Cognitive-Emotional Functioning in Somatic Symptom and Related Disorders: Self-Reports Versus Observer-Rated Findings

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Abstract

Objective: Literature on cognitive-emotional functioning reflects indications that patients with somatic symptom- or related disorder may suffer from diminished affective mentalizing/ psychological mindedness that is impairment in the ability for reflectivity about psychological processes, relationships and meanings. Affective mentalizing/ psychological mindedness seems to play an important role in cognitive-emotional functioning especially in a social context as engaging in group-psychotherapy. The present study investigated psychological mindedness in somatic symptoms- and conversion disorder (SSCD) patients, by examining similarities and differences between self-reports and their psychotherapists’ observations of social-cognitive-emotional functioning i.e. dysfunctional self-regulation.

Methods: A cross-sectional design was applied to 43 patients with SSCD and their psychotherapists, who independently rated the patient’s (dysfunctional) emotional-, dissociative-, and interpersonal self-regulation.

Results: Compared to the psychotherapists’ observations, patients under reported their degree of dysfunctional emotional self-regulation i.e. under-regulation of affect, interpersonal self-regulation (fears of abandonment and closeness, lack of interpersonal trust) and dissociative self-regulation (somatoform- and psychoform dissociation). Patients over reported problems dysfunctional emotional self-regulation, i.e., insight into their own emotions and problems with verbalizing of emotions. Patients were generally consistent with their psychotherapists regarding difficulties emotional self-regulation, i.e., analyzing of affect and insight into others’ emotions. Although patients who disclosed a history of childhood traumatic experiences involving a primary caregiver (TPC) reported higher levels of problems with under-regulation of affect and lack of interpersonal trust than patients denying such childhood trauma, TPC was not associated with deficits in psychological mindedness in this sample of somatoform disorder patients.

Conclusion: It seems of clinical relevance to add clinical observations to self-reported dysfunctional self-regulation in somatic symptom- and conversion disorder patients to assess affective mentalizing/ psychological mindedness. It seems that patient- compared to clinician ratings are in agreement on emotional constriction (difficulty in analyzing own- and understanding others’ emotions), but under-rate problems with dissociative-, interpersonal- and emotional/hyperarousal self-regulation, and over-rate their problems with insight and verbalizing emotions.

Keywords: Somatic symptom disorders; Conversion disorder; Psychological mindedness; Self-reports; Observer ratings; Self-regulation; Affect-regulation

Abbreviations: SSRD: Somatic Symptoms and Related Disorders, SSCD: Somatic Symptoms and Conversion Disorder, PM: Psychological Mindedness, TPC: Trauma involving a Parent or other Primary Caregiver

Introduction

Somatic symptoms and related disorders (SSRDs) are a group of mental disorders that are characterized by somatic symptoms or illness anxiety. Somatic symptom and conversion disorder (SSCD) are characterized by the presence and burden of persistent physical symptoms for which there seems no (adequate) medical explanation [1]. SSCD patients have significant degrees of impairment in activities of daily living, social functioning and occupational functioning [2] and tend to report physical symptoms while attributing them to medical disease and denying that psychosocial factors may play a role [3]. Therefore, they frequently seek medical help, resulting in approximately twice the outpatient and inpatient medical care utilization and twice the annual medical care costs in comparison with other psychiatric patients [4].

The conceptualization of these disorders as being 'unexplained' is being challenged by our increasing understanding of the neurophysiological perspective [5] on functional somatic symptoms. The functional-unawareness neurobiological framework, mediated by right hemisphere-lateralized, large-scale brain network dysfunction, may play a significant role in the neurobiology of conversion disorder [6]. When pain is reported, this reflects dynamic interactions of the CNS with sensations, but also with current context, and prior (adverse) experiences. Pain perception requires neuroplasticity, whereby repeated sensory information on adverse experiences may result in habituation (reduced response), and -in more severe and chronic cases a paradoxical 'lack-of-pain' (anesthesia, analgesia, paralyses) [7], or

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Researchers have shown that patients with SSCDs, compared to patients with other psychiatric diagnoses, have significantly lower levels of emotional awareness [14,15,17]. They have a greater tendency to experience emotional distress as bodily symptoms rather than as discrete verbally-mediated emotions. In addition, they tend to not detect emotions and instead misinterpret them as bodily sensations only. SSCD-patients also blend emotional awareness and experiencing emo...
observation rating scale that are completed by respectively the patients and observers during the O&A period [30].

Measures

**Traumatic experiences:** Reports of potentially traumatic events were collected using the Traumatic Experiences Checklist (TEC; Dutch version [31]) a retrospective self-report questionnaire that measures a wide range of adverse experiences and potentially traumatic events. For this study we used the TEC score for the number of attachment related childhood traumatic experiences [32]. The TEC’s internal consistency, test-retest reliability and validity were good among a sample of psychiatric outpatients [33].

**Dysfunctional self-regulation using self-report questionnaires**

**Dysfunctional emotional regulation:** In order to assess under-regulation of affect, participants completed the Structured Interview for Disorders of Extreme Stress (SIDES) [34]. In this study we used the Dutch self-report version of the SIDES (self-report version [35], Dutch self-report version [36]). To assess under-regulation of affect we looked at the first three items of the questionnaire. These are as follows: (1) “often getting quite upset over daily matters”, (2) “being unable to get over the upset for hours or not being able to stop thinking about it”, and (3) “having to stop everything to calm down and it took all your energy, or getting drunk, using drugs or harming yourself to cope with emotional distress”. The items refer to last month. Total scores were the sum of scores on these three items which can vary from 0 to 9. The subscale of “affect dysregulation” has a good internal consistency (Cronbach’s α=0.75) in a sample of adults diagnosed with borderline personality disorder and/or somatofortom dissociation [19].

In order to assess cognitive-emotional functioning and over-regulation of affect subjects completed the Bermond-Vorst Alexithymia Questionnaire (BVAQ) [37]. This instrument measures the cognitive, emotional and social aspects of emotional (dy)function and can differentiate between subtypes of alexithymia. The questionnaire consists of five subscales. In this study we included the following three subscales to assess emotional functioning: Identifying/Differentiating/Insight (insight into own emotions and insight into others’ emotions), Verbalizing of emotions, and Analyzing own emotions. Each subscale consists of 8 items that are scored on a 5-point Likert scale. Total scores on each subscale therefore range from 8 to 40. To assess over-regulation of affect we looked at the sum of scores on the following three subscales: Insight into own emotions, Verbalizing of emotions and Analyzing own emotions. This total score range from 24 to 120. The scale has good convergent validity [37].

**Dysfunctional dissociative regulation:** Somatofortom dissociation was measured with the Somatofortom Dissociation Questionnaire (SDQ-20) [38]. This is a 20 item self-report questionnaire, assessing positive and negative symptoms of somatofortom dissociation (e.g. “It sometimes happens that my body, or part of it, is insensitive to pain”). Items are scored on a 5-point Likert scale, ranging from 1, “not applicable”, to 5 “highly applicable”. Total scores are the sum of scores on the 20 items and range from 20 to 100. The scale has high internal consistency (Cronbach’s α=0.96) and good construct validity [38,39].

Psychoform dissociation was assessed using the Dissociative Experiences Scale (DES) [40] (Dutch version [41]), a 28 item self-report questionnaire (e.g. “Some people have the experience of finding themselves in a place and having no idea how they got there”). Participants indicated on a scale from 0 to 100 how frequently various dissociative symptoms occur in their daily life. Total scores are the mean of all item scores, with scores varying from 0 to 100. The scale has high internal consistency (Cronbach’s α=0.93), good test-retest reliability (0.78-0.93) and good convergent validity [42].

**Dysfunctional interpersonal regulation:** The interpersonal interaction style of the participants is measured with the Relationship Styles Questionnaire (RSQ) [43] (Dutch version [44]), a 30 item self-report questionnaire. Items are scored on a 5-point Likert scale, with scores varying from strongly disagree (1) to totally agree (5). For this study, we looked at three important dimensions of attachment behaviours, these include: Fear of abandonment, Fear of closeness and Lack of interpersonal trust. The scale has good construct validity and test-retest reliability with adult psychiatric samples [45].

**Dysfunctional self-regulation using an observation-based rating scale:** The observational rating scale for psychotherapists consisted of 15 items which relate to self- and affect regulation and emotional functioning (e.g. de-activating self-regulation strategies; attachment fears; signs of somatofortom dissociation) and measure the same constructs as the self-report questionnaires [30] as presented in Figure 1. The items are scored on a 5-point Likert scale, ranging from 1, “not applicable”, to 5 “highly applicable”. For this study we used 11 of the 15 items, which are shown verbatim in Table 1. The observation scale is a widely used
Insecure attachment representations containing information on "self, other and self-other relatedness" activating
-when exposed to adverse or ambiguous/ neutral (interpersonal) situations-
Insecure cognitive-emotional-information processing and Insecure attachment-based Self Regulation Strategies encompassing

**Statistical analyses**

First, correlations for all variables were performed for patients and for psychotherapists separately. Next, paired-samples *t*-tests were conducted on means of self-report scores and means of observation rating scale scores, to examine whether patients underestimate their degree of dysfunctional self-regulation relative to the observers (psychotherapists). Scores on the (sub)scales of the self-report questionnaires were transformed into a scale from 1, "not applicable/ strongly disagree", to 5 "highly applicable/totally agree" comparable to the scores on the items of the observation rating scale. Finally, independent-samples *t*-test was performed for TPC+ group and TPC-group in order to compare SSCD-patients with and without a history of traumas involving a parent or primary caregiver (TPC+ (Table 1). The total number of childhood traumas involving a parent or primary caregiver correlated significantly with self-reported lack of interpersonal trust (r=0.443, p<0.01).

Correlations between the self-report measures and observational ratings are presented on the diagonal. Self-report and psychotherapist ratings were consistently uncorrelated, with only one statistically significant correlation which reflected an inverse relationship between self-reported and observer rated insight into others' emotions.

Below the diagonal correlations among self-report scores are reported. Over-regulation of affect was strongly (r ≥ 0.75) correlated with problems with affect verbalization, insight, and analysis. Strong correlations (r=0.45-0.71) also were found for fear of closeness with lack of interpersonal trust, psychoform dissociation, problems with verbalizing and insight into emotions, and both under- and over-regulation of affect.

Above the diagonal correlations between the items of the observational rating scale are reported. Strong correlations were found (r ≥ 0.75) among the affect processing problem variables (i.e., over-regulation of affect and intense and overwhelming emotion; under-regulation of affect and fear of closeness with lack of interpersonal trust; negative processes, e.g., alexithymia and inhibition of emotion; mainly constraining executive function; mixed disinhibition; mainly activating sympathetic system dominance).

A sub-group met criteria for Axis II personality disorders (18.6%) that were not sufficiently severe to prevent inclusion in the treatment program. Almost half (48.8%) were married or living together, while another large sub-group had no primary partner (41.9%), and the rest were divorced or widowed (9.4%). Most participants have completed low-level secondary education (35.0%) or middle-level secondary education (51.1%), while the rest had completed high-level secondary education (14.0%).

More than half of the participants (53.7%) reported having experienced one or more childhood traumas involving a parent or other primary caregiver (TPC+) (Table 1). The total number of childhood traumas involving a parent or primary caregiver correlated significantly with self-reported lack of interpersonal trust (r=0.443, p<0.01).

Results

Descriptive and correlational analyses

Participants were 43 adults aged 19 to 63 (*M*=38.6, *SD*=12.0), of whom 31 were women (72.1%). About half of the participants met DSM 5 criteria as assessed by trained psychiatrists or clinical psychologists for conversion disorder (55.8%); all others met criteria for somatic symptom disorder without (30.2%) or with chronic pain (14.0%). A sub-group met criteria for Axis II personality disorders (18.6%) that were not sufficiently severe to prevent inclusion in the treatment program.

Instrument for trained raters and has proven clinical feasibility in different patient groups (including patients with somatoform disorders, borderline personality disorder, anxiety disorders, and depression). All raters were clinical psychologists/psychotherapists and were trained and supervised in using the instrument and adherence to the model by AvD. Final scores are consensus-based scores after four weeks of careful observation of the patients and clinical supervision [30].

Figure 1: Multi-faceted dysfunctional self-and affect regulation operating in cycles [30].
insight into, verbalizing, and analyzing emotions), and between fear of closeness and lack of interpersonal trust.

**Psychological mindedness**

Mean scores, standard deviations and effect sizes (Cohen's $d$) of pairwise differences between patient and psychotherapist ratings are presented in Table 2.

**Dysfunctional emotional self-regulation:**

Under-regulation of affect and over-regulation of affect: On average, patients reported less under-regulation of affect, compared to the psychotherapist's observations, $t(37)=3.35$, $p=0.002$. Patients scored on average slightly lower than their psychotherapists in terms of their problems with over-regulation of affect/alexithymia, but this difference was not significant, $t(42)=1.67$, $p=0.103$.

Emotional functioning: In contrast to the hypothesis, patients reported a higher degree of difficulties with insight into their own emotions, compared to psychotherapists' observations, $t(42)=-2.33$, $p=0.025$. Patients also reported a higher degree of difficulties with the ability to verbalize emotions than their psychotherapists. This difference was also significant, $t(42)=-4.27$, $p<0.001$. Patients and their psychotherapists reported comparable levels of difficulties with the ability to analyze their own emotions, $t(42)=-0.98$, $p=0.333$.

**Dysfunctional dissociative self-regulation:**

Somatoform and psychoform dissociation: Patients reported significantly fewer symptoms of somatoform dissociation, compared to observers, $t(41)=12.13$, $p<0.001$. Patients also reported fewer symptoms of psychoform dissociation, than their psychotherapists, $t(41)=12.42$, $p<0.001$.

**Dysfunctional interpersonal self-regulation:**

Adult attachment fears: Patients reported less severe fear of abandonment than their psychotherapists, $t(42)=4.47$, $p<0.001$. Patients also reported significantly less severe fear of closeness than their psychotherapists, $t(42)=6.10$, $p<0.001$. Finally, patients reported a lesser degree of lack of interpersonal trust than their psychotherapists, $t(42)=6.43$, $p<0.001$.

Social emotional functioning: Patients and their psychotherapists reported a similar degree of difficulties with insight into others' emotions (emotional reflective function), $t(42)=-0.52$, $p=0.612$.

**Childhood trauma and psychological mindedness**

Table 3 shows the analyses testing whether SSCD-patients reporting

| Table 2: Results of paired-samples $t$-tests comparing the self-report questionnaires of the patients with the observational rating scale of the psychotherapists. Mean scores (M), standard deviations (SD), significance levels and Effect Sizes (Cohen's $d$) are reported. |

<table>
<thead>
<tr>
<th>Emotional self-regulation</th>
<th>Patients</th>
<th>Observers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-regulation of affect</td>
<td>2.73 (0.88)</td>
<td>3.45 (0.90)</td>
</tr>
<tr>
<td>Over-regulation of affect</td>
<td>2.83 (0.76)</td>
<td>3.12 (0.93)</td>
</tr>
<tr>
<td>Difficulties insight into own emotions</td>
<td>2.70 (0.92)</td>
<td>2.30 (0.64)</td>
</tr>
<tr>
<td>Difficulties verbalize own emotions</td>
<td>3.41 (1.06)</td>
<td>2.53 (0.74)</td>
</tr>
<tr>
<td>Difficulties analyze own emotions</td>
<td>2.39 (0.75)</td>
<td>2.23 (0.65)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Dissociative self-regulation</th>
<th>Patients</th>
<th>Observers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatoform dissociation</td>
<td>1.68 (0.56)</td>
<td>3.33 (0.82)</td>
</tr>
<tr>
<td>Psychoform dissociation</td>
<td>1.66 (0.51)</td>
<td>3.14 (0.72)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Interpersonal self-regulation</th>
<th>Patients</th>
<th>Observers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of abandonment</td>
<td>2.64 (0.67)</td>
<td>3.30 (0.83)</td>
</tr>
<tr>
<td>Fear of closeness</td>
<td>2.80 (0.84)</td>
<td>3.72 (0.59)</td>
</tr>
<tr>
<td>Lack of interpersonal trust</td>
<td>2.39 (0.84)</td>
<td>3.37 (0.69)</td>
</tr>
<tr>
<td>Difficulties insight into others' emotions</td>
<td>2.27 (0.72)</td>
<td>2.19 (0.63)</td>
</tr>
</tbody>
</table>

Note: *** $p<0.001$, ** $p<0.01$, * $p<0.05$

| Table 3: Results of paired-samples $t$-tests for patients reporting trauma involving primary caregiver (TPC+) and patients not reporting trauma involving primary caregiver (TPC-), separately. Results of independent-samples $t$-test, comparing the self-reports of the TPC+ and TPC- group. Mean scores (M), standard deviations (SD) and significance levels are reported. |

<table>
<thead>
<tr>
<th>TPC+</th>
<th>TPC-</th>
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<tbody>
<tr>
<td>Emotional self-regulation</td>
<td></td>
</tr>
<tr>
<td>Under-regulation of affect</td>
<td>3.06 (0.80)</td>
</tr>
<tr>
<td>Over-regulation of affect</td>
<td>2.87 (0.71)</td>
</tr>
<tr>
<td>Difficulties insight into own emotions</td>
<td>2.71 (0.82)</td>
</tr>
<tr>
<td>Difficulties verbalize own emotions</td>
<td>3.47 (1.01)</td>
</tr>
<tr>
<td>Difficulties analyze own emotions</td>
<td>2.43 (0.72)</td>
</tr>
</tbody>
</table>

| Dissociative self-regulation | |
| Somatoform dissociation | 1.69 (0.64) | 3.43 (0.75) | *** | 1.65 (0.47) | 3.11 (0.81) | *** |
| Psychoform dissociation | 1.74 (0.56) | 3.19 (0.75) | *** | 1.57 (0.44) | 3.00 (0.67) | *** |

| Interpersonal self-regulation | |
| Fear of abandonment | 2.81 (0.64) | 3.45 (0.86) | * | 2.52 (0.68) | 3.21 (0.79) | ** |
| Fear of closeness | 2.90 (0.85) | 3.82 (0.50) | *** | 2.64 (0.84) | 3.63 (0.68) | ** |
| Lack of interpersonal trust | 2.75 (0.72) | 3.50 (0.67) | ** | 1.99 (0.82) | 3.21 (0.71) | *** |
| Difficulties insight into others' emotions | 2.23 (0.70) | 2.18 (0.73) | ** | 2.26 (0.77) | 2.21 (0.54) |

Note: *** $p<0.001$, ** $p<0.01$, * $p<0.05$ (paired-samples $t$-test); ++ $p<0.01$, + $p<0.05$ (independent-samples $t$-test)
trauma involving a primary caregiver (TPC+) had the same or different deficits in psychological mindedness than patients who did not report childhood trauma involving a primary caregiver (TPC-). The only difference in deficits in psychological mindedness was found on under-regulation of affect. Patients reporting trauma involving a primary caregiver reported on average a similar degree of under-regulation of affect compared to their psychotherapists, t(18)=1.44, p=0.166. Patients who did not report childhood trauma involving a primary caregiver reported lower levels of under-regulation of affect than their psychotherapists, t(17)=3.21, p<0.01.

Patients of both groups reported lower levels of somatoform- and psychoform dissociation, fears of abandonment and closeness, and lack of interpersonal trust, compared to psychotherapists. Patients of both groups reported a similar degree of over-regulation of affect, difficulties with insight into own emotions, difficulties with the ability to analyze own emotions and difficulties with insight into others' emotions, compared to psychotherapists. Finally, patients of both groups reported a higher level of difficulties with the ability to verbalize emotions, than their psychotherapists.

Table 3 also shows additional analyses comparing the TPC+ and TPC- sub-groups using an independent-samples t-test. The TPC+ group reported higher levels of under-regulation of affect, (t(35)=-2.38, p=0.023) and of lack of interpersonal trust (t(39)=-3.13, p<0.01) than the TPC- group.

Discussion

This study contributes to the literature of signs and symptoms of dysfunctional self-regulation by assessing cognitive-emotional functioning and psychological mindedness in an explicit manner, i.e., patients' self-reports of dysfunctional self-regulation in contrast to ratings based on clinical observation by their psychotherapists, rather than implicit measures or experimental tasks. Overall, ratings by SSCD patients and their psychotherapists were very weakly correlated, reflecting a distinct discrepancy consistent with the study's principal hypothesis. In addition, patients tended to under-report their degree of dysfunctional over-regulation of affect in comparison with their psychotherapists, consistent with the hypothesis that SSCD would be associated with diminished psychological mindedness. SSCD patients also tended to under-report the severity of somatoform and psychoform dissociation, and of their fears of closeness and abandonment, compared to their psychotherapists. As hypothesized, SSCD patients thus appear to have important deficits in psychological mindedness across a range of measures related to a hallmark feature of their disorder, substantially underestimating their problematic tendency to over-regulate (i.e., consciously or unconsciously reduce awareness of) emotions and affective distress. In this sense, SSCD patients show a consistent pattern of distorted self-perception consistent with an 'illusion of mental health.' These results are in line with previous studies that found over-regulation of affect as characteristic of SSCD patients [19,21,29] as well as studies indicating that SSCD patients have difficulties with social cognition [13,15,16]. Treatments addressing affect and experiential awareness [47], in combination with intervention to enhance self-regulation and interpersonal skills as an alternative to affective over-regulation [48-50], therefore warrant further clinical and research investigation with SSCD patients. Study findings demonstrate the clinical relevance of assessing dysfunctional self-regulation not only from the perspective of the patient alone or of the therapist alone. Shared decision making on choice of treatment goals seems warranted for this patient group and may facilitate therapeutic alliance. In this study-group concordance/agreement was found for patients' self-reported difficulties analyzing one's own emotions, experiencing over-regulation of affect, and experiencing difficulties with insight into others' emotions. This agreement is important in formulating therapy goals, for choice of treatment techniques and for receiving patients' consent for intensive interpersonally-focused forms of treatment such as group psychotherapy. However, in contrast with study hypotheses but consistent with the proposed role of psychological mindedness in SSCD, patients tended to over-report difficulties with verbalizing and insight into one's own emotions compared to their psychotherapists' ratings. This is in line with previous studies by Lane [13] showing diminished emotional awareness and emotional agnosia in SSCD patients compared to healthy controls. However, these results contradict findings from a prior study indicating that SSCD patients have no difficulty with insight in their own emotions but rather experience difficulties cognitive elaborations or fantasizing during therapy compared to other patient groups [24]. The underreporting of fears of closeness and abandonment may seem remarkable in light of the finding that over 50% of the SSCD-patients in this study reported attachment traumas involving primary caregivers (TPC). TPC was associated with problems with under-regulation of affect and trust in relationships, but did not appear to contribute to problems in psychological mindedness in these domains—SSCD patients with histories of TPC actually tended to be in closer agreement with their psychotherapists about problems with under-regulation compared to patients with no history of TPC. The underreported fears of attachment could indicate that (a subgroup of) SSCD-patients have become detached from attachment figures as a defensive compensation to deal with the adverse emotional impact of early life traumatic experiences on the ability to regulate intense emotions and trust close relationships [51]. Overly, the presentation of attitudes toward close relationships may seem unproblematic, but covertly SSCD patients with histories of TPC might have a tendency to detach from important others as a way of coping with affective distress. This is in line with findings from the current study that SSCD patients over-reported difficulties with verbalizing and insight into their own emotions, as well as with the results of previous studies which demonstrated problems with emotion regulation and detachment in relationships by patients with SSCD [16,18,21,50].

Therefore, it seems warranted to clinically assess dysfunctional self-regulation with SSCD patients both with and without TPC by both self-report and clinical observation. Problems with over-regulation of affect and psychological mindedness deficits in awareness of these problems appear likely in SSCD patients and may be under-detected unless external observers’ perspectives are included. Problems with under-regulation of affect are most likely in this clinical population among those with histories of childhood trauma by primary caregiver(s), and can be identified by self-report as well as by external observers. For both forms of affect dysregulation, psychotherapeutic techniques aimed at increasing the ability of patients with dysfunctional self-regulation to raise emotional awareness, recognize, tolerate, differentiate, label and talk about emotions may be useful to overcome diminished psychological mindedness [30].

The results of the study need to be viewed in the context of the following strengths and limitations. First, the study needs replication. Although the effect sizes are sufficiently satisfying, the number of included subjects in this study is relatively small. Second, all included patients in the present study were patients with severe somatoform symptoms. Future research should investigate whether patients with mild somatoform symptoms also have a diminished psychological mindedness. Third, in the present study, the number of subjects was too small to examine a potential moderating effect of diagnosis on...
the results obtained. Fourth, because of the cross-sectional nature of the study there are no causal inferences possible. Future research should investigate the predictive power of psychological mindedness with regard to treatment outcome and drop-out during therapy for somatoform patients with different levels of psychological mindedness, comparable to previous studies [22,23].

Conclusion

Study findings indicate that deficits in psychological mindedness among SSCD patients are not limited to presenting with the illusion of mental health. SSCD patients’ difficulties with awareness of problems with self-regulation appear to be multi-faceted. Diminished awareness of problems with over-regulation of affect appears to co-exist with distorted (over-) reporting of problems with verbalizing and insight into one’s own emotions. Thus, SSCD may involve generalized deficits in awareness of both emotional expression and attempts to inhibit or distance oneself from distressing emotions, particularly those involved in close relationships. More research is needed on deficits in psychological mindedness and illusionary mental health in SSCD patients. It seems warranted to obtain both self-reported and clinically observed information of dysfunctional self-regulation.

References


