PLAYING SICK?
SOMATIC SYMPTOMS AND RELATED DISORDERS

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MEDICALLY UNEXPLAINED SYMPTOMS (MUS)

Functional
Psychosomatic
Hypochondriac
Hysteria
Feigning
Malingering
Functional Overlay
Somatic
Idiopathic
Non-organic
Psychogenic
Conversion
Pseudoseizures

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MEDICALLY UNEXPLAINED SYMPTOMS (MUS)

- Very common - at least a third to half of all somatic symptoms are MUS
- Universal
- Every specialty in medicine has its own 'unexplained' syndrome
- Are rated by practitioners as among the most difficult of all conditions

(Janca, Isaac & Ventouras, 2006; Kroenke, 2007)

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CASE STUDY

- Penny* is a 32 year old married, stay at home mother of a 3 year old
- Travelled over 1.5 hours to attend a hospital for treatment. States hospital closer to home refuses to treat her "with respect"
- **Complaining of bilateral below knee numbness and weakness. Claims cannot walk. Also incontinent of urine**
- Medical file states patient has Seronegative or Rheumatoid Arthritis, Obesity, Fibromyalgia and Depression
- Letter from rheumatologist denied diagnosis of arthritis but mentioned Penny has Borderline Personality Disorder

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CASE STUDY

- Penny was well versed in medical jargon, runs online support group for people with arthritis
- Inconsistent historian, attitude alternates between cooperation and evasiveness or disinterest
- Presents as calm and unfazed, denies worries about the future

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DSM 5 CLASSIFICATION OF SOMATIC DISORDERS

Moved away from symptoms having to be medically unexplained

More focused on the distress and the disruption to life the symptoms create

"Medically Unexplained" should not be synonymous with "Psychiatrically Explained"

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SOMATIC SYMPTOM DISORDER - DESCRIPTION

- Formally called Somatoform Disorder, DSM criteria also changed
- The most common unexplained symptoms were musculoskeletal pain, ear, nose, and throat symptoms, abdominal pain and gastrointestinal symptoms, fatigue, and dizziness.
- Somatic symptoms without an evident medical explanation are not sufficient to make this diagnosis.
- The **individual's suffering is authentic**, whether or not it is medically explained.
- Individuals with somatic symptom disorder **tend to have very high levels of worry about illness**
- A **high level of medical care utilization, which rarely alleviates the individual's concerns.**
- Some individuals with the disorder seem unusually sensitive to medication side effects

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SOMATIC SYMPTOM DISORDER - DESCRIPTION

- Any reassurance by the doctor that the symptoms are not indicative of serious physical illness tends to be short-lived and/or is experienced by the individuals as the doctor not taking their symptoms with due seriousness
- The suggestion of **referral to a psychologist may be met with surprise or even frank refusal** by individuals with somatic symptom disorder.
- Prevalence is unknown (due to changes in DSM 5 criteria) may be around 5%–7% (Rief et al. 2011). More common in females
- Comorbid anxiety or depression is common
- More frequently seen in individuals with **few years of education and low socioeconomic status**
- When a concurrent medical illness is present, the degree of impairment is more marked than would be expected from the physical illness alone.

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SOMATIC SYMPTOM DISORDER - MANAGEMENT

- Comprehensive clinical assessment (history, mental state, and physical examination).
- Interview key family members
- Minimise number of clinicians involved. Ensure a consistent, coordinated management plan.
- Minimise invasive diagnostic and therapeutic procedures.
- Ensure regular, structured sessions. Avoid as-needed visits to doctors and emergency departments.
- Recognise reality of symptoms and provide diagnostic feedback to both patient and family member. Where appropriate, link symptoms to stressful life events.
- Identify and minimise secondary reinforcers.
- Treat associated medical and psychiatric conditions appropriately.

(Mai, 2004)

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SOMATIC SYMPTOM DISORDER - MANAGEMENT

Avoid explaining symptoms with statements such as "Your symptoms are all in your head."

The treatment is described as ''stress management.'' The rationale presented is that because stress is likely to aggravate physical symptoms, the reduction of stress is likely to alleviate physical discomfort. Many patients are open to this idea.

(Woolfolk, Allen & Tiu, 2007).

Pharmacotherapy

- Minimise use of habit-forming drugs.
- Avoid as-needed medication.
- Use antidepressant medication where appropriate.

Psychotherapy

- Acceptance & Commitment Therapy
- Relaxation training
- Interpersonal skills training

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FUNCTIONAL NEUROLOGICAL SYMPTOM DISORDER / CONVERSION DISORDER - DIAGNOSTIC CRITERIA

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder.

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Coding note: The ICD-9-CM code for conversion disorder is 300.11, which is assigned regardless of the symptom type. The ICD-10-CM code depends on the symptom type (see next slide).

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FUNCTIONAL NEUROLOGICAL SYMPTOM DISORDER / CONVERSION DISORDER - DIAGNOSTIC CRITERIA

- *Specify* symptom type:
  - With weakness or paralysis (F44.4)
  - With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder) (F44.4)
  - With swallowing symptoms (F44.4)
  - With speech symptom (e.g., dysphonia, slurred speech) (F44.4)
  - With attacks or seizures (F44.5)
  - With anaesthesia or sensory loss (F44.6)
  - With special sensory symptom (e.g., visual, olfactory, or hearing disturbance) (F44.6)
  - With mixed symptoms (F44.7)

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FUNCTIONAL NEUROLOGICAL SYMPTOM DISORDER / CONVERSION DISORDER - DIAGNOSTIC CRITERIA

- Specify if:
  Acute episode: Symptoms present for less than 6 months.
  Persistent: Symptoms occurring for 6 months or more.

- Specify if:
  With psychological stressor (specify stressor)
  Without psychological stressor

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- Although the diagnosis requires that the symptom is not explained by neurological disease, it **should not be made simply because results from investigations are normal or because the symptom is "bizarre**."
- It is important to note that the diagnosis of conversion disorder should be based on the **overall clinical picture and not on a single clinical finding**. Non-epileptic seizures, loss of consciousness, and motor conversion symptoms are the most common functional neurological complaints
- Symptoms **are not feigned or deliberately produced**;
- While assessment for stress and trauma is important, the diagnosis should not be withheld if none is found
- **Prevalence** - approximately 30% of referrals to neurology clinics.
- Two to three times more common in females, generally before the age of 35 years.
- Common comorbidities of major depression disorder and anxiety disorder, seen in about 30% of patients with conversion disorder

(Brown & Lewis-Fernandez, 2011; Feinstein, 2011; Marcus, Aldam, Lennox & Laing, 2010; Nicholson, Stone & Kanaan, 2011)

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FNSD – PROPOSED MANAGEMENT

Step 1	Step 2	Step 3
Diagnosis and Initial Management - Neurologist	Brief Intervention - Physiotherapy with support from Neurologist	Complex Care - Neurology / Rehab Medical, Psychology / Psychiatry, PT, OT or Speech & Chronic Pain Service

(Gelauff, Dreissen, Tijssen, & Stone, 2014)

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FNSD – COMMUNICATING

Table 1. Some commonly agreed initial ingredients of a successful explanation of functional neurological symptoms.

Element	Example
Give the patient a diagnosis.	"You have a functional movement disorder."
Emphasise that symptoms are genuine (and common).	"Your symptoms are not 'imagined' or 'crazy.'" "Software problem rather than a hardware problem"
Explain on what basis the diagnosis has been made.	e.g., showing patient positive features of the diagnosis such as Hoover's sign or tremor entrainment test
Emphasise potential for reversibility.	"Your Hoover's sign shows us that your leg has the potential to improve."
Emphasise the role of self-help/education.	"I'd like you to read this information (e.g., www.neurosymptoms.org). It's not your fault that you have this, but you will need to work at it to get better."

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FNSD - TREATMENT

- Research is sparse and generally with very small sample sizes including single case studies including using antidepressants and transcranial magnetic stimulation – needs further research
- Multidisciplinary approach preferably as outpatient has been shown to be effective, however inpatient rehabilitation for chronic FNDS has also been found to be beneficial
- Medical professionals should reassure the patient that they believe their symptoms to be genuine while explaining that although the patient does not have a 'structural' problem, they do have 'functional' problem. They should emphasize that this is common and reversible.

(Feinstein, 2011; Marcus, Aldam, Lennox & Laing, 2010; Saifee, et al., 2012)

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FNSD – CONTROVERSIES

Labels

Also know as psychosomatic, non-organic, hysterical, psychogenic, medically unexplained or functional overlay / weakness

Patients prefer some names over others –

- Although "medically unexplained" is scientifically neutral, it had surprisingly negative connotations for patients.
- Conversely, although doctors may think the term "functional" is pejorative, patients did not perceive it as such.

"Functional" (in its original sense of altered functioning of the nervous system) has the advantage of avoiding the "non-diagnosis" of "medically unexplained" and side steps the unhelpful psychological versus physical dichotomy implied by many other labels. It also provides a rationale for pharmacological, behavioural, and psychological treatments aimed at restoring normal functioning of the nervous system.

(Marcus et al., 2010; Stone, et al, 2002).

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FNSD - CONTROVERSIES

Common belief that FNSD / Conversion Disorder is that the symptoms reflect the "conversion" of underlying emotional distress into physical (neurologic) symptoms.

Though this is very trickly to prove

- Psychological stress is universal
- Should the stress be historical (childhood trauma) or more recent? About the disease or person, or be symbolic?
- Stress is known to not only to be associated with exacerbation or the precipitation of not only psychiatric illness, such as depression and schizophrenia, but also physical illnesses such as acute coronary syndromes or multiple sclerosis. **These associations don't prove causation.**
- The processes of how stress is 'converted' to neurological complaints is unknown (Nicholson, Stone & Kanaan, 2011)

Conversion disorder patients often do not experience more significant life events in the period prior to symptom development than controls. Hence the inability to identify psychosocial precipitants for many such patients, and the lack of a similar rule in ICD-10 have led the DSM-5 somatoform disorders working group to recommend removal of this criterion

(Brown & Lewis-Fernandez, 2011; Feinstein, 2011)

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HEALTH PROFESSIONALS ARE TRAINED TO ASSESS AND TREAT INDIVIDUALS WHO ACTUALLY HAVE MEDICAL SYMPTOMS. A HEALTH CARE PROVIDER'S NATURAL INCLINATION—ONE REINFORCED BY EDUCATION AND TRAINING—IS TO *ACCEPT THE PERSON'S REPORTED* SYMPTOMS AT FACE VALUE

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FACTITIOUS DISORDER – DESCRIPTION

- Factitious disorders refer to those conditions that individuals wilfully (i.e., consciously) create by producing signs *and/or* symptoms of physical or mental illness in order to assume the "sick role"
- Chronic FD historically has been called Munchausen's syndrome
- Most common medical **presentations** of factitious disorder include sepsis, non-healing wounds, fever and electrolyte disorders.
- There are several known risk factors for factitious disorder, including:
  - The presence of other mental or physical disorders in childhood that resulted in the patient's getting considerable medical attention.
  - A history of significant past relationships with doctors, or of grudges against them.
  - Present diagnosis of borderline, narcissistic, or antisocial personality disorder.

(Frey, 2014; Maldonado, 2002).

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MOST COMMON WAYS OF PRETENDING ILLNESS

LIE - false history of a diagnosis (i.e., cancer, seizures, sickle cell, HIV, trauma, PTSD, fever, pain)

CREATE

- simulate a medical illness (i.e., haematuria by seeding a drop of blood in urine, fever by tampering with thermometers and feigning seizures),
- self-injecting exogenous substances or organisms (e.g., producing abscesses by injecting saliva into the skin, manipulating intravenous catheters with faecal material to cause sepsis),
- taking exogenous medications or poisons which may create symptoms characteristic of a disease process (e.g., injecting insulin to create episodes of hypoglycaemia, self-administering thyroid hormone to produce a hyperthyroid state, ingesting warfarin or other blood thinners to cause a bleeding disorder, ingesting laxatives to cause diarrheal processes)

INTERFERING WITH TREATMENT FOR AN ALREADY EXISTING ILLNESS – manipulation wounds and fractures, inappropriate use of prescribed medication

(Maldonado, 2002)

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FACTITIOUS DISORDER - CHARACTERISTICS

- The individual's history is vague and inconsistent; or the individual has a long medical record with many admissions at different hospitals. Seems to have a lot of bad luck, **'black cloud phenomenon'.**
- The patient has an **unusual knowledge of medical terminology** or describes the illness as if they are reciting a textbook description of it.
- The patient is employed in a **medical or hospital-related occupation**.
  - Nurses (54%). Other health professionals include medical technicians (17%), nurses' aides (7%), and student nurses, physicians, hospital administrators, and medical secretaries (4% each)
- *Pseudologia fantastica*, a Latin phrase for **"uncontrollable lying,"** is a condition in which the individual provides fantastic descriptions of events that never took place.
- The patient visits emergency rooms at times such as holidays or late Friday afternoons when experienced staff are not usually present and obtaining old medical records is difficult.

(Feldman, 2004; Frey, 2014; Maldonado, 2002).

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FACTITIOUS DISORDER - CHARACTERISTICS

- The patient has few visitors even though he or she claims to be an important person.
- The patient is **unusually accepting of surgery** or uncomfortable diagnostic procedures.
- The patient's **behaviour is controlling, attention-seeking, hostile, or disruptive.**
- The symptoms are present only when the patient thinks he or she is being watched.
- The patient is **abusing substances**, particularly prescription pain-killers or tranquilisers.
- The course of the "illness" fluctuates, or complications develop with unusual speed.
- The patient has **multiple surgical scars**, a so-called "gridiron abdomen," or evidence of self-inflicted wounds or injuries.

(Feldman, 2004; Frey, 2014; Maldonado, 2002).

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FACTITIOUS DISORDER - DIAGNOSING

- Factitious disorders are extremely difficult to diagnose and even more difficult to confirm than most mental health conditions.
- There is an unwritten, unspoken contract between patients and doctors. It is **the patient's responsibility to accurately report symptoms** in a timely fashion to his physician
- **The deceitfulness of their actions usually baffles physicians** who will continue to develop a differential diagnosis and an increasingly complex treatment plan, either blaming themselves for being unable to accurately diagnose or treat the presenting symptoms, or blaming a "virulent or unusual variant" of a known disease process. Unfortunately, this delay in diagnosis does more than deceive doctors. It often leads to inappropriate diagnostic tests, invasive interventions and iatrogenic complications. Furthermore, it may lead to enormous financial drains on the health care system.
- The prevalence of factitious disorder is unknown, likely because of the role of deception in this population. **Among patients in hospital settings, it is estimated about 1% of individuals**.

(APA 2013; Maldonado, 2002).

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FACTITIOUS DISORDER - DIAGNOSING

- There are only three "fool-proof' or definitive ways of diagnosing a factitious disorder.
  - **"caught in the act"** of injuring him/herself (e.g., nurse or doctor walks in, or surveillance system records, while patient is in the process of injecting the medication or contaminant in order to produce the symptoms.), or
  - the **patient "confesses"** to inflicting self harm after being confronted with evidence acquired from previous physicians, medical records, or a room search turns out evidence of self-injurious behaviour.
  - The third and most likely way of making a diagnosis of factitious disorder is by **consensus of the multiple consultants** commonly involved in the puzzling picture created by factitious patients.

(Maldonado, 2002).

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FACTITIOUS DISORDER – CLINICAL MANAGEMENT

- Start with a thorough review of the medical record/s
- Avoid unnecessary and potentially dangerous diagnostic or operative procedures.
- There is conflicting evidence in the literature about the effectiveness of pharmacological agents as part of treatment. If there is underlying depression or anxiety then it is best to try antidepressants.
- The goal of treatment is not to cure, but to prevent further morbidity and surgery (thus minimising iatrogenic injury), to prevent further hospitalisations, to promote more socially acceptable and mature ways to express distress, and to have their need to be cared for met.
- The overall prognosis for all forms of factitious disorder is poor. However …

(Catalina, de Ugarte & Moreno, 2009; Maldonado, 2002).

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FACTITIOUS DISORDER – CLINICAL MANAGEMENT – NON-PUNITIVE CONFRONTATION

- Confrontation is usually the foundation of effective management. When this approach is used, the confrontation should be done by the patient's primary care physician (PCP) or treating psychologist. Confrontation should be **non-punitive and supportive.** It is imperative that the PCP stresses the need for continuity of care and that he/she recognise the patient as a sick person and the need for further treatment.
- Physicians must maintain consistent and clear communication among all members of the management team and with the patient, both in the inpatient and outpatient settings to reduce team splitting.
- **A single physician** (preferably the PCP) to be "the identified care giver" whose **responsibility it is to coordinate and approve any needed specialist consultation and any diagnostic test and/or treatment** suggested by members of the consulting team.
- In order to minimise or avoid the patient's feelings of abandonment, regular medical visits are recommended. Physicians are advised to **not wait for crises to occur.** Prophylaxis is always the best treatment.
- It is imperative to continue to monitor for the possibility of real organic illness. Remember that even patients with factitious disorder do eventually get sick.

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MALINGERING – OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION V65.2 (Z76.5)

- The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives
- Malingering should be strongly suspected if any combination of the following is noted:

1. Medicolegal context of presentation (e.g., the individual is referred by an attorney to the clinician for examination, or the individual self-refers while litigation or criminal charges are pending).
2. Marked discrepancy between the individual's claimed stress or disability and the objective findings and observations.
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen.
4. The presence of antisocial personality disorder.

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MALINGERING - DESCRIPTION

- Malingering is not considered to be a mental disorder, it is a criminal behaviour
- Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, which is motivated purely by **secondary gain** including
  - the receipt of monies (legal settlements or verdicts, worker's compensation, disability benefits);
  - the procurement of abusable prescription medications, such as opioids or benzodiazepines;
  - the avoidance of unpleasant work or military duty; or
  - In other cases, the incentives can be more subtle, such as avoidance of onerous household responsibilities.
- Most likely ailment to be malingered was **mild head injury**, followed by **fibromyalgia or chronic fatigue syndrome, pain, neurotoxic disorders, electrical injury, seizure disorders, and moderate or severe head injury**

(Maldonado, 2002; McDermott & Feldman, 2007; Overholser, 1990).

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MALINGERING - DIAGNOSIS

- It is rather difficult to differentiate factitious disorder from malingering. Because the mechanism of symptom formation is conscious in both presentations
- The main difference between factitious behaviour and malingering hinges on the motivation for symptom production. Malingerers fake their symptoms in order to obtain tangible secondary gains. Though this can be difficult to ascertain as one can rarely know another's motivations.
- One unfortunate result of the wide availability of high quality medical information on the Internet is that malingerers now have abundant guidance on how to convincingly display pain and disability

(Feldman, 2004; Maldonado, 2002; McDermott & Feldman, 2007).

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Domain	Malingering	Factitious
Behaviour during interview	Guarded	Guarded
Typical setting	Out-patient	Inpatient
Discharge status	By doctor	Against medical advice
Stability of problems	Situational	Continual
Recurrent episodes	Occasionally	Definitely
Nature of treatment provided	Medications	Surgery
Somatic response	Poor	Poor
Emotional response	Agreeable	Belligerent
Behavioural response	Cooperative	Uncooperative
Production of symptoms	Conscious	Conscious
Control over symptoms	Voluntary	Involuntary
Primary source of motivation	External	Internal
External motivation	Clearly present	Apparently absent

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OVERVIEW

	Somatic Symptom Disorder & Conversion Disorder	Factitious Disorder	Malingering
Symptom production	Unconscious	Conscious	Conscious
Symptom motivation	Unconscious	Unconscious	Conscious
Investigation motivation	Open	Very open	Closed (in case they are found out)
Intervention motivation	Engage well	Will engage but don't make gains	Don't engage, don't want to improvement
Treatment	MDT rehabilitation as normal with combination of emotional therapy	One primary physician & emotional therapy if willing to engage	No treatment available
Patient's reaction to symptoms	Confused and worried	Calm and unfazed	Calm and unfazed

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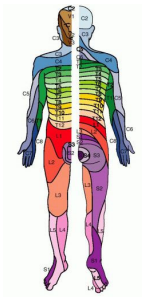
BACK TO THE CASE STUDY

- Penny* is a 32 year old married, stay at home mother of a 3 year old
- Complaining of bilateral below knee numbness and weakness. Claims cannot walk. Also incontinent of urine
- Symptoms don't fit a medical cause – e.g., the dermatomes don't match the symptoms
- Penny also will walk out for a cigarette if the wheelchair is taken from her

Diagnosis ? More information?

- Doesn't fit Conversion Disorder
- Diagnosed with Factitious Disorder



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Questions?

''It is devilish to suffer from a pain that is all but nameless. Blessed are they who are stricken only with classifiable diseases! Blessed are the poor, the sick, the crossed in love, for at least other people know what is the matter with them and will listen to their belly-achings with sympathy.'

- George Orwell

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