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### RESEARCH ARTICLE

#### A REVIEW ON SOMATOFORM DISORDERS.

Ali Mahmood Khan<sup>1</sup>, Sukaina Rizvi<sup>1</sup>, Danish Kherani<sup>2</sup>, Sohaib Siddiqui<sup>3</sup>, Muhammad Fawwaz Haq<sup>2</sup>,  
 Muhammad Mustafa Ahmed<sup>2</sup>, Ashraf Farooq Arain<sup>2</sup> and Syed Kazim Raza<sup>4</sup>.

1. Kings County Hospital Center, NY, USA.
2. Ziauddin University, Karachi, Pakistan.
3. Ross University School of Medicine, FL, USA.
4. Dow University of Health Sciences, Karachi, Pakistan.

#### Manuscript Info

#### Abstract

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#### Introduction:-

This article provides an overview of somatoform disorders. It focuses on the symptoms presented and factors that contribute to the development of somatoform disorders.

#### Discussion:-

Somatoform disorders, now also known as somatic symptom disorder (SSD) are a group of physiological disorders in which a patient experiences physical symptoms that cannot be classified nor fully explained by any general medical or neurological condition. Medically unexplained physical symptoms account for as many as 50% of new medical outpatient visits (1). Emotional symptoms, anxiety disorders, depression and substance use as well as personality disorders and childhood abuse are often comorbid with both unexplained physical symptoms and somatoform disorders (2).

Somatoform disorders cause excessive and disproportionate levels of distress. It can present with symptoms such as pain which is the most common symptom, weakness, paralysis, abnormal movements such as tremor or unsteady gait, blindness, hearing loss or loss of sensation and numbness. Somatoform disorders are observed worldwide, more often in woman, with first symptoms appearing by age 25 (3).

The diagnosis was historically referred to as hysteria or *briquet's syndrome* (4). The diagnosis of somatoform disorders can create a lot of stress and frustration for patients because they may feel unsatisfied if there's no better physical explanation for their symptoms. The somatic symptoms are neither intentionally produced nor simulated. Somatization may be suspected when the panoply of dysfunctional organ systems is belied by the patient's apparent health (3). All of the following historical criteria are required for a DSM-IV (Diagnostic and statistical manual of mental disorders 4<sup>th</sup> edition) diagnosis of somatoform disorders (5): Four different pain sites (head, abdomen, back, joints, extremities, chest, and rectum) or painful functions (e.g. menstruation, sexual intercourse, urination). Two gastrointestinal symptoms other than pain (e.g. nausea, bloating, vomiting or intolerance of several different foods). One sexual or reproductive symptom other than pain (e.g. erectile or ejaculatory dysfunction, irregular menses or

excessive menstrual bleeding). One pseudoneurological symptom (e.g. impaired balance, paralysis, aphonia or urinary retention). The criteria for somatoform disorders were designed for adults, and attempts have been made to apply this criteria in pediatric populations since adolescents can present with many of these symptoms. Extensive evaluation is best avoided. Functional imaging studies have demonstrated alterations in cortical and limbic networks, which promote disengagement from and suppression of mild or chronic pain (6). But it is said to have no role in diagnosis. Difficulty expressing emotional distress verbally is widely thought to underlie the presentation of physical symptoms that cannot be explained in medical terms (7).

There are certain factors that contribute to the development of somatoform disorders. These disorders follow a sequence of events which starts from affective distress in the form of somatic sensations which later progress as the age increases. Prior to puberty, the male to female ratio of somatic symptoms is nearly equal. However, adolescent girls tend to report nearly twice as many functional somatic symptoms than adolescent boys (8). It is believed that somatizing behavior is encouraged by real or perceived rejecting responses from significant others. Higher levels of anger mood, rumination, and support-seeking coping styles have shown to predict somatic complaints (9). In addition to using ineffective coping strategies, children with recurrent somatic symptoms tend to focus more intently on bodily sensations and have a heightened emotional response to stress (10). Somatization disorders occur in as many as 10-20% of first degree relatives and have a higher concordance rate in monozygotic twin studies (11). In families with somatizing children, functional abdominal pain, anxiety, depression and other somatic symptoms are common (12). These evidence indicate that physical symptoms have an inheritance component. Trauma also plays its part in developing somatoform disorders as people with previous histories of physical and sexual abuse present with more symptoms than people without histories of abuse. Severity of abuse and number of traumatic events experienced correlate with the number of somatoform symptoms reported (13). School stressors have been demonstrated as one of the most common environmental factors for the development and maintenance of somatic disorders (14).

For the treatment of somatoform disorders an integrated medical and psychiatric approach is strongly recommended (15). The main goal of the treatment is both to alleviate symptoms and reduce unnecessary medical care. Effective treatment of patients with somatoform disorders is difficult, time consuming and requires patience and understanding (3). CBT (cognitive behavioral therapy) is found to be effective in paroxysmal non-epileptic attacks (16). Selective serotonin reuptake inhibitors (SSRI) may also be beneficial (17). It is also suggested to change the therapist if the current one is not experienced with treating these disorders.

### **Conclusion:-**

In the end we can conclude that the diagnosis of somatoform disorders can only be done after ruling out organic medical conditions also known as organic brain syndrome followed by psychiatric conditions. After establishing a positive diagnosis of a somatoform disorder further strategy and treatment options are planned. Though the benefit of making a specific diagnosis may not be as useful considering the limited amount of treatment options available, but at least it will lay down the foundation for appropriate assessment of new cases.

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