



# Somatisation Disorder

*A fact sheet produced by the Mental Health Information Service*

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**Somatisation** is when physical symptoms develop through stress or emotional problems. Anxiety and depression can cause physical symptoms like chest pain, dizziness, diarrhoea or fatigue. To 'somatise' is very common; most people have experienced headaches or nausea as a result of worry or a stressful situation. These symptoms really exist, they are genuine and by no means could be considered imagined.

## What is Somatisation Disorder?

Somatisation disorder (formerly known as hysteria or Briquet's syndrome) is diagnosed when a person has experienced multiple physical complaints and symptoms over a long period of time. These symptoms cannot be identified or explained through medical examinations or tests. People with this disorder have a history of physical problems occurring in different areas of their body. They have usually approach a variety of medical practitioners in an attempt to find answers to the pain and distress they are experiencing. They have often undergone unnecessary medical procedures and tried an array of medications to no avail.

Somatisation disorder is a very real and debilitating condition that can cause great anguish to the affected individual. It is often accompanied by extremes of frustration for the patient and doctor alike as medical understanding and procedures fail to recognise the cause and existence of the undeniable physical complaints under investigation.

Somatisation disorder is classed as a somatoform disorder. The somatoform disorders listed in the Diagnostic and Statistical manual of Mental Disorders, Fourth Edition (DSM IV) are somatisation disorder, undifferentiated somatoform disorder, conversion disorder, pain disorder, hypochondriasis, body dysmorphic disorder and somatoform disorder not otherwise specified (NOS). The common feature of the somatoform disorders is unexplained physical symptoms that can cause the individual immense difficulties in social, occupational, or other areas of life.

## What Are the Symptoms?

Somatisation disorder usually develops between the ages of 18 and 30. The diagnostic criteria is usually met before age 25 with initial symptoms regularly appearing by adolescence or sooner. It can manifest for a period of many years and is characterised by a combination of pain, gastrointestinal, sexual, and replicated neurological complaints.

This disorder often seems to co-exist with other psychiatric conditions like major depression, anxiety disorders, personality disorders and panic disorders. Somatisation disorder is very risky to confirm because of the severe consequences a misdiagnosis might cause. Even with a confirmed diagnosis the patient is still susceptible to developing a clinically recognised illness that requires treatment. Due to this fact the diagnostic criteria are very intricate. According to DSM IV a comprehensive and precise array of symptoms must be apparent before a diagnosis of somatisation disorder can be considered.

Some of the numerous symptoms that can occur with somatisation disorder include:

Vomiting	Pain during urination	Vision changes
Abdominal pain	Headaches	Paralysis or muscle weakness
Nausea	Shortness of breath	Sexual apathy
Bloating	Palpitations	Pain during intercourse
Diarrhoea	Chest pain	Impotence
Pain in the legs or arms	Dizziness	Painful menstruation
Back pain	Amnesia	Irregular menstruation
Joint pain	Difficulty swallowing	Excessive menstrual bleeding

### **Common Myths**

Somatisation disorder is not the same as factitious disorder or Munchausen's syndrome. These are psychiatric conditions where symptoms are deliberately faked in order to gain attention and receive care. It is very important for the person with somatisation disorder to have their symptoms acknowledged as being involuntary and genuine.

Another setback is when malingering is thought to be connected to somatisation disorder. Malingering is when a person deliberately fakes an illness with the intention of deceit to obtain personal or financial gain. Malingering is not considered a mental illness and is no way connected to somatisation disorder.

### **What Are the Causes?**

Research suggests both genetic and environmental factors may contribute to the risk of developing this disorder, it appears to affect women at a much higher rate than men. Somatisation disorder may originate as a reaction to depression or anxiety or as a response to severe psycho-social stress, it then persists long after the problem has resolved. It is this persistence that makes it so difficult for the patient to believe there is no medical justification for their symptoms. They then go on to seek repeated medical opinions and treatments in a vain attempt to find the answer to their illness.

## What Help is Available?

Treating a patient with somatisation disorder is usually difficult because it is often extremely hard for them to accept their illness could be of a psychiatric nature. Cognitive behaviour therapy may be quite useful when attempting to alter obstructive attitudes surrounding the symptoms. Counselling may help to identify and face emotional issues. Medication can be useful when co-existing mental health problems such as depression, anxiety or substance abuse are present. Sometimes there may be an underlying mood disorder, which may respond to antidepressant medication.

An encouraging association with a compassionate doctor seems to be very helpful in treatment. Regular appointments may be necessary to evaluate symptoms and assess the person's coping mechanisms. Physical examinations and medical tests may be required to insure the patient's symptoms do not stem from physical causes.

Confusion and misunderstanding can often interfere with the management and care of people experiencing the effects of somatisation disorder. It is valuable for friends and relatives to be accepting and receptive to the genuineness of the problems exhibited by the person undergoing treatment.

## References

- 1) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, 1995, American Psychiatric Association
- 2) Taylor, D (MD) MedStar Health  
<http://www.medstarhealth.org/body.cfm?id=124&action=display&articlenum=955>
- 3) Holloway, K L, MD & Zerbe, K J, MD.  
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[http://www.postgradmed.com/issues/2000/11\\_00/holloway.htm](http://www.postgradmed.com/issues/2000/11_00/holloway.htm)
- 4) Psynet-UK, Factitious Disorder  
[http://www.psychnet-uk.com/dsm\\_iv/factitious\\_disorder.htm](http://www.psychnet-uk.com/dsm_iv/factitious_disorder.htm)

## Further Reading

*Somatoform and Factitious Disorders*, by Katherine A Phillips, American Psychiatric Association, 2001, ISBN: 1585620297

*Hypochondria: Woeful Imaginings*, by Susan Baur, University of California Press, 1989, ISBN: 0520067517

*Clinical Faces of Childhood: The Hysterical Child, The Anxious Child, The Borderline Child*, edited by E James Anthony and Doris C Gilpin, Rowman & Littlefield Publishers, 1994, ISBN: 1568213352

## Where to Get Help

- General Practitioner
- Local Community Mental Health Centre - see 'Community Health Centre' in *White Pages*
- For a referral to a psychologist, contact the Australian Psychological Association on 1800 333 497.
- Association for Relatives and Friends of the Mentally Ill (ARAFMI): Phone service and support groups for families and relatives of the mentally ill 1300 794 992
- Mental Health Information Service (for services in your area) on 1300 794 991

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