, Conversion, and Hysteria Dissociative phenomena have been a recognized part of human history for a very long time. Written records from ancient Egypt described cases of spirit possession, which in retrospect have been interpreted as dissociative phenomena [1]. Evidence of dissociation was also recorded in Christian scripture. Biblical passages in Mark 5: This story has been interpreted as representing a case of dissociative identity disorder, successfully cured with exorcism [3]. Accounts of spirit possession in this period included descriptions of dramatic hysterical and hypochondriacal presentations and convulsive fits [4]. The practice of exorcism of demons and evil spirits came to dominate as the preferred treatment for such problems around this time. Though Paracelsus claimed to be a physician, his doctoral degree in medicine could never be located [5 , 6]. Additional case reports of alternate personalities cropped up over the next two centuries, many of which had prominent hysterical features with dramatic physical and neurological symptoms. Approaches to treatment of altered states of experience of self began to evolve as physicians came to consider these cases to be medically rather than spiritually based [7]. Paracelsus advanced an elaborate theory of magnetism in the human body and its role in medical illness [8]. His methods induced states of anesthesia, paralysis, and hysterical convulsions in his patients. Mesmer was apparently quite a showman in demonstrations of these dramatic states and their cures in his patients. His critics were convinced that influences of suggestion and social contagion played a central role in the emergence of the hysterical presentations that emerged, and many considered him a charlatan [8]. Hypnotism, like magnetism and mesmerism, was also extensively applied in treating hysterical syndromes. The use of these methods was sometimes observed to result in the emergence of separate personalities within individuals [9]. Fascination

with magnetism is thought to have further contributed to the growing popularity of occult practices and charlatanism in the nineteenth century [10]. The French psychiatrist Pierre Janet is credited with having first coined the term dissociation, borrowing the concept from an earlier conceptualization of hysterical seizures by Moreau de Tours [11]. A student of Charcot, Janet developed his theory of dissociation based on his work with patients with hysteria [11]. Janet considered dissociation to represent abnormal splitting of mental processes resulting in compartmentalization of the personality into segments inaccessible to one another [12 , 13 , 14 , 15]. The fascination with these cases was short-lived. In the first half of the twentieth century, attention to dissociative disorders dwindled to the point of near extinction of the syndrome. Dissociative syndromes were conceptually subsumed into hysteria, the forerunner of the modern diagnosis of somatization disorder [14]. The history of dissociation has evolved in the long shadow of the history of the much older concept of hysteria. Written records from ancient Egypt dating back at least years described a syndrome known as hysteria, which was characterized as manifestation of multiple physical and behavioral dysfunctions [16 , 17]. Apparently hysterical and dissociative syndromes had much in common: The term hysteria, derived from the Greek word hystera signifying the uterus , dates back to at least the time of Hippocrates, when it was thought that the uterus became physically displaced from its normal position in the pelvis, wandering throughout the body to create symptoms in the various places that it inhabited [19 , 20]. In , the English physician Thomas Sydenham conceived of hysteria as an emotional condition rather than as a physical disorder, moving the source of the disorder from the uterus to the central nervous system [5 , 18]. The symptoms presented by his patients included physical complaints about bodily functions, neurological symptoms such as amnesia, paralysis, anesthesia, pain, spasms, and convulsive fits [21]. His patients exhibited dramatic physical symptoms such as hysterical vomiting and neurological symptoms including anesthesia, paralysis, deafness, bizarre movements, and epileptic-like seizures [25 , 27]. Charcot used hypnosis with his patients. He concluded that only hysterics could be hypnotized [19]. Both Charcot and Janet considered the hysterical phenomena in their patients to largely represent neurodegenerative conditions and they sought to separate these conditions from their historical enmeshment in occult and superstitious beliefs [29 , 30 , 31]. He was further criticized for failing to consider potential contributions of malingering and suggestion in the production of hysterical phenomena, especially when hypnosis was used, and for promoting social contagion by housing hysterics and epileptics together [7 , 13 , 19]. He was also criticized for various other methodological shortcomings [7 , 32]. Despite being discredited by his peers, Charcot successfully paved the way for the influential work of Austrian neurologist Sigmund Freud. Freud spent a few months early in his career studying hysterical phenomena, especially hysterical seizures, under Charcot [31], using hypnosis with these patients. The classic case of Anna O. Freud is credited with having first introduced the concept of hysterical conversion, and he originally coined this term [29 , 34]. In summary, this history reflects centuries of commingling of spirit possession, dissociation, hysteria, and conversion. Mainstream interest in spirit possession eventually faded, but major conversion and dissociative syndromes with dual multiple personalities have persisted to the present, with subsequent periodic spurts in reporting of these phenomena. Louis, who established a set of criteria for hysteria known as the Perley-Guze checklist [39] based on seminal work by Briquet [23], Savill [38], and Purtell, Robins, and Cohen [40]. Patients with this disorder visit many physicians with a plethora of complaints lacking medical explanation or physiologic basis. Their medical histories are often dramatic and complicated. These patients tend to undergo extensive surgical procedures and invasive tests, often with complicated courses and poor outcomes. There is no cure for this disorder and no specific psychotropic medication indicated for it, but with effective management, many of these patients can be stabilized. Treatment is ideally orchestrated by one physician who forms a supportive relationship with the patient to help redirect her from her many symptoms to address the many psychosocial issues typically accompanying this disorder. The ultimate goal of treatment is to prevent iatrogenic morbidity through protecting the patient from excessive medications, diagnostic procedures, and surgeries [45 , 46]. Symptom presentations that are confined to medically-unexplained neurological symptoms are, however, considered to represent a conceptually related, but separate disorder classified as conversion disorder. Evidence to support the separation of these two syndromes is based on the different distinctive clinical

presentations and very different longitudinal courses of these two syndromes [47]. The above history documents that in American psychiatry by the middle of the twentieth century, the syndrome of hysteria was firmly established and was defined as multiple recurrent unexplained physical symptoms presenting in many different organ systems [40]. At the time of these historic developments in St. Louis, the American system of diagnostic criteria for mental disorders was evolving. Somatic symptoms, which refer to any physical symptom without regard to medical basis, are differentiated from somatoform symptoms, which are physical symptoms that are medically unexplained [53]. Historically, psychodynamic theory with its long-held assumptions of etiology of dissociation, conversion, and somatization provided the main process for distinguishing these syndromes and categorizing them separately from one another [54]. However, the basis of psychodynamic theory in the formulation of criteria for psychiatric disorders was formally abandoned 35 years ago beginning with the third edition of the Diagnostic and Statistical Manual of Mental Disorders DSM-III [55]. Thereafter, an atheoretical and agnostic approach to psychiatric diagnosis based on measurable and reliable features of disorders including characteristic symptoms, longitudinal course, and familiality came to dominate the American system of diagnostic criteria [56]. The phenomenological and atheoretical St. DSM-III separated dissociative from somatoform disorders and grouped conversion with the somatoform disorders. The dissociative disorders section was placed immediately after the somatoform disorders section to reflect the recognition of a conceptual proximity of these two groups of syndromes. In the agnostic and atheoretical approach to American psychiatric diagnosis established with DSM-III, the grouping of conversion with somatoform phenomena emphasized the phenomenological association of physical symptom complaints. This convention displaced the causal assumptions of psychoanalytic theory that had previously driven the categorization of these syndromes [11]. The DSM-III dissociative disorders included psychogenic amnesia, psychogenic fugue, multiple personality, depersonalization disorder, and atypical dissociative disorder. The text explained that placement of depersonalization disorder in this section was controversial because depersonalization disorder, unlike all the other disorders in this section, did not involve memory disturbance. In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV [62] and its subsequent text revision DSM-IV-TR [63], the criteria for somatization disorder were further simplified to require only eight symptoms from a list of 32 symptoms listed as examples distributed among four symptom groups. In DSM-IV, perception was added to the previous list of disrupted functions of consciousness, memory, identity disrupted as the essential feature of dissociative disorders. The major diagnosis in this section is now somatic symptom disorder, which requires one or more physical symptoms that cause distress or significant disruption of daily life. The prior somatoform disorders requirement that the symptoms be medically unexplained was not included in somatic symptom disorder criteria. Diagnoses of hypochondriasis, pain disorder, and undifferentiated somatoform disorder were dropped. Conversion disorder was retained in DSM-5 and it received a new subtitle: The previous requirement that the symptom s must be associated with psychological conflicts or stressors, which invoked a theoretical etiology, was removed. The prior requirement that the symptom or deficit not be intentionally produced or feigned has been removed from DSM-5 criteria for conversion disorder, allegedly because this distinction is difficult or impossible to make; the text, however, states that definite evidence of intentionality or feigning would alternatively suggest diagnoses of factitious disorder or malingering. Additionally, DSM-5 eliminated the factitious disorders section and moved its content into the section for somatic symptom and related disorders. Although functional impairments considered central to the psychopathology of dissociative disorders have varied across editions of the American diagnostic manual, DSM-5 describes dissociative disorders as broadly involving impairments in the integration of all of the following: Motor functions were re-inserted, and emotion and body representation were added. The DSM classification system and its directional changes have had far-reaching ramifications for diagnostic practice. As noted by Paris [12], once the dissociative disorders had finally obtained a separate diagnostic category dedicated to them in the American diagnostic criteria in , a following of believers emerged who fervently maintained that dissociative disorders are common, under-recognized, and very important. Around that time, a sudden upsurge in reported cases followed publication of the best-selling book Sybil [65] describing a dramatic case of multiple personality disorder with 16 alternate personalities. The popularity of

this book and a subsequent Hollywood movie based on the book heralded a veritable epidemic of this disorder in the decades to follow [12 , 66]. These modern cases were concentrated in the United States and were contributed by a limited number of authors who extensively cross-referenced one another [14]. Not only did the numbers of reported cases expand rapidly, but the numbers of separate personalities reported in these cases also markedly increased [14]. More recently, Pope and colleagues [69] tracked the number of scientific articles on dissociative identity disorder and repressed memory, finding the emergence of a dramatic increase in the s that spiked in the late s and then plummeted to about one-fourth of the peak by the early s. Over this same period, academic publication rates for 25 other psychiatric disorders were either constant or sustained gradual increases. Continuing Controversies over Classification of Dissociative, Conversion, and Somatoform Disorders The classification of dissociative disorders in the American diagnostic system for mental disorders fell out of line with the international diagnostic criteria in the late twentieth century.

SOMATIZATION DISORDER (HYSTERIA) pdf

7: Somatization disorder - causes, DSM, functioning, therapy, drug, examples, person, people

Somatization disorder is a psychiatric condition marked by multiple medically unexplained physical, or somatic, symptoms. In order to qualify for the diagnosis of somatization disorder, somatic complaints must be serious enough to interfere significantly with a person's ability to perform important activities, such as work, school or family and social responsibilities, or lead the person.

Yanik Chauvin Definition Somatization disorder is a psychiatric condition marked by multiple medically unexplained physical, or somatic, symptoms. The term "somatoform" means that the physical symptoms have a psychological origin. Description Individuals with somatization disorder suffer from a number of vague physical symptoms, involving at least four different physical functions or parts of the body. The physical symptoms that characterize somatization disorder cannot be attributed to medical conditions or to the use of drugs, and individuals with somatization disorder often undergo numerous medical tests with negative results before the psychological cause of their distress is identified. They often use impressionistic and colorful language to describe their symptoms, describing burning sensations, pains that move from place to place, strange tastes on the tongue, tingling, or tremors. While many symptoms resemble those associated with genuine diseases, some of the symptoms reported by people with somatization disorder are not. It is important to note that while the physical symptoms of somatization disorder frequently lack medical explanations, they are not intentionally fabricated. The typical person with somatization disorder has suffered from physical pain, discomfort, and dysfunction for an extended period of time and consulted several doctors; they are hopeful that they one can be found who can identify the cause of their illness and provide relief. Somatization disorder can be dangerous, since patients may end up taking several different medications, thereby risking harmful drug interactions. One of the oldest theories about the cause of somatization disorder suggests that it is a way of avoiding psychological distress. Rather than experiencing depression or anxiety, some individuals will develop physical symptoms. According to this model, somatization disorder is a defense against psychological pain that allows some people to avoid the stigma of a psychiatric diagnosis. While getting the care and nurturing they need from doctors and others who are responsive to their apparent medical illnesses, many patients are encouraged to continue their manipulative behavior. Many patients described by Sigmund Freud would be diagnosed today with somatization disorder. His patients were usually young women who complained of numerous physical symptoms. In the process of speaking with Freud, they would often recall a number of distressing memories; discussing these memories frequently led to the relief of physical symptoms. Although this theory offers a plausible explanation for somatization disorder, research indicates that people with multiple physical symptoms are actually more likely to report psychiatric symptoms than those with few physical problems. These findings appear to support a connection between psychological and physical distress, but are inconsistent with the idea that physical symptoms offer a defense against overt psychiatric symptoms. An alternative theory suggests that somatization disorder arises from a heightened sensitivity to internal sensations. People with somatization disorder may be keenly aware of the minor pains and discomforts that most people simply ignore. A similar theory has been offered to account for panic disorder. Studies have shown that people with panic disorder are particularly sensitive to internal sensations like breathing rate and heartbeats, which may lead them to react with intense fear to minor internal changes. The physiological or psychological origins of this hypersensitivity to internal sensations and their relevance to somatization disorder are still not well understood. According to these thoughts, somatization disorder results from negative beliefs and exaggerated fears about the significance of physical sensations. Individuals with somatization disorder are thus more likely to believe that vague physical symptoms are indicators of serious disease and to seek treatment for them. For instance, someone with somatization disorder may fear that a headache signals a brain tumor, or that shortness of breath indicates the onset of asthma. When their doctors can find no medical explanation for the symptoms, the patients may fear that they have a rare disease; they frantically look for specialists who can provide a diagnosis. Anxiety causes them to focus even more intensely on their symptoms, which in turn become more disabling. Many people with somatization disorder reduce or

eliminate many activities out of fear that exertion will worsen their symptoms. With fewer activities to distract them from their symptoms, they spend more time worrying about physical problems, resulting in greater distress and disability. Symptoms Gastrointestinal GI complaints, such as nausea, bloating, diarrhea, and sensitivities to certain foods are common, and at least two different GI symptoms are required for the diagnosis. Sexual or reproductive symptoms, including pain during intercourse, menstrual problems, and erectile dysfunction are also necessary features for a diagnosis for somatization disorder. Other frequent symptoms are headaches, pain in the back or joints, difficulty swallowing or speaking, and urinary retention. To qualify for the diagnosis, at least one symptom must resemble a neurological disorder, such as seizures , problems with coordination or balance, or paralysis. Sex ratios may arise from different rates of seeking treatment. However, studies of unexplained somatic symptoms in the general population find less striking differences in rates between men and women. Specific symptoms may vary across cultures. Diagnosis To receive a diagnosis of somatization disorder, the individual must have a history of multiple physical complaints that began before age 30 and that continued for several years DSM-IV-TR. These symptoms must cause significant impairment to social, occupational or other areas of functioningâ€”or lead the patient to seek medical treatment. Each of the following four criteria must be met. The individual must report a history of pain affecting at least four different parts or functions of the body. Examples include headaches, back, joint, chest or abdominal pain, or pain during menstruation or sexual intercourse. A history of at least two gastrointestinal symptoms, such as nausea, bloating, vomiting, diarrhea, or food intolerance must be reported. There must be a history of at least one sexual or reproductive symptom, such as lack of interest in sex, problems achieving erection or ejaculation, irregular menstrual periods, excessive menstrual bleeding, or vomiting throughout pregnancy. One symptom must mimic a neurological condition. Examples include weakness, paralysis, problems with balance or coordination, seizures, hallucinations , loss of sensations such as touch, seeing, hearing, tasting, smellingâ€”or difficulty swallowing or speaking, or amnesia and loss of consciousness. Pseudo-neurologic symptoms like these are the primary characteristics of another somatoform disorder known as "conversion disorder. People with genuine medical conditions can qualify for the diagnosis if the level of functional impairment reported is more than would be expected based on medical findings. The symptoms must not be intentionally produced. If the patient is feigning symptoms, a diagnosis of factitious disorder or malingering would most likely be considered. Treatments Cognitive behavior therapy Cognitive-behavioral therapy CBT for somatization disorder focuses on changing negative patterns of thoughts, feelings, and behavior that contribute to somatic symptoms. The cognitive component of the treatment focuses on helping patients identify dysfunctional thinking about physical sensations. With practice, patients learn to recognize catastrophic thinking and develop more rational explanations for their feelings. The behavioral component aims to increase activity. Patients with somatization disorder have usually reduced their activity levels as a result of discomfort or out of fear that activity will worsen symptoms. CBT patients are instructed to increase activity gradually while avoiding overexertion that could reinforce fears. Other important types of treatment include relaxation training, sleep hygiene, and communication skills training. Preliminary findings suggest that CBT may help reduce distress and discomfort associated with somatic symptoms; however, it has not yet been systematically compared with other forms of therapy. Medications Antidepressant medications may help to alleviate symptoms of somatization disorder. According to one study, patients with somatization disorder who took the antidepressant nefazodone Serzone showed reductions in physical symptoms, increased activity levels, and lower levels of anxiety and depression at the end of treatment. Prognosis Untreated somatization disorder is usually a chronic condition, though specific symptoms can come and go and overall severity may fluctuate over time. Somatization disorder poses a serious problem for society, since many who suffer from it become functionally disabled and unable to work. In addition, patients with unexplained physical symptoms strain already overburdened health care resources. Unexplained physical symptoms are extremely common among patients visiting general practitioners, with some estimates suggesting that over two-thirds of general medical patients have symptoms that cannot be explained by medical tests. Fortunately, there is preliminary evidence that psychotherapy and medication can effectively reduce symptoms and disability. Prevention Greater awareness of somatization disorder, particularly among

physicians, can help them identify individuals with somatization disorder, and help these patients get appropriate psychological or psychiatric treatment. Diagnostic and Statistical Manual of Mental Disorders. Breuer, Josef and Sigmund Freud. University of Minnesota Press, The inside storyâ€”A model for psychosomatic process. Hmaer, and Javier Escobar. A prospective, open-label study. An epidemiological study in seven specialties. Other articles you might like:

8: Somatization Disorder

Somatization disorder is not an imagined or fictitious disorder as associated with conditions like malingering; rather, the symptoms are very real, and the pain felt by the patient is real as well. The disorder used to be dismissed as something made up in the patient's head, or a form of hysteria.

9: Somatization disorder - Wikipedia

This new category included traditional psychiatric disorders like hysteria and hypochondriasis, together with newly proposed categories like somatization disorder. Somatoform disorders and dissociative disorders were introduced in DSM III "to rationalize what has been previously regarded as neurosis".

SOMATIZATION DISORDER (HYSTERIA) pdf

Understanding the Afterlife in This Life Handbook of media for clinical and public health microbiology Silk in Africa (Fabric Folios) III-V Nitrides Semiconductors and Ceramics Ebook business model generation Grimes Graves, Norfolk (Archaeological reports Department of the Environment) 9. Ungendering in Art and Academia A wworld full of women We can still dream Iob net banking application Geotechnical engineering by av venkatramaiah The lyrics of Tennyson. Mr. Sherlock Holmes The Brimstone Network Free economy versus planned economy, by L. Erhard. Examples of libelli. Thinking like a writer a lawyers guide If I Were Just a Little Taller Head and shoulders pattern Motivational novels for students Get out of debt plan Ninth key meg cabot bud Honey and Clover 5 Crucified with Christ Susan Sorensen Quick reaction checklist. The economics and evolutionary biology of love We reap what we sow The Fifth American Chess Congress V. 4. Map package (1 map package (12 maps)). Introduction Donald P. Hilty Meeting Bill Ward and the rest Gandhis technique of mass mobilization Brief lives, chiefly of contemporaries The complexity of many faces in arrangements of lines and of segments Advanced web design tutorial How do cybercriminals use online media to commit crimes? Jurassic park operation genesis prima official strategy guide The lives of ethnic Americans Guide to Ohio newspapers, 1793-1973 The Baptismal Formula 5