# Somatoform Disorders and Factitious Disorders

# DEFINITION

- Patients with somatoform disorders present with physical symptoms that have no organic cause. They truly believe that their symptoms are due to medical problems and are not consciously feigning symptoms. Examples of somatoform disorders include:
- Somatization disorder
- Conversion disorder
- Hypochondriasis
- Pain disorder
- Body dysmorphic disorder

- Primary and secondary gain often result from symptoms expressed in somatoform disorders, but patients are not consciously aware of gains and do not intentionally seek them.
- **Primary gain: Expression of unacceptable feelings as physical symptoms** in order to avoid facing them
- **Secondary gain: Use of symptoms to benefit the patient (increased attention** from others, decreased responsibilities, avoidance of the law, etc.).
- With the exception of hypochondriasis, somatoform disorders are more common in women. One half of patients have comorbid mental disorders, especially anxiety disorders and major depression.

# SOMATIZATION DISORDER

- Patients with somatization disorder present with multiple vague complaints involving many organ systems. They have a long-standing history of numerous visits to doctors. Their symptoms cannot be explained by a medical disorder.
- DIAGNOSIS AND DSM-IV CRITERIA

1. At least two gastrointestinal (GI) symptoms
2. At least one sexual or reproductive symptom
3. At least one neurological symptom
4. At least four pain symptoms
5. Onset **before age 30**
6. Cannot be explained by general medical condition or substance use

# SOMATIZATION DISORDER

- **EPIDEMIOLOGY**

1. Incidence in females 5 to 20 times that of males
2. Lifetime prevalence: 0.1 to 0.5%
3. Greater prevalence in low socioeconomic groups
4. Fifty percent have comorbid mental disorder.
5. First-degree female relatives have 10 to 20% incidence.
6. 30% concordance in identical twins

- **COURSE AND PROGNOSIS**

Usually chronic and debilitating. Symptoms may periodically improve and then worsen under stress.

- **TREATMENT**

There is no cure, but management involves regularly scheduled frequent visits to a primary care practitioner, since these patients will usually not agree to see a psychiatrist. Secondary gain should be minimized. Medications should be used with caution and only with a clear indication; they are usually ineffective, and patients tend to be erratic in their use. Relaxation therapy, hypnosis, and individual and group psychotherapy are sometimes helpful.

# CONVERSION DISORDER

Patients have at least one neurological symptom (sensory or motor) that cannot be explained by a medical disorder. Onset is always preceded or exacerbated by a psychological stressor, although the patient may not connect the two. Patients are often surprisingly calm and unconcerned *(la belle indifference)* when describing their symptoms, which may include blindness or paralysis.

- DIAGNOSIS AND DSM-IV CRITERIA

1. At least one neurological symptom
2. Psychological factors associated with initiation or exacerbation of symptom
3. Symptom not intentionally produced
4. Cannot be explained by medical condition or substance use
5. Causes significant distress or impairment in social or occupational functioning
6. Not accounted for by somatization disorder or other mental disorder
7. Not limited to pain or sexual symptom

# CONVERSION DISORDER

- **Common Symptoms**

1. Shifting paralysis
2. Blindness
3. Mutism
4. Paresthesias
5. Seizures
6. Globus hystericus (sensation of lump in throat)

- **EPIDEMIOLOGY**

1. Common disorder
2. 20 to 25% incidence in general medical settings
3. Two to five times more common in women than men
4. Onset at any age, but most often in adolescence or early adulthood
5. Increased incidence in low socioeconomic groups
6. High incidence of comorbid schizophrenia, major depression, or anxiety disorders

- **DIFFERENTIAL DIAGNOSIS**

Must rule out underlying medical cause, as 50% of these patients eventually receive medical diagnoses

# CONVERSION DISORDER

- **COURSE**

Symptoms resolve within 1 month. Twenty-five percent will eventually have future episodes, especially during times of stress. Symptoms may spontaneously resolve after hypnosis or **sodium amobarbital interview if the psychological** trigger can be uncovered during the interview.

- **TREATMENT**

Insight-oriented psychotherapy, hypnosis, or relaxation therapy if needed. Most patients spontaneously recover.

# HYPOCHONDRIASIS

Hypochondriasis involves prolonged, exaggerated concern about health and possible illness. Patients either fear having a disease or are convinced that one is present. They misinterpret normal bodily symptoms as indicative of disease.

- **DIAGNOSIS AND DSM-IV CRITERIA**

1. Patients fear that they have a serious medical condition based on misinterpretation of normal body symptoms.
2. Fears persist despite appropriate medical evaluation.
3. Fears present for at least **6 months**

- **EPIDEMIOLOGY**

Men affected as often as women

Average age of onset: 20 to 30

Eighty percent have coexisting major depression or anxiety disorder.

# HYPOCHONDRIASIS

- **DIFFERENTIAL DIAGNOSIS**

1. Must rule out underlying medical condition
2. Somatization disorder—hypochondriacs are worried about disease, whereas patients with somatization disorder are concerned about their symptoms.

- **COURSE**

Episodic—symptoms may wax and wane periodically. Exacerbations occur commonly under stress. Up to 50% of patients improve significantly

- **TREATMENT**

No cure exists, but management involves frequently scheduled visits to *one* primary care doctor who oversees the patient's care. Patients are usually resistant to psychotherapy. Group therapy or insight-oriented psychotherapy may be helpful if patient is willing.

# BODY DYSMORPHIC DISORDER

- Patients with body dysmorphic disorder are preoccupied with body parts that they perceive as flawed or defective. Though their physical imperfections are either minimal or completely imagined, patients view them as severe and grotesque. They are extremely self-conscious about their appearance and spend significant time trying to correct perceived flaws with makeup, dermatological procedures, or plastic surgery.
- **DIAGNOSIS AND DSM-IV CRITERIA**

1. Preoccupation with an imagined defect in appearance or excessive concern about a slight physical anomaly
2. Must cause significant distress in the patient's life

# BODY DYSMORPHIC DISORDER

- **EPIDEMIOLOGy**

1. More common in women than men
2. More common in unmarried than married persons
3. Average age of onset: Between 15 and 20
4. Ninety percent have coexisting major depression.
5. Seventy percent have coexisting anxiety disorder.
6. Thirty percent have coexisting psychotic disorder.

- **COURSE AND PROGNOSIS**

Usually chronic; symptoms wax and wane in intensity.

- **TREATMENT**

Surgical or dermatological procedures are routinely unsuccessful in pleasing the patient. Selective serotonin reuptake inhibitors (SSRIs) reduce symptoms in 50% of patients.

# PAIN DISORDER

- Patients with pain disorder have prolonged, severe discomfort without adequate medical explanation. The pain often co-exists with a medical condition but is not directly caused by it. Patients often have a history of multiple visits to doctors. Pain disorder can be acute (< 6 months) or chronic (> 6 months).
- **DIAGNOSIS AND DSM-IV CRITERIA**

1. Patient's main complaint is of pain at one or more anatomic sites.
2. The pain causes significant distress in the patient's life.
3. The pain has to be related to psychological factors.
4. The pain is not due to a true medical disorder.

- **DIFFERENTIAL DIAGNOSIS**

1. Must rule out underlying medical condition
2. Hypochondriasis and malingering

# PAIN DISORDER

- **EPIDEMIOLOGY**

1. Women are two times as likely as men to have pain disorder.
2. Average age of onset: 30 to 50
3. Increased incidence in first-degree relatives
4. Increased incidence in blue-collar workers
5. Patients have higher incidence of major depression, anxiety disorders, and substance abuse.

- **COURSE**

Abrupt onset and increase in intensity for first several months; usually a chronic and disabling course

- **TREATMENT**

Analgesics are not helpful, and patients often become dependent on them. SSRIs, transient nerve stimulation, biofeedback, hypnosis, and psychotherapy may be beneficial.

# FACTITIOUS DISORDER

- Patients with factitious disorder intentionally produce medical or psychological symptoms in order to assume the role of a sick patient. *Primary gain is a* prominent feature of this disorder (see definition p. 105).
- **DIAGNOSIS AND DSM-IV CRITERIA**

1. Patients **intentionally produce signs of physical or mental disorders.**
2. They produce the symptoms to assume the role of the patient *(primary gain).*
3. There are no external incentives (such as monetary reward, etc.)
4. Either predominantly psychiatric complaints or predominantly physical complaints

- **Commonly Feigned Symptoms**

1. *Psychiatric—hallucinations, depression*
2. *Medical—fever (by heating the thermometer), abdominal pain, seizures,* skin lesions, and hematuria

# FACTITIOUS DISORDER

- **RELATED DISORDERS**

1. **Münchhausen syndrome—another name for factitious disorder with predominantly** physical complaints. These patients may take insulin, consume blood thinners, or mix feces in their urine in order to produce symptoms of medical disease. In addition, they will often demand specific medications. They are very skilled at feigning symptoms necessitating hospitalization.
2. **Münchhausen syndrome by proxy—intentionally producing symptoms** in someone else who is under one's care (usually one's children) in order to assume the sick role by proxy

# FACTITIOUS DISORDER

- **EPIDEMIOLOGY**

1. > 5% of all hospitalized patients
2. Increased incidence in males
3. Higher incidence in hospital and health care workers (who have learned how to feign symptoms)
4. Associated with higher intelligence, poor sense of identity, and poor sexual adjustment

- Many patients have a history of child abuse or neglect. Inpatient hospitalization resulting from abuse provided a safe, comforting environment, thus linking the sick role with a positive experience.
- **COURSE AND PROGNOSIS**

Repeated and long-term hospitalizations are common.

- **TREATMENT**

No effective treatment exists, but it is important to avoid unnecessary procedures and to maintain a close liaison with the patient's primary medical doctor. Patients who are confronted while in the hospital usually leave.

# MALINGERING

- Malingering involves the feigning of physical or psychological symptoms in order to achieve personal gain. Common external motivations include avoiding the police, receiving room and board, obtaining narcotics, and receiving monetary compensation.
- **PRESENTATION**

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. However, their symptoms improve once their desired objective is obtained.

- **EPIDEMIOLOGY**

1. Common in hospitalized patients
2. More common in men than women

# REVIEW OF DISTINGUISHING FEATURES

- **Somatoform disorders: Patients *believe they are ill.***
- **Factitious disorders: Patients *pretend they are ill with no obvious external* reward.**
- **Malingering (most common): Patients pretend they are ill with obvious *external incentive.***