15 - Chapter 12 Somatic Symptom and Factitious Disorder

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142 SOMATIC SYMPTOM AND FACTITIOUS DISORDERS Patients with somatic symptom disorders present with prominent physical symptoms; these are associated with significant distress or impairment in social, occupational, or other areas of functioning. While these patients may or may not have an associated medical condition, their focus is on their distressing somatic symptoms as well as their thoughts, feelings, and behaviors in response to these symptoms. ■ Types of somatic symptom and related disorders include: • Somatic symptom disorder. • Conversion disorder (functional neurological symptom disorder). • Illness anxiety disorder. • Psychological factors affecting other medical conditions. • Factitious disorder. • Other specified somatic symptom and related disorder. • Unspecified somatic symptom and related disorder. Up to 30% of primary care patients present with medically unexplained symptoms. In many cases, unspoken psychological needs manifest as physical symptoms. The symptoms may not make physiological “sense” but rather follow the patient’s conception of how their body works. Ms. Thomas is a 31-year-old woman who was referred to a psychiatrist by her gynecologist after undergoing multiple exploratory surgeries for abdominal pain and gynecologic concerns with no definitive findings. The patient reports that she has had extensive medical problems dating back to adolescence. She reports periods of extreme abdominal pain, vomiting, diarrhea, and possible food intolerances. The obstetrician is her fourth provider because “my other doctors were not able to help me.” Ms. Thomas reports fear that her current physician will also fail to relieve her distress. She was reluctant to see a psychiatrist and did so only after her obstetrician agreed to follow her after her psychiatric appointment. Ms. Thomas states that her problems worsened in college, which was the first time she underwent surgery. She reports that due to her health problems and severe lack of energy, it took her 5½ years to graduate from college. She did better for a year or two after college but then had a return of symptoms. She reports recently feeling very lonely and isolated because she has not been able to find a boyfriend who can tolerate her frequent illnesses. She also reports that physical intimacy is difficult for her because she finds sex painful. Additionally, she is concerned that she might lose her job due to the number of days she has missed from work due to her abdominal pain, fatigue, and weakness. What is the diagnosis? Somatic symptom disorder. Ms. Thomas has a history of multiple somatic complaints lasting at least 6 months, along with a high level of anxiety about her symptoms and excessive time and energy devoted to her health concerns. She has had multiple medical procedures and significant impairment in her social and occupational functioning. Somatic Symptom Disorder Patients with somatic symptom disorder present with at least one (and often multiple) physical symptom. They frequently seek treatment from many

doctors, often resulting in extensive lab work, diagnostic procedures, hospitalizations, and/or surgeries. Note that somatic symptom disorder and a related medical illness are not mutually exclusive. DIAGNOSIS AND DSM-5 CRITERIA ■ One or more somatic symptoms (may be predominantly pain) that are distressing or result in significant disruption. ■ At least one of the following: • Disproportionate and persistent thoughts about the seriousness of one’s symptoms. • Persistently high level of anxiety about health or symptoms. • Excessive time and energy devoted to these symptoms. ■ Persistent state of being symptomatic (typically >6 months; though the specific somatic symptoms may shift over time). EPIDEMIOLOGY ■ Incidence in females likely greater than males. ■ Prevalence in general adult population: 5–7%. ■ Risk factors include older

age, fewer years of education, lower socioeconomic status, unemployment, and history of traumatic experiences in childhood. TREATMENT AND PROGNOSIS ■ The course tends to be chronic and debilitating. Symptoms may periodically improve and then worsen under stress. ■ The patient should have regularly scheduled visits with a single primary care physician, who should minimize unnecessary medical workups and treatments. ■ All treating physicians should recognize that the patient's suffering is genuine, whether or not there is an identifiable medical cause. ■ Address psychological issues slowly. Patients will likely resist referral to a mental health professional. Conversion Disorder (Functional Neurological Symptom Disorder) Patients with conversion disorder have at least one neurological symptom (sensory or motor) which cannot be fully explained by a neurological condition. Examples include blindness, paralysis, and paresthesia. Patients may be surprisingly calm and unconcerned (la belle indifference) when describing their symptoms. DIAGNOSIS AND DSM-5 CRITERIA ■ At least one symptom of altered voluntary motor or sensory function. ■ Evidence of incompatibility between the symptom and recognized neurological or medical conditions. ■ Not better explained by another medical or mental disorder. SOMATIC SYMPTOM AND FACTITIOUS DISORDERS KEY FACT Somatic symptom disorder patients typically express lots of concern over their condition and chronically perseverate over it. Conversion disorder patients often have an abrupt onset of their neurological symptoms (blindness, etc.) but appear unconcerned. WARDS TIP When treating a patient with a somatic symptom disorder, it is important for the psychiatrist to work closely with the patient's primary care physician. WARDS QUESTION Q: Are patients with conversion disorder consciously faking their symptoms? A: No. Patients with conversion disorder unconsciously produce symptoms, and cannot control when they occur. Symptoms may persist even after they become aware of their conversion disorder.

144 SOMATIC SYMPTOM AND FACTITIOUS DISORDERS KEY FACT Conversion-like presentations in elderly patients have a higher likelihood of representing an underlying neurological deficit. EPIDEMIOLOGY TREATMENT AND PROGNOSIS Illness Anxiety Disorder DIAGNOSIS AND DSM-5 CRITERIA ■ High level of anxiety about health. WARDS QUESTION Q: In what setting are you most likely to diagnose a somatic symptom-related disorder? A: Patients most commonly seek out care in medical settings—for example, primary care offices, medical specialty clinics, or emergency rooms. Patients are relatively unlikely to present to psychiatric settings, unless referred by a medical provider. EPIDEMIOLOGY ■ Men are affected as often as women. ■ Average age of onset 20–30 years. TREATMENT ■ Psychotherapy (primarily CBT). PROGNOSIS ■ Can result in significant disability. ■ Causes significant distress or impairment in social or occupational functioning or warrants medical evaluation. ■ Common symptoms: Paralysis, weakness, blindness, mutism, sensory complaints (paresthesias), psychogenic nonepileptic seizures (PNES), globus sensation (globus hystericus or sensation of lump in throat). ■ Two to three times more common in women than men. ■ Onset at any age, but more often in adolescence or early adulthood. ■ High incidence of comorbid neurological, depressive, or anxiety disorders. ■ The primary treatment is education about the illness. Cognitive-behavioral therapy (CBT), with or without physical therapy, can be used if education alone is not effective. ■ While patients often spontaneously recover, the prognosis is poor: Symptoms may persist, recur, or worsen in 40–66% of patients. ■ Preoccupation with having or acquiring a serious illness. ■ Somatic symptoms are not present, or if present, are mild in intensity. ■ Performs excessive health-related behaviors or exhibits maladaptive behaviors. ■ Persists for at least 6 months (the specific illness that is feared may change over time). ■ Not better explained by another mental disorder (such as somatic symptom disorder). ■ Approximately 67% have a coexisting major mental disorder. ■ Regularly scheduled visits with one primary care

physician. ■ Comorbid anxiety and depressive disorders should be treated with selective serotonin reuptake inhibitors (SSRIs) or other appropriate psychotropic medications. ■ Chronic but episodic—Symptoms may wax and wane periodically.

■ Up to 60% of patients improve significantly. ■ Factors predicting better prognosis include fewer somatic symptoms, shorter duration of illness, and absence of childhood physical punishment. Psychological Factors Affecting Other Medical Conditions A patient with one or more psychological or behavioral factors (e.g., distress, coping styles, maladaptive health behaviors) adversely affecting a medical symptom or condition. Examples include anxiety worsening asthma, denial that acute chest pain needs treatment, and manipulating insulin doses in order to lose weight. DIAGNOSIS AND DSM-5 CRITERIA ■ A medical symptom or condition (other than mental disorder) is present. ■ Psychological or behavioral factors adversely affect the medical condition in at least one way, such as influencing the course or treatment, constituting an additional health risk factor, influencing the underlying pathophysiology, precipitating, or exacerbating symptoms or necessitating medical attention. ■ Psychological or behavioral factors are not better explained by another mental disorder. EPIDEMIOLOGY ■ Prevalence and gender differences are unclear. ■ Can occur across the lifespan. TREATMENT AND PROGNOSIS ■ Treatment includes education and frequent contact with a primary care physician. ■ SSRIs and/or psychotherapy (especially CBT) should be used to treat underlying anxiety or depression. Factitious Disorder Patients with factitious disorder intentionally falsify medical or psychological signs or symptoms in order to assume the role of a sick patient. They often do this in a way that can cause legitimate danger (central line infections, insulin injections, etc.). The absence of external rewards is a prominent feature of this disorder. DIAGNOSIS AND DSM-5 CRITERIA ■ Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception. ■ The deceptive behavior is evident even in the absence of obvious external rewards. ■ Behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder. SOMATIC SYMPTOM AND FACTITIOUS DISORDERS

146 SOMATIC SYMPTOM AND FACTITIOUS DISORDERS KEY FACT ■ Commonly feigned symptoms: Münchhausen syndrome is another, older name for factitious disorder with predominantly physical complaints. Münchhausen syndrome by proxy is intentionally producing symptoms in someone else who is under one’s care (usually one’s child). EPIDEMIOLOGY ■ May be at least 1% of hospitalized patients. ■ More common in women. ■ Associated with personality disorders. TREATMENT AND PROGNOSIS Malingering PRESENTATION ■ Individual can present themself, or another individual (as in factitious disorder imposed on another). • Psychiatric—Hallucinations, depression. • Medical—Fever (by heating the thermometer), infection, hypoglycemia, abdominal pain, seizures, and hematuria. ■ Higher incidence in hospital and health care workers (who have learned how to feign symptoms). ■ Many patients have a history of illness and hospitalization, as well as childhood physical or sexual abuse. ■ Collect collateral information from medical providers and family. Collaborate with primary care physician and treatment team to avoid unnecessary procedures. ■ Patients may require confrontation in a nonthreatening manner; however, patients who are confronted may leave against medical advice and seek hospitalization elsewhere. ■ Repeated and long-term hospitalizations are common. A 37-year-old patient claims that he has frequent episodes of “seizures,” starts on medications, and joins an epilepsy support group. It becomes known that he is doing this in order to collect social security disability money. Diagnosis? Malingering. In contrast, in factitious disorder, patients look for some kind of unconscious emotional gain by playing the

“sick role,” such as sympathy from the physician. The fundamental difference between malingering and factitious disorder is in the intention of the patient; in malingering, the motivation is external, whereas in factitious disorder, the motivation is internal. Malingering involves the intentional reporting of physical or psychological symptoms in order to achieve secondary (external) gain. Common external motivations include avoiding incarceration, receiving room and board, obtaining narcotics, and receiving monetary compensation. Note that malingering is not considered a psychiatric condition. ■ Patients usually present with multiple vague complaints that do not conform to a known medical condition. ■ They often have a long medical history with many hospital stays.

■ They are generally uncooperative and refuse to accept a good prognosis even after extensive medical evaluation. ■ Symptoms quickly improve or resolve once the desired objective is obtained. EPIDEMIOLOGY ■ Not uncommon in hospitalized patients. ■ Significantly more common in men than women. MANAGEMENT ■ Neuropsychological testing can help to identify feigned or exaggerated cognitive symptoms. Assessments routinely include embedded validity measures and tests more specifically designed to catch malingering or low effort, such as the TOMM (Test of Memory Malingering). ■ Work with the patient to manage their underlying distress, if possible. ■ Gentle confrontation may be necessary; however, patients who are confronted may leave the hospital Against Medical Advice (AMA) and seek treatment elsewhere. Review of Distinguishing Features ■ Somatic symptom disorders: Patients believe they are ill and do not intentionally produce or feign symptoms. ■ Factitious disorder: Patients intentionally produce symptoms of a psychological or physical illness because of a desire to assume the sick role, not for external rewards. ■ Malingering: Patients intentionally produce or feign symptoms for external rewards. SOMATIC SYMPTOM AND FACTITIOUS DISORDERS KEY FACT Malingering is the conscious feigning of symptoms for some secondary gain (e.g., monetary compensation or avoiding incarceration).