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Psychosomatic Complaints of the Patient: Differential Diagnosis

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ABSTRACT

The viscero-vegetative manifestations of anxiety and depression that dominate the clinical picture, imitating to a certain extent various organic diseases, sometimes cannot help but mislead the practitioner. Complaints of pain clearly localized around a specific organ (the object of the patient's hypochondriacal fixation), and the extreme similarity of such complaints, which do not go "beyond the possible," with the usual symptoms of somatic suffering almost inevitably direct the diagnostic search along the wrong path. Somatic disorders in such cases are sometimes so significant that even a psychiatrist does not recognize the depression that is sometimes veiled by them during a single consultation with the patient.

Keywords: Antioxidant Systems; Oxidative Reactions

Introduction

The viscero-vegetative manifestations of anxiety and depression that dominate the clinical picture, imitating to a certain extent various organic diseases, sometimes cannot help but mislead the practitioner. Complaints of pain clearly localized around a specific organ (the object of the patient's hypochondriacal fixation), and the extreme similarity of such complaints, which do not go "beyond the possible," with the usual symptoms of somatic suffering almost inevitably direct the diagnostic search along the wrong path. Somatic disorders in such cases are sometimes so significant that even a psychiatrist does not recognize the depression that is sometimes veiled by them during a single consultation with the patient; The entry in the medical history reads as follows: "No acute psychotic symptoms were detected." The absence of noticeable psychomotor retardation and active appeal to various specialists for medical help, not so much the classic ideas of self-accusation and self-reproach, but rather reproaches and even ideas of accusation against doctors who seemed insufficiently qualified or attentive, not so much a general "moral depressive assessment", but "local" depressive ideas about the state of one's body as a whole and of certain organs separately, the frequent "loss of affective resonance" and the seemingly paradoxical inability to experience melancholy cause undeniable difficulties in the timely diagnosis of somatized depression, which is always colored more or less in hypochondriacal tones [1-4].

The functional nature of viscero-autonomic disorders is often established in practice by the method of exclusion, gradually sorting out the nosological rosary from a wide variety of pathological processes - from the most common to the casuistic. The psychogenic nature of suffering must be diagnosed, however, not by excluding organic pathology, but based on well-defined symptoms and psychosomatic correlations. The identification of affective disorders should be considered as a positive criterion, not reducible to the patient's biography and the formal connection of his painful feelings with a stressful situation. In the absence of reliable signs of affective disorders, attributing to a patient a depressive state with hypochondriacal attitudes is unlawful, since we are essentially talking not so much about "masked" as about unrecognized depression, not counting those cases where the use of antidepressants completely and quite stably normalizes the patient's condition . Only long-term dynamic observation sometimes makes it possible to ascertain typical manifestations of vital fluctu-

ations in well-being and the phase course of the disease, or genuine organic suffering that was not detected at the time [1,5,6]. Patients with erased depression usually clearly object to the reduction of their condition to "neurotic" disorders with hypochondriacal tendencies (which, undoubtedly, is akin to anosognosia in many cases), but even these patients can admit (in the process of conversation with a doctor who "understands" them and, therefore, evokes a feeling of trust) in the loss of taste for life and the painful alienation from the family for them, anxiety about their well-being and the consciousness of incurability.

Denial of anxiety and melancholy in the clinic of hypochondriacal depression is most often due to the incorrect form of the doctor's questions. A qualified (targeted, but not too straightforward) survey makes it possible to establish in the patient affective tension and general mental hyperesthesia, a feeling of some kind of trouble; mental discomfort; increasing irritability, often politeness, "nervousness," constant readiness to cry" and anxiety with an inadequate reaction to any surprise; "absent-mindedness" that is, decreased concentration; morning of initiative, every interest and warm feeling for loved ones; lack of joy," indifference to everything; feeling of hopelessness in life; a feeling of worthlessness, a decrease in previous attachments and habits, and, conversely, the emergence of a need for tonics (alcoholic beverages; excessive smoking - the number of cigarettes smoked per day increases); increased anxiety and affective tension. Especially in the same respect, the clear "affective" effect of small doses of alcohol, which gives these people the "key to joy", returns the "smile", releases them, and distracts them from gloomy thoughts and insomnia. Symptoms also include weight loss; constipation or diarrhea; palpitations at night, most often after nightmares or upon awakening; periodically increasing difficulty breathing. With good contact with the patient, the latter's fixation on unpleasant sensations in the urogenital area, decreased libido and potency is often revealed [1,4,7,8].

Of decisive importance for establishing the affective or predominantly affective genesis of suffering are daily fluctuations in the patient's general vitality and well-being (primarily a decrease in mood in the first half of the day, when "every morning seems like either a rainy Monday or Black Friday"), obvious lability of mood, daily fluctuations in well-being, intensity and nature of pathological sensations and a clear connection between the occurrence and intensification of the latter with the influence of strong (mostly negative) emotions are usually revealed through a thorough, detailed interview of the patient without much difficulty. Along with this, it is possible to detect a deterioration in the patient's condition in the evenings (after the attending physician leaves the department) and on weekends or holidays, alone (for example, after the husband leaves on a business trip), before X-ray and other instrumental or even banal laboratory tests, when called to a consultant, before the most insignificant surgical intervention (not to mention major operations), after an unpleasant or emotionally significant visit for the patient, or after watching films and television programs that worried him [6,8]. Even during a conversation with a doctor, pronounced vegetative symptoms are finally determined: dilated pupils (sometimes the subject of the patient's hypochondriacal fixation), decreased salivation with a painful feeling of increasing dryness in the mouth, hyperhidrosis (when the patient almost constantly wipes wet hands, and often and forehead with a handkerchief), hyperemia or pallor of the face, etc.

This group of phenomena also includes all sorts of unpleasant or sharply painful sensations caused by spastic contraction of smooth muscles - from signs of an irritable stomach or irritable colon to acute hypertensive reactions at altitude affect [5]. An equally important role in the timely diagnosis of erased depression is played by a scrupulous analysis of the development and course of purely somatic, at first glance, disorders. What makes us think about the possibility of a psychogenic nature of seemingly somatic disorders is, first of all, the obvious discrepancy, the inadequacy of their objective findings, confirmed by the most thorough examination of the patient using modern instrumental and laboratory diagnostic methods, the obvious gap between the abundance of painful sensations and the paucity of reliable deviations (disproportion of emotional the patient's reactions to these sensations to physical symptoms, a clear predominance of a powerful subjective element over the objective). It should be borne in mind, however, that the absence of a proper organic basis (i.e., the complete absence or extreme insignificance of reliable symptoms of organic origin) does not in itself exclude the possibility of some real, but not recognized, somatic suffering. Hypochondriacal depression with pronounced psychosomatic disorders (and above all a sharp intensification and expansion of pathological sensations) is nevertheless possible in the undoubted presence of a certain (most often insignificant) somatic disease, if the volume and nature of complaints are constantly changing or go beyond the scope of the organ pathology present in the patient.

patient, and a causal relationship between objective disorders and these complaints cannot be established [1,4,7]. The psychogenic nature of the complaints is also supported by the generally significant duration of the disease (from several months to several years) in the absence of corresponding structural changes that should have already emerged during this time, or the objective dynamics of the latter. It is affective disorders that often cause the protracted course of one or another somatic syndrome; the hidden "depressive core" of somatic complaints is often discovered after many months and even years. In this regard, special attention should be paid to long-term (up to several months or even years) asthenia of unknown etiology or prolonged asthenic conditions after the patient has suffered an acute respiratory disease, surgery, abortion, or childbirth, etc. The longer the duration of complaints without an appropriate organic frame, the greater the likelihood of the psychogenic nature of the malaise. The absence of signs of organic damage to a particular organ or system for a long time serves, therefore, as one of the most important diagnostic

criteria for psychosomatic disorders in the structure of sub depressive and depressive states [1,2,9]. The diagnostic contours of somatized depression become more noticeable when the phase course of the disease or its oscillatory nature is established with a clear periodicity in the development of somatic disorders that arise suddenly, for no apparent reason, and just as suddenly disappear after a few weeks or months.

Of particular diagnostic importance is the possibility of spontaneous remission, when the patient literally "falls into health" without any medical intervention or under the influence of clearly inadequate treatment (for example, massage or so-called restorative therapy); Characteristic is a transient improvement in well-being or even its complete normalization in case of intercurrent infections (influenza, acute tonsillitis, etc.) and other diseases accompanied by a significant increase in body temperature. The exact day and hour of illness determined by such a patient (although most often we are talking about a gradual deterioration in well-being with the emergence or intensification of pathological sensations as the general vital tone and, accordingly, mood decrease) and the too rapid, "avalanche-like" exit from this state should alert practitioners in connection with the possibility of endogenous depression. Patients (especially at a young age) who wander around sick and unhappy for whole weeks and suddenly begin to feel better, and such recovery can last weeks or even months, but then usually comes back, obviously need to consult a psychiatrist to exclude that nature of their somatic disease [2,7]. The threat of subsuming everything unknown under the category of hypochondria determines, at the same time, the need for a position according to which neither the pathological sensations and complaints of the patient, incomprehensible to the doctor, nor even his behavior at the reception gives the right to talk about hypochondria.

The abnormality of the patient's condition is evidenced not so much by the content of his statements, but by the amount of energy and time spent by him on his hypochondria. A convincing criterion for the latter can only be the specific hypochondriacal attitude of the patient, which determines all his behavior - the increasing and all-consuming focus of his attention on the altered or disturbed feeling of his own body with excessive concern for it (a consequence of increasing self-doubt with fear of death and a feeling of threatening or already allegedly developing severe somatic suffering). It is this "double limitation" (the closure of the individual's entire world within the confines of his body, on the one hand, and the decrease in overall vitality, "physicality", on the other) that acts as the most important feature of hypochondria in the proper sense of the word. Almost obligatory when changing synesthesia, reflection on the entire scale of behavioral reactions to the action of various environmental stimuli inevitably contributes ultimately to the weakening of the patient's active and passive connections with others, a sharp narrowing of the range of his interests and active activities. Hypochondriacal reactions are undoubtedly pathological in nature when they become permanent and lead to disorganization of interpersonal relationships and social isolation of the patient [9-11]. The psychogenic or predominantly psychogenic nature of the disease is often indicated by the manner in which complaints are presented: excessive liveliness, extraordinary eloquence and inexhaustibility of patients who are ready to talk for hours, sometimes almost with pleasure, about their physical suffering.

The most important differential diagnostic factors include the patient's emotional inadequacy (obvious preoccupation with his "idea" (with anxious ideas of the irreversibility of a still unclear or already defined somatic suffering), anxiety about his own body, some kind of ideas of his own body with a refusal of interpersonal relationships and activity, etc. d. Persistent hypochondriacal fears with the patients' extreme involvement in the function of their digestive tract and genitourinary system always make one think about the possibility of depression. However, the patient's appearance, his clothing and posture, movements, facial expressions, emotional and vegetative-vascular reactions to certain other comments from the doctor and an exaggerated subjective assessment of the severity of his condition, the focus of the patient's attention on changes or violations of his own body with a certain attitude towards it, or persistent hypochondriacal fears and fear of death, thus, somatic pain is not always able to describe the essence of the disease, but it is worth pay attention to how he speaks, how he behaves at the reception, how he experiences his sensations and what conclusions he draws from them [9-11].

These patients are characterized by the extreme verbosity and "super precision" of these patients, listing all previous consultations and prescriptions, the most insignificant details and dates relating to their condition, and compiling long lists of their painful sensations, daily and sometimes almost minutely changing in intensity, localization and prevalence; an abundance of dramatic and obviously hyperbolic definitions that turn into peculiar speech cliches (terrible, wild, hellish pain; a nightmare state; disgusting appetite with a good complexion and sufficient fatness, etc.) and the very terminology of the descriptions, saturated with incorrectly perceived or perverted medical concepts (complaints, for example, of pain in the left half of the heart or in the tail of the pancreas, left-type ECG and malnutrition of the left ventricle, delayed evacuation of food due to pyloric spasm, or even achylia and psychasthenia). The psychogenic nature of suffering is also evidenced by the vague and difficult to correlate complaints of patients, whose language turns out to be much poorer than their painful sensations. The confused babbling and panicky behavior of these patients creates, for example, with cardiophobia, a specific clinical picture that does not fit into any true somatic disease and often does not even require a special examination (and in particular, ECG registration), since parenteral administration of 2–4 ml 0 A .5% solution of diazepam (Seduxen, Relanium) usually immediately normalizes the patient's well-being [9,12,13].

It is this extraordinary affective saturation of complaints reflecting the "bodily feelings of the vital series", the specific "sensory" shade

of pathological sensations that persists even with their retrospective description (the heart aches, yearns, trembles, freezes, aches, trembles, becomes numb, etc.) , and the complete impossibility of any adaptation to these not so much painful, but rather painful, depressing sensations in themselves allow us to speak about the anxious-depressive state of the patients. The more concerned the patient is with his condition, the more he dramatizes his feelings and symptoms, the more likely, therefore, is the psychogenic or predominantly psychogenic nature of his suffering. However, extreme monotony, stereotypical descriptions ("I feel bad", "hurt"), extreme taciturnity, an almost negative attitude towards a conversation with a doctor with "silent" depression and completely calm, seemingly indifferent behavior, and sometimes even resentment and indignation when trying to clarify the nature of the patient's unpleasant sensations [5,9,12]. As one of the features of functional disorders in the clinic of depressive states, it should be noted the extraordinary abundance and multiplicity of viscero-vegetative disorders, which, as a rule, are not limited to any specific organ or system and truly "overwhelm" such patients and their attending physicians. The countless ailments of these patients, capable of providing the most unusual information about almost any organ, fit essentially into one syndrome.

A "beautiful set," for example, of 13 symptoms and syndromes, each of which would be enough for one "real" patient, is by no means uncommon in the clinic of psychosomatic disorders (one of our patients increased this non-standard record to 22 nosological units). The more physical complaints in the absence of structural pathology, the greater, therefore, the likelihood of their psychogenic origin and the greater the need for consultation with a psychiatrist who is sufficiently competent in the issue of functional somatic disorders [6,14]. Monotonous "monosymptomatic depression with isolated functional disorders (painful sensations only in the hypochondrium, in the lower extremities or in one testicle, preventing sleep and thinking during the day) are relatively rare; they occur in only 1/5 of patients. Most often, we are not talking about some kind of autonomous manifestation of anxiety, but only about a psychosomatic phenomenon that covers all the symptoms in the patient's mind. The multiple nature of somatic symptoms is usually considered as one of the most important differential diagnostic signs of somatized symptoms. A wide range of vegetative-vascular disorders and sufficient erudition of such patients, who often read medical journals, allow them to feel or simply impose a corresponding set of complaints to the doctor of any obviousness (to a neurologist - complaints of headache, dizziness, pain in the lumbar region, to a cardiologist - to pain in the lumbar region, heart) and it is no coincidence that, therefore, when having an appointment with an unfamiliar doctor, such a patient is interested in his specialties and reads the relevant information from which he gives strictly memorized information on a specific organ or location.

Only a preliminary conversation to establish all the patient's disorders and the relationships between them encourages him to reveal all undisclosed symptoms that may indicate somatization symptoms. The same symptoms that are incomprehensible to the doctor are often explained by "neurosis" in a young patient, and "atherosclerosis" in an elderly patient; the same vegetative-vascular disorders are interpreted either as hypothalamic (or diencephalic) syndrome, or as vegetative-vascular dystonia or hypotensive disease, or as mitral valve insufficiency or idiopathic prolapse of its valves. A change in the subject of complaints almost automatically switches the diagnostic relay of the attending physician, and the patient, who has suffered from "chronic coronary insufficiency" or "hypertension" for several years, now acts as a permanent patient of a gastroenterological or urological clinic, forgetting about his "vascular pathology". Another change in the object of the patient's hypochondriacal fixation essentially means a new diagnosis [1,3,12,14]. Since it is the patient's complaints that form the basis of the presumptive diagnosis, many patients received diagnoses from various specialists: including lumbosacral radiculitis and various types of neuralgia, osteochondrosis and cervical syndrome, chronic gastritis and colitis, biliary dyskinesia, atherosclerosis, chronic coronary insufficiency, hypotension, etc. even syringomyelia appeared. The abundance of all kinds of (sometimes even contradictory) diagnoses, due to the complete fiasco that conventional research methods suffer in the clinic of psychosomatic disorders, already requires the exclusion of the psychogenic nature of viscero-vegetative disorders [15].

It should also be noted that such patients often develop unusual relationships between individual sensations in various organs and parts of the body, "movement", "movement" of these unpleasant sensations, for example, from the head to the feet and from the feet to the heart. The sometimes very peculiar anatomical and physiological representations of patients undoubtedly indicate a hypochondriacal processing of vegetative symptoms [13,15]. Severe general hyperesthesia, in which not only palpation of the abdomen, but also the pressure of a stethoscope (when auscultating the heart area) or a tonometer cuff (when measuring blood pressure) can cause " terrible, indescribable pain"; and a sharp increase in pain when the patient's attention is fixed on them with a clear weakening or disappearance when his attention is diverted; and the extraordinary ease of psychosomatic switching (sometimes almost instantaneous "realization" of an alarming thought or hypochondriacal idea into painful sensations); and a sharp increase in heart rate when talking about unpleasant topics that are affectively significant for the patient with a decrease in heart rate ("like in a warm bath") after the cessation of the negative emotion or during a psychotherapeutic conversation. In the same regard, we should consider most often (in the presence of other viscero-vegetative phenomena and depressive symptoms proper in the structure of affective disorders) staggering when getting out of bed and walking, or the occurrence and intensification of pain in the presence of a doctor and a noticeable weakening or disappearance of these symptoms during communication with other persons.

Regarded most often as an indicator of the patient's rental attitudes, this phenomenon, like a sudden rise in blood pressure or a

slight systolic murmur at the apex of the heart, noted in some cases only during a consultation with an authoritative specialist and therefore not detected by any doctor, usually reflects in reality only extreme the degree of affective tension of a patient who perceives a banal procedure of examination or morning rounds from the standpoint of Hamlet's "to be or not to be" and expects pardon, a reprieve or a final verdict from the doctor [12]. The fate of such patients, who sometimes turn out to be almost malingerers in the minds of others, is more than unenviable. "Psychogenic" pain is subjectively endured much more severely than "organic" pain, which does not usually reduce the "irritation and annoyance" of individual doctors and nurses who demand the transfer of these difficult patients to a psychiatric hospital. Patients themselves often believe, in turn, that "attributing" symptoms of depression to them essentially means only a correct accusation of "inventing and simulating," and therefore react especially sharply to any critical remarks. Cardialgia or attacks of psychogenic hyperventilation occur in several patients only at work, at home or alone, but do not bother them at all, as soon as they cross the threshold of a clinic or hospital, where "they will not let you die" (suspicions of simulation or aggravation in this case, of course, intensify).

Even more unenviable, however, is the fate of the attending physician, who enters an inevitable conflict with the patient: the mere mention of imminent discharge from the hospital causes a sharp deterioration in the condition of such patients with a rise in blood pressure or body temperature, complaints of pain in the left half of the chest, and sometimes even negative dynamics of ECG indicators [6,10,15]. It is also necessary to note the incredible suggestibility in some cases of such patients, for whom it is sometimes enough to look and listen to a neighbor in the ward or read the corresponding article in a popular science magazine to immediately detect all the symptoms of similar suffering in themselves, against the background of immediate anxiety. In this regard, the presence of a seriously ill patient in the ward and the issues of "microclimate" in the department in general become especially important. The disappearance of painful sensations when the environment changes in conditions where they should only intensify allows us to think about the psychogenic origin of somatic disorders. The patient's severe shortness of breath and heart pain stopped him every 30-40 steps on the way to work or home. Of particular importance is the behavior of such patients: the absorption of a huge amount of different medications (sometimes "handfuls", sometimes up to 40–60 nitroglycerin per day and with the most insignificant pain due to fear of death, essentially a drug addiction that these patients often acquire; one thought that they forgot some drug or left it on the table in the room can immediately cause them to develop a corresponding attack.

At the same time, it is possible that patients have an extremely negative attitude towards medical recommendations and prescriptions, due to a persistent own system (with an attitude towards certain medications or from plant medicines, etc.), and a categorical refusal to use any drugs due to supposedly "total" intolerance in the form of peculiar "side effects" that, as a rule, do not receive explicit confirmation [14]. A more obvious clinical sign of the pathological hypochondriacal attitude of such patients is their visiting doctors, a paradoxical insistence on understanding specialized medical care in connection with anxious fears. The endless wanderings of patients to different specialized clinics (with countless laboratory tests, X-ray and cardio graphic studies) contribute, in turn, to becoming an insoluble problem for doctors. The outpatient card or medical history gradually turns into multi-volume thick dossiers, the cause of suffering remains unclear, and the patient continues to test the patience and qualifications of various specialists [11,15]. An important sign of the psychogenic or predominantly psychogenic origin of somatic disorders is ultimately the complete failure of repeated (usually very numerous) courses of treatment for erroneously diagnosed organic suffering or even the deterioration of the patient's condition as a result of various therapeutic interventions.

As clinical experience shows, one should think about latent depression, especially in the elderly, not only in case of atypical, but also in case of any somatic symptoms that appear against the background of an inadequate deterioration in the patient's well-being and do not regress under the influence of a variety of therapeutic interventions with repeated changes of drugs . The absence of any noticeable improvement or even deterioration of the patient's condition during sanatorium treatment and physiotherapeutic procedures is most typical for cyclothymic conditions. Endless courses of long-term treatment, the ineffectiveness of which often forces these patients to seek help from healers and homeopaths, by their very nature indicate a most likely erroneous recognition of structural pathology. No less important for determining the true genesis of suffering is the lack of proper therapeutic action of certain drugs: analgesics (sometimes even narcotics) for all kinds of painful sensations, nitrites and nitrates for cardialgia, theophedrine for false neurotic asthma, etc. [14]. The most important evidence of the psychogenic origin of viscero-vegetative symptoms is, finally, the pronounced therapeutic effect of psychotropic drugs, the administration of which clearly reveals the pathogenic role and proportion of depression in the structure of the patient's syndrome. The great diagnostic value of tranquilizers and antidepressants for distinguishing states of acute fear with functional vegetative-vascular disorders (one of the most common reasons for calling an emergency medical team at night) from true somatic diseases has long been beyond doubt among clinicians.

Warming the patient and intravenous administration of diazepam make it possible to stop psych vegetative paroxysms literally "at the end of the needle." Significant improvement or complete normalization of the condition of these patients under the influence of adequate therapy with psychotropic drugs gives reason to consider the psychogenic or predominantly psychogenic nature of somatic disorders as almost indisputable [6,14]. Reasons for late recognition of somatized depression. One of the most important reasons for diagnostic errors in psychosomatic disorders is a kind of "outpatient" approach to the

patient. The very limited time allotted for examining each patient in somatic medical institutions essentially excludes the possibility of a detailed interview, especially in a clinic setting. It is difficult to understand complex psychophysiological disorders in a primary patient with trivial somatic complaints in the structure of affective disorders if, for example, a cardiologist in the USA spends 6–12 minutes on a patient, and a local therapist in our country spends 10 minutes. As noted in the 11th report of the WHO Expert Committee on Mental Hygiene, general practitioners too often claim that they do not have time to deal with the "mental distress" of their patients, although "attention to mental health problems at their early stages saves time in the future" [2,7]. A superficial, hastily collected anamnesis of life and illness is reduced practically to an official medical questionnaire.

A dry and dispassionate recording of the main contours of physical complaints and fragmentary information about the course of suffering does not allow us to reflect the essence of the latter and differentiate functional and organic disorders. Constructed on the same principle, these formal records ultimately testify only to the doctor's firm determination to search for objective signs of suffering (the desire to narrow the anamnesis to determine the minimum prerequisites for somatic examination). It is when collecting anamnesis, which often takes up no more than 10–20 lines in modern medical history, that, as is known, the largest number of defects in medical work are revealed. The extreme shortness of a superficial conversation cannot but give rise to a conscious, or rather unconscious desire in the doctor to "adjust" the patient's condition to certain forms of pathology without proper supervision. Like an artist who creates the desired image by applying paints to a canvas, the practical doctor follows, according to Freud's analogy, the wrong path and ends up with an inevitable artifact of the internal picture of the disease; Meanwhile, the only other path that is legitimate for the doctor is when everything superfluous is cut off from the patient's formless story (i.e., the intellectual, interpretive part of it) and everything that is necessary is left (i.e., the emotional, sensual part of it, reflecting subjective reality). The analysis of intellectual disorders is of particular interest only to a psychiatrist who is deciding the nosological affiliation of a patient's mental disorders.

At the same time, untimely recognition of psychosomatic disorders is facilitated by the apparent familiarity of non-detailed pseudo-organic symptoms, the true content of which is not clarified by the doctor. The extraordinary similarity of verbal "formulas of complaints" with genuine somatic suffering and affective disorders predetermines the wrong direction of medical thought.

References

1. Beck AT, Alford BA (2009) Depression: Causes and treatment. – University of Pennsylvania Press.
2. Hammen C (2005) Stress and depression. Annu Rev Clin Psychol 1: 293-319.
3. Ito M (1989) Long-term depression. Annual review of neuroscience 12(1): 85-102.
4. Duman CH (2010) Models of depression. vitamins & Hormones 82: 1-21.
5. Fava GA, Cosci F, Sonino N (2017) Current psychosomatic practice. Psychotherapy and psychosomatics 86(1): 13-30.
6. Wright L (1977) Conceptualizing and defining psychosomatic disorders. American Psychologist 32(8): 625-628.
7. Nezu AM, McClure KS, Nezu CM (2015) The Assessment of Depression. Treating Depression: MCT, CBT, and Third-Wave Therapies, p. 24-51.
8. Paykel ES (2008) Basic concepts of depression. Dialogues in clinical neuroscience 10(3): 279-289.
9. Abramowitz JS, Schwartz SA, Whiteside SP (2002) A contemporary conceptual model of hypochondriasis. Mayo Clinic Proceedings Elsevier 77(12): 1323-1330.
10. Nissen B (2018) Hypochondria as an actual neurosis. The International Journal of Psychoanalysis 99(1): 103-124.
11. Kenyon FE (1964) Hypochondriasis: a clinical study. The British Journal of Psychiatry 110(467): 478-488.
12. Abramowitz JS, Olatunji BO, Deacon BJ (2007) Health anxiety, hypochondriasis, and the anxiety disorders. Behavior Therapy 38(1): 86-94.
13. Taylor S, Asmundson GJG, Coons MJ (2005) Current directions in the treatment of hypochondriasis. Journal of Cognitive Psychotherapy 19(3): 285-304.
14. Wittkower ED (1964) Treatment of psychosomatic disorders. Canadian Medical Association Journal 90(18): 1055-1060.
15. Fava GA, Sonino N (2000) Psychosomatic medicine: emerging trends and perspectives. Psychotherapy and psychosomatics 69(4): 184-197.

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