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Somatoform Disorders, Factitious Disorder and Malingering

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Somatization Disorder

- A chronic syndrome in which the patient, usually a woman, has multiple physical complaints associated with frequent medical help seeking

Somatization Disorder Epidemiology

- Prevalence in women 1-2%
- Ratio of women to men as high as 20 to 1
- 5-10% of all ambulatory primary care patients
- Familial pattern
- Medical expenses 9X higher than the average patient
- Lower socioeconomic class

Somatization Disorder Etiology

- Unknown
- Adoption studies suggest both genetic and environmental factors
- Theories
  - Psychosocial
  - Behavioral
  - Biologic

Table 9–3 **Diagnostic Criteria for Somatization Disorder***

A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.

B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:
   1) *four pain symptoms:* a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)
   2) *two gastrointestinal symptoms:* a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods)
   3) *one sexual symptom:* a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)
   4) *one pseudoneurological symptom:* a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia, or loss of consciousness other than fainting)

C. Either (1) or (2):
   1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)
   2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

D. The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering)

* DSM-IV criteria (American Psychiatric Association, 1994)

American Psychiatric Association, DSM-IV criteria, 1994.

Somatization Disorder: Clinical Features

- Psychological distress
- Interpersonal problems
- Alcohol or substance abuse often coexists
- Depression, anxiety, and personality disorders are often present
- Dramatic presentations
- Poor historians

Somatization Disorder: Differential Diagnosis

- Medical disorders
- Factitious Disorder
- Other psychiatric disorders

Somatization Disorder: Course and Prognosis

- Chronic
- Increased complaints in times of stress
- Prognosis is poor; cure unlikely
- Goal of treatment is to decrease medical procedures

Conversion Disorder

- A disorder characterized by neurological symptom(s) that cannot be explained by a known neurologic or medical disorder. Psychological factors must be associated with the initiation or exacerbation of the symptom(s).

Conversion Disorder: Epidemiology

- Annual incidence as high as 22/100,000
- Ratio of women to men as high as 5 to 1
- Onset most often in adolescence or young adulthood

Conversion Disorder: Epidemiology, continued

- More common in:
  - Rural populations
  - Those with little education
  - Lower socioeconomic groups
  - Medically unsophisticated
- Commonly associated with:
  - Major Depression
  - Anxiety Disorders
  - Schizophrenia
  - Personality Disorders

Conversion Disorder: Etiology

- Psychoanalytic theory
- Biological factors

Conversion Disorder: Clinical Features

- Symptoms:
  - Sensory
  - Motor
  - Special senses
  - Seizures
  - Mixed
- Primary and/or secondary gain
- Symptoms may be unconsciously modeled
- Symptoms are often not medically accurate

Conversion Disorder: Differential Diagnosis

- Medical or neurological disease:
  - 25-50% of patients initially thought to have Conversion Disorder are eventually found to have a “real” illness
- Other Somatoform Disorders
- Factitious Disorder or Malingering

Conversion Disorder: Course and Prognosis

- In 90% of cases symptoms resolve in a few days or less than a month
- 25% have a recurrence at some point
- Longer the symptoms last, the poorer the prognosis for ever recovering

Table 9–5 **Diagnostic Criteria for Pain Disorder**[*,†]

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows: **Pain Disorder Associated with Psychological Factors:** psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if: **Acute:** duration of less than 6 months; **Chronic:** duration of 6 months or longer

Pain Disorder Associated With Both Psychological Factors and a General Medical Condition: both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.

Specify if: **Acute:** duration of less than 6 months; **Chronic:** duration of 6 months or longer

[*] Pain per se may be associated with psychological factors and/or a general medical condition; it may be acute with a duration of less than 6 months or chronic. The anatomical site(s) is coded Axis III of DSM-IV.
[†] DSM-IV criteria (American Psychiatric Association, 1994).

American Psychiatric Association, DSM-IV criteria, 1994.

Hypochondraisis

- A disorder in which the patient's inaccurate interpretation of physical symptoms or sensations leads to preoccupation and fear that he or she has a serious illness, even though no medical evidence of illness can be found.

Hypochondraisis: Epidemiology

- Six-month prevalence of 4-6% in general medical patients
- Ratio of women to men: 1 to 1
- Usual age of onset is 20's to 40's

Hypochondraisis: Etiology

- Several theories
  - Symptom amplification
  - Learned behavior
  - Symptom of another psychiatric disorder
  - Psychodynamic theory: Deserved punishment

Hypochondraisis: Clinical Features

- Specific diseases are feared
- Over time, fear can shift from one disease to another
- Multiple medical opinions are sought
- Complaints about care received are common

Hypochondraisis: Clinical Features

- High risk of complications, from diagnostic, or possibly, therapeutic procedures
- Depression or Anxiety Disorders often coexist

Hypochondraisis: Differential Diagnosis

- Medical illness
- Other Somatoform Disorders
- Factitious Disorder or Malingering
- Other Psychiatric Disorders: If hypochondraisis develops for the first time in an elderly patient, suspect depression.

Hypochondraisis: Course and Prognosis

- Episodic, with episodes occurring at times of stress
- 1/3 to 1/2 of patients improve with time

Body Dysmorphic Disorder

- A rare disorder in which the patient becomes preoccupied with a bodily defect that is either imagined entirely, or is a greatly exaggerated distortion of a true, but minor, defect.

Management of Somatoform Disorders

- Provide care, rather than aiming for cure - focus on the psycosocial problems not the physical ones
  - Do not try to completely eliminate symptoms
  - Focus on coping and functioning strategies

Management of Somatoform Disorders, continued

- Establish one physician to manage care and schedule regular brief but frequent visits
- Establish an empathetic relationship to minimize doctor-shopping

Management of Somatoform Disorders, continued

- Minimize the use of psychotropic drugs
  - No medication has been shown to be useful in Somatoform Disorders
  - These patients may tend to become dependent upon drugs easily, particularly sedative-hypnotics
  - Do provide psychotherapy

Management of Somatoform Disorders, continued

- Minimize medical diagnostic tests and procedures to reduce expense and iatrogenic complications
  - Review old records before ordering tests
  - Consider benign remedies

Factitious Disorder

- A disorder in which the patient intentionally produces signs of illness and misrepresents his or her history to assume the patient role. The patient is aware that the behavior is intentional, but the motivation for the behavior is unconscious, and not easily controlled.

Factitious Disorder: Epidemiology

- Prevalence unknown
- Occurs in women more than men
- Patients frequently have medical backgrounds
- Patients may travel from place to place, assuming different names, and simulating different illnesses

Factitious Disorder: Etiology

- Psychodynamic theories
  - Hospital seeking
  - Difficulty recognizing self-boundaries, thus taking on patient role
  - Seeking painful procedures for self-punishment

Factitious Disorder: Clinical Features

- Symptoms can be physical, psychological, or both
- May occur by proxy: A parent (usually the mother) simulates illness in a child

Factitious Disorder: Differential Diagnosis

- Medical Illness
- Somatoform Disorders
- Malingering

Factitious Disorder: Course and Prognosis

- Onset in early adulthood, often after an illness or loss
- Increasing frequency of episodes
- Incapacitation results from the patient's own illness behavior as well as from untoward reactions to treatments
- Chronic with a poor prognosis

Factitious Disorder: Management

- Recognition
- Verification of past medical history
- Minimize procedures
- One primary physician
- ? Confronting the patient
- Psych consultant's main role may be in helping medical staff deal with their own countertransference to these patients

Malingering

- A disorder in which the patient intentionally produces symptoms for some sort of secondary gain. The patient knows that he or she is producing the symptoms, and knows why he or she is doing it.

Disorder	Mechanism of Illness Production	Motivation for Illness Behavior
Somatoform Disorders	Unconscious	Unconscious
Factitious Disorder	Conscious	Unconscious
Malingering	Conscious	Conscious

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Slide 7: American Psychiatric Association, DSM-IV criteria, 1994.

Slide 18: American Psychiatric Association, DSM-IV criteria, 1994.