Chapter 8
Mind and body

LEARNING OBJECTIVES

After reading and studying this chapter and participating in lectures and discussions, students should have an understanding of:

1. The causes and treatments of Somatic Symptom Disorder.
2. The causes and treatments of Illness Anxiety Disorder.
3. The causes and treatments of Body Dysmorphic Disorder.
4. The causes and treatments of Functional Neurological Symptom Disorder.

CHAPTER OUTLINE

8.1 Somatic Symptom Disorder
- Aetiology of SSD
  - Developmental models
  - Biological mechanisms
  - A psychobiological model
- Treatment of SSD
  - Pharmacological treatment
  - Psychological interventions

8.2 Illness Anxiety Disorder
- Prevalence of IAD
- Aetiology of IAD
  - Psychoanalytic explanations
  - Developmental models
  - IAD as threat
  - A psychobiological variant of the threat model
- Treatment of IAD
  - Psychological treatment
  - Pharmacological treatment

8.3 Body Dysmorphic Disorder
- Aetiology of BDD

Sociocultural factors
Psychanalytic models
A psychological model
Treatment of BDD
Psychological treatment
Pharmacological treatment

8.4 Functional Neurological Symptom Disorder
Aetiology of FNSD
Social processes
Psychoanalytic explanations
Behavioural explanations
Functional disorders as a form of hypnosis
The role of stress
Treatment of FNSD

QUESTIONS FOR DISCUSSION

These may helpful to include at the beginning of the teaching session to get a sense of where people lie on these issues, to spark some interest in them, and as a link to refer to as the lecture progresses.

1. Which of the following is **not** a symptom of somatic symptom disorder?
   a. The belief the individual has a somatic illness
   b. The experience of distressing somatic symptoms
   c. High levels of anxiety about health
   d. Disproportionate degree of worry about the seriousness of somatic symptoms

2. Which of the following is true of people with a diagnosis of illness anxiety disorder?
   a. They have a poor awareness of the physical sensations they experience
   b. They have an above average sensitivity to the physical sensations they experience
   c. They have a normal level of awareness of physical sensations

3. Which of the following statements has been used to explain functional neurological disorder?

   a. Faking physical symptoms to avoid stressful situations

b. A placebo/social response to stressful events
c. A neurological process through which opposing neurological processes result in the nett outcome of paralysis or muscular weaknesses
d. A hypnotic state
e. All of the above

4. Which of the following statements is true?
a. Psychoanalytic approaches may be of significant benefit to the treatment of FND
b. Psychoeducational approaches may be successful in the treatment of FND
c. People with FND have proven markedly resistant to treatment using CBT
d. All of the above

LECTURE SUGGESTIONS

Well, this chapter is a bit of a rag bag of issues and conditions. The one common factor is that they involve concerns about somatic issues or presentations with odd somatic symptoms. The first two conditions are similar in many ways, so it is important to draw out the distinctions between them:

- *Somatic symptom disorder*: in this, the individual experiences a range of somatic 'symptoms' that interfere with day-to-day living. The patient has concerns about their seriousness, but do not label them as a particular illness.
- *Illness Anxiety Disorder*: the individual experiences no, or only mild, 'symptoms', but is nevertheless convinced they have, or are developing, a serious illness.

The conditions are therefore separated by the presence or lack of experienced symptoms, but otherwise have much in common. They also could be considered under the rubric of anxiety disorders. In fact, IAD is one of the conditions I consider in my 3rd year option on anxiety disorders.

Feeling unhappy about part of one's body is a fairly normal experience, so it is easy to dismiss *body dysmorphic disorder* as a slight exaggeration of a relatively normal experience. However, this significantly underestimates the psychological toll associated with BDD, which is linked to high rates of suicide, social isolation, and substance abuse. It is not a trivial disorder and is difficult to treat, with success rates for interventions still leaving around 50% of people with ongoing problems.

Finally, the absolutely intriguing *functional neurological symptom disorder*. Previously known as hysterical conversion, this is the classic psychoanalytic subversion of psychological trauma to physical symptoms. It remains an intriguing process and is underpinned by fundamental models of unconscious neurocognitive functioning. It is therefore fascinating that some of the most effective treatments have involved relatively simple educational interventions.

CLASSROOM ACTIVITIES

Homework: is there a part of your body with which you are dissatisfied? Your stomach is not flat enough, your legs are too thin, and so on. Magnify your concerns about this by a factor of ten, and then think through an exposure programme plus cognitive restructuring you could use to reduce your concerns/increase your confident in exposing this part of your body to the world.

Case discussion in pairs: Jane is a middle-aged woman who has a fear of having or developing breast cancer. As a consequence, she frequently visits her GP, who is happy to palpate her breasts to assure her that there are no sinister lumps or bumps. She, herself, checks on a more than daily basis, but feels more reassured when a trained physician has checked her. She will not let her husband touch her breasts, so there are sexual/relationship problems. She constantly worries about developing breast cancer and is concerned that by the time she identifies any lumps or bumps in her breasts, it will mean that the cancer will has spread to the rest of her body and may not be treatable. How would you set about responding to these problems? Hints! Gradual fading of GP visits and, when she does visit, she does so at regular and pre-planned times so she is not rewarded by the relief of reassurance when she is particularly worried. Similarly, gradual fading of her self-checking with the use of mindfulness as a way of helping her cope. Cognitive challenge may be difficult as future worries about illness can be difficult to discount: “I didn’t have a lump last time I checked... but this does not mean I won’t have one the next time…”. Maybe try mindfulness?

Small group discussion: is functional neurological symptom disorder no more than a convenient way of avoiding stress or unwanted challenges? If someone presents with FNSD, how would you try to disentangle ‘genuine’ neurological processes from ‘fakes’? Oh, and why do so many people diagnosed with the disorder bring a teddy bear to the assessment clinics???