

Somatoform (s. Psychosomatic) Disorders

Last updated: September 5, 2017

CLASSIFICATION 1
 ETIOLOGIC THEORIES..... 1
 DIFFERENTIAL DIAGNOSIS 2
 TREATMENT..... 3
SOMATIZATION DISORDER..... 3
CONVERSION DISORDER (S. HYSTERIA) 3
BODY DYSMORPHIC DISORDER (S. DYSMORPHOPHOBIA)..... 4
HYPOCHONDRIASIS..... 4
(SOMATOFORM, S. PSYCHOGENIC) PAIN DISORDER 4
FACTITIOUS DISORDER..... 5
MALINGERING 6
PLACEBO RESPONSE..... 6

SOMATOFORM DISORDERS - **chronic*** disabling **mental disorders with presenting features suggesting physical illnesses** (i.e. unconscious mimicry of medical disease).

*vs. most normal people **occasionally** experience mental state with accompanying physical symptoms (e.g. upset stomach when anxious)

SOMATIZATION - expression of mental phenomena as physical (somatic) symptoms; typically leads to seeking medical evaluation and treatment.

- somatization extends in continuum from symptoms that develop unconsciously and nonvolitionally (e.g. true somatoform disorders) to symptoms that develop consciously and volitionally (e.g. malingering).
- somatization may involve any body systems.
- physical symptoms are:
 - a) **unexplained** by general medical condition.
 - b) **disproportionate** to symptoms that might be expected from general medical condition.
- all are more common in **women** (except *hypochondriasis & body dysmorphic syndrome* – equal in women and men).

To establish diagnosis, clinician must rule out:

- 1) occult physical conditions
- 2) substance abuse
- 3) other psychiatric disorders that might better explain symptoms (esp. **major depressive illness** [e.g. delusion of having fatal cancer], **schizophrenia**, **panic disorder**).

N.B. all somatoform disorders begin at young adulthood; if onset is late – major depression is most likely diagnosis (and somatic complaint is secondary to it)

- some of **diagnostic blurring in DSM-IV** is intentional: it helps clinicians avoid dichotomous thinking about patients (e.g. "patient has somatization disorder; now I can make psychiatric referral and stop looking for physical disease").
- **substance abuse** (opiates, benzodiazepines, alcohol) may develop.
- **costs to health care system** (excessive disability, excessive medical evaluations, unnecessary invasive diagnostic procedures and surgery*) are enormous!
 *frequently, initial surgery is followed by multiple subsequent surgeries for "adhesions"

CLASSIFICATION

1. Somatization disorder
2. Conversion disorder (s. hysteria)
3. Body dysmorphic disorder
4. Hypochondriasis
5. (Psychogenic) Pain disorder
6. Undifferentiated somatoform disorder
7. Somatoform disorder not otherwise specified.

- A. Subjective symptoms unexplained by physical findings** (e.g. **conversion symptoms**); does not include disorders involving conscious or intentional misrepresentation of symptoms.
CONVERSION REACTION - psychological problem is symbolically manifested physically, although physiologic tissue damage cannot be demonstrated.
- B. Unusual attention to and preoccupation:**
 - a) preoccupation with body part that patient considers defective, deformed, weak, or ugly in contrast with external evidence to contrary (e.g. **body dysmorphic disorder**).
 - b) unusual degrees of attention to physical symptoms (e.g. mole that person incorrectly believes to be malignant).
 - c) unusual degrees of attention to organ systems (e.g. excessive preoccupation with examining feces for blood or deformity believed to be evidence of malignancy).
- C. Physical symptoms incorrectly reported or created by patients for purpose of gaining specific benefit**, i.e. conscious fabrication of symptoms (e.g. man putting blood from finger stick into his urine sample and complaining of flank pain); (e.g. **factitious disorder**, **malingering**).

ETIOLOGIC THEORIES

There are as yet no credible neurobiologic explanations for somatoform disorders!
 Psychological phenomena with variable levels of self-awareness.

EMOTIONAL SPECIFICITY THEORY

(i.e. physiologic expression of blocked emotions); theory has, in general, **lost favor** as comprehensive explanation.

SIGMUND FREUD believed that symptoms are produced by process of **dissociation** - expulsion from consciousness of painful memory or feeling and its replacement by physical symptom.

FRANZ ALEXANDER theorized that **specific unconscious conflicts cause specific illnesses** in organs innervated by autonomic nervous system (because of prolonged tension can produce physiologic disorders, leading to eventual pathology).

- constitutional predisposing factors are involved.
- theory led to concept of **classic psychosomatic diseases**:
 - 1) bronchial asthma
 - 2) rheumatoid arthritis
 - 3) ulcerative colitis
 - 4) essential hypertension
 - 5) neurodermatitis
 - 6) thyrotoxicosis
 - 7) peptic ulcers

STRESS RESPONSE THEORIES

- in each culture, different events may carry different "weights" as stressors.

- psychological reactions to stress can alter neuroendocrine, immune, cardiovascular, and other physiologic parameters that can lead to nonspecific cause of disease.
- physiologic reaction to stress is **fight-or-flight response**;
 - when individual can neither fight nor flee, this state of arousal can lead to organic dysfunction.
- when individual is threatened with loss (real or imagined), metabolism can slow down (individual withdraws, and conserves energy) - pulse and body temperature decrease, individual may become susceptible to illness (particularly infection).
 - morbidity and mortality rates are higher during first year after death of spouse.
 - elderly people placed in nursing homes have increased risk of cardiovascular death.

BIOPSYCHOSOCIAL MODEL

- proposed by **GEORGE ENGEL**.

- biologic event can alter psychological perceptions and cognitive set → can alter social behaviors → social environment responds by treating individual differently → response to that different treatment is alteration in physiology.
- **perception of pain or physiologic events** is conscious registering of stimulus or event; perception can be altered by number of factors such as state of arousal, individual differences in threshold, mood, other stimuli, and physiologic events.
 - literature contains many reports of broken legs and war wounds that go unnoticed by injured person; vs. patient who believes that change in physical symptom is sign of worsening or fatal illness pays great deal of attention to symptom.
 - **primary gain from physical symptom** is abatement of psychological symptom that results from attention demanded by physical symptom (e.g. broken leg takes attention away from worries about relationship and may even be more "comfortable").
- **SICK ROLE** (Parsons, 1951) – **functional meaning of being sick person in Western societies**; illness is **socially undesirable** state, which **prevents person from performing** ordinary tasks and roles, and which **must be remediated ASAP**;
 - Rights of sick role:**
 - 1) sick person is not responsible for his illness (therefore, cannot be blamed).
 - 2) exemption from work obligations & social responsibilities
 - Duties of sick role:**
 - 1) obligation to "want to get well" (therefore, cooperation in any therapeutic effort).
 - 2) obligation to seek competent & appropriate treatment
 - in some cultures, sick role is very limited; sick person is allowed only to lie down and stop eating.
 - in other cultures, sick role may be highly elaborated on basis of type of sickness, chronicity, and supposed role of individual in bringing on illness.
 - positive aspect of sick role - **secondary gain** from social benefits (avoid work, gain financial rewards, avoid conflict, gain sympathy).
 - negative aspect of sick role - "**socially stigmatized**" illnesses (HIV, mental illness, epilepsy) may preclude persons from working, finding housing, or enjoying social relationships.
 - some sick roles may **create disability** independent of or disproportionate to disability associated with illness.
 - acutely*, sick role elicits caring responses from others; as sick role becomes more chronic, it elicits increasing anger and rejection from others (even from unsophisticated physicians and caregivers).
 - *development of socially stigmatized illnesses may elicit acute rejection from social network (e.g. HIV, mental illness).
 - communication between ill persons and others may become increasingly centered on illness, creating cycle in which exacerbation of symptoms becomes mechanism for eliciting response from others.

DIFFERENTIAL DIAGNOSIS

In reality, overlap between somatoform disorders and other physical and psychological disorders is great!

- A. Psychiatric disorders that present with physical symptoms** (e.g. **major depression*** presents with headaches or malaise; **panic disorder** presents with symptoms of myocardial infarction, dyspnea, hyperventilation; vague GI complaints are common in association with psychiatric disorders).
- *strong tendency exists for major depression to present with somatic complaints in some cultures
- B. General medical conditions ← exacerbated by psychological factor** (e.g. stress):
- 1) **cardiovascular disorders** (cardiovascular system reacts to patient's emotional state!) – CAD (**type A behavior pattern** is risk factor), essential hypertension (common reaction to stress is BP elevation), arrhythmias (stress may cause arrhythmias by arousing sympathetic nervous system).
 - 2) **GI disorders** (emotional states have long been known to cause reaction in GI tract!) - irritable bowel syndrome, peptic ulcers, ulcerative colitis
 - 3) **psoriasis**
 - 4) **thyroid dysfunction** (altered in major mental illnesses, particularly depression).
 - 5) **respiratory disorders** - bronchial asthma (stress and inconsistent relationship between asthmatic child and overly protective mother may be factors in onset of episodes of illness).
 - 6) **migraine**
 - 7) **immune disorders** - stress may depress cell-mediated immune response (via T lymphocytes); increasing evidence suggests immune system dysfunction in disorders such as depression; stresses and mental illness are associated with flare-ups in disorders kept in some control by immune system (e.g. melanoma, tuberculosis).
- C. General medical condition → causing / exacerbating psychiatric symptoms.**
N.B. medical conditions can cause psychiatric symptoms resembling almost any psychiatric disorder
Most important physical disorders presenting as somatoform disorders (i.e. often misdiagnosed as psychiatric illness early in course):
1. **Autoimmune disorders** (esp. SLE).
 2. **Endocrine disorders**: hyperthyroidism, hypothyroidism, hyperparathyroidism.
 3. **Neurologic disorders**: MS, temporal lobe or complex partial seizures.
 4. Acute intermittent porphyria, toxic delirium
- D. Physician mistake** (medical disorders is mistaken for psychiatric condition).
- E. Folk beliefs**
N.B. if other members of culture or subgroup share belief system, beliefs should not be called "psychotic"!
Examples:
Koro (Asian men) - patients believe that penis is shrinking into body, with death as expected result.
Dhat (India) - concerns with semen discharge are associated with beliefs about weakness and exhaustion.

In USA, *health-related subcultures* have beliefs about such health topics as cause of disease, nutrition, vitamin use, and crystals; on occasion, these beliefs lead to behaviors that can cause major health problems and even psychotic symptoms (e.g. fat-soluble vitamin overdose, scopolamine poisoning from too much herbal tea).

TREATMENT

- to convert patient from medical into psychiatric patient.
- if *pharmacologically accessible symptom complex* (anxiety, depression) accompanies conversion phenomena, it may be helpful to initiate psychopharmacologic treatment (but **avoid habit-forming medications!!!**).

SOMATIZATION DISORDER

- **persistent / recurring physical complaints in multiple (!!!) body parts** (any body part may be affected) over several years that cannot be explained fully by physical disorder.
- symptoms begin before age 30.
- patient has at least 4 **pain** symptoms, 2 **gastrointestinal** symptoms, 1 **sexual** symptom, and 1 **pseudoneurologic** symptom (e.g. double vision, weakness, deafness, dissociative symptoms*) at any time during course of disturbance.
 - *e.g. amnesia or loss of consciousness (other than fainting);
 - association between somatization disorder and dissociative symptoms is so frequent that they were considered to be in same diagnostic class in previous editions of DSM (i.e. "psychoneurotic reactions" in DSM-I, "hysterical neurosis" in DSM-II).
 - dissociative symptoms are often found in patients with somatization disorder; some odd symptoms (e.g. picking at skin, pulling own hair) may be mechanisms to keep from dissociating.

If criteria are not fully met, diagnosis is **UNDIFFERENTIATED SOMATOFORM DISORDER**.

- typically, patients are dramatic and emotional when recounting their symptoms ("unbearable", "beyond description", "worst imaginable").
- patients may become extremely dependent with treatment-seeking or impaired functioning.
- patients tend to be frustrated and angered by suggestions that their symptoms are mental.
- associated psychiatric disorders:
 - 1) anxiety and depressive symptoms.
 - 2) wide range of interpersonal difficulties (incl. marital and parenting problems)
 - 3) substance abuse (incl. prescribed medications)
 - 4) suicidal ideation
 - 5) sexual function impairment (lack of interest in sex, specific sexual dysfunctions)
- lifelong disorder! (symptoms tend to fluctuate with stress; *complete symptom relief* for any extended period is rare).

EPIDEMIOLOGY

- ≈ 1% women have somatization disorder
- **women** to men is 10:1.
- less common in individuals with *higher education*.

ETIOLOGY

- significant **genetic component**:
 - high incidence of *somatization disorder, alcoholism, antisocial personality disorder* in first-degree relatives.
 - **adoption studies** of female children of somatizing women showed markedly increased rate of somatization disorder.
- **environmental influences** - increased rate of somatization disorder when children are raised in chaotic circumstances (involving parental divorce, poverty, and alcoholism).
- patients may have impaired ability to screen out somatic sensations.
- **secondary gains** of sick role may provide learned component of disorder.

TREATMENT

- establishing consistent, supportive physician-patient relationship with **one physician** that avoids exposing patient to unnecessary diagnostic testing and therapies.
- **regular appointments**;
 - focus on life stresses and patient's functioning rather than on symptoms.
 - no medication should be given for questionable indications.
 - **appropriate evaluation of new symptoms** when they occur (patients are still at risk for organic illness!).
- **antidepressants** are effective only for patients with depressive symptoms.

CONVERSION DISORDER (s. HYSTERIA)

- **unconscious (!) "conversion of psychological conflict" into physical symptom**, which suggests *neurologic disease* or other disease.
 - N.B. conversion symptoms are not intentionally produced!
 - N.B. conversion disorders are also seen in patients with real organic physical illness! (15-30% patients diagnosed as having conversion disorder have undiagnosed physical illness!!!)
- onset usually in adolescence ÷ twenties; however, it can occur at any age.
- classically present with **acute symptoms of sensory / voluntary motor function**, which suggests *neurologic disease*.
 - N.B. symptoms are not limited to pain or sexual dysfunction!
- symptoms are severe enough to cause distress or disrupt social, occupational, or other important areas of functioning.
- virtually any symptom may become conversion symptom, but to make firm diagnosis, symptoms must not conform to known neuropathophysiologic mechanisms or neuroanatomic pathways, but instead follow **individual's unconscious conceptualization of neurologic function** (e.g. stocking-glove anesthesia but avoids painful stimulus; blindness but avoids visual threat).
- symptoms are brief*, *temporally related to (preceded by) psychosocial stressor / conflict* – i.e. psychological factors are associated with symptom (unintentional psychological motivation)
 - *some can have chronic course (e.g. sensory loss or weakness) → significant disability
- DSM-IV requires specification of subtype:
 - a) **with motor symptoms or deficits** (e.g. impaired coordination or balance, paralysis or localized weakness (see p. D1 >>), difficulty swallowing or "lump in throat", aphonia, inability to speak in full voice, urinary retention)
 - b) **with sensory symptoms or deficits**, e.g. sensory disturbances (see p. D1 >>), double vision, blindness (see p. Eye62 >>), deafness* (see p. Ear32 >>), hallucinations.
 - *much more common in malingering than in hysteria!
 - c) **with seizures or convulsions** (with voluntary motor or sensory components) see p.E9 >>
 - d) **with mixed presentation** (if symptoms are evident in more than one category; e.g. psychogenic coma → see p. S30 >>)
- **"la belle indifférence"** - patients exhibit *little concern over symptoms* (patients with real physical illness may also be stoic about their condition!).
- **modeling** - patients unconsciously imitate symptoms observed in important individuals in their lives.

- **additional psychiatric diagnosis** (e.g. adjustment disorder, schizophrenia, personality disorder*) can be made in 30-50% patients.
 - *conversion is traditionally linked with hysterical (histrionic) behavior
- in **MASS HYSTERIA (EPIDEMIC HYSTERIA)**, variation of conversion, group of persons suddenly become concerned about problem (e.g. food poisoning or toxic substance in air) and develop symptoms in imitation of those who imagined problem first;
 - most commonly occurs in preadolescent and adolescent children who become ill at school, but it can occur in other settings.

EPIDEMIOLOGY

- seems to be less common now than in past, and it may present with less classic symptomatology
- seen more frequently in low socioeconomic classes.
- some cultures have much greater rates of conversion disorder than others.
- **women** > men.

ETIOLOGY

- **psychological**; gains experienced by patients:
 - (1) **primary gain** - internal conflict is kept from consciousness.
 - (2) **secondary gain** - reinforcement from environment (e.g. patient who avoids unpleasant duties because of symptoms).

TREATMENT

Attention to possibility of organic disease is critical! (workups should be based only on objective findings)

Psychotherapy:

- consistently trusting and supportive physician-patient relationship is essential.
- patients are unaware of unreality of their symptoms, but confronting patient with fact that symptoms have psychological basis is not helpful!!!
- best approach is explanation that *disorder is reaction to stress* and reassurance that *condition will resolve over time!* → majority experience resolution in short time.
- **suggestion** during *HYPNOSIS* or *AMOBARBITAL INTERVIEW* that symptoms will improve can result in dramatic resolution.

BODY DYSMORPHIC DISORDER (s. DYSMORPHOPHOBIA)

- **preoccupation with imagined or slight visible defect in body** (usually of face).
 - Men may have form of disorder called **MUSCLE DYSMORPHIA** - preoccupation with idea that body is not sufficiently lean and muscular.
- patients spend many hours day thinking about their perceived defect - significant distress, and impaired functioning.
- most check themselves often in mirrors, others avoid mirrors.
- many patients avoid appearing in public.
- history shows frequent visits to doctors (esp. dermatologists or plastic surgeons); men with muscle dysmorphia may use androgen supplements.
- depressive mood and obsessive compulsive traits are common.
- incidence and etiology are unknown; begins in adolescence; **men ≈ women**.
- differential diagnosis
 - a) if symptom is of delusional intensity, it should be classified as **delusional disorder, somatic subtype**.
 - b) **major depression**
 - c) **schizophrenia**.
 - d) **OCD** (strong links with body dysmorphic disorder)
 - e) **anorexia nervosa** - only concern is body shape and weight.
 - f) **gender identity disorder** - only concern is sex characteristics.

TREATMENT

Unnecessary surgery should be avoided! (patients are unlikely to be satisfied with results!)

- **antidepressants** (SSRIs!!!) are mainstay of treatment!
- **neuroleptics** (pimozide) and **cognitive-behavioral therapy** may also help.

HYPOCHONDRIASIS

- **chronic preoccupation with fears of having serious illness** despite thorough evaluation and reassurance from physician that no organic problems can be found.

N.B. preoccupation is with illness in general rather than with symptoms!

- persists for ≥ 6 mo despite reassurance.
- impairment can be so severe as to result in invalidism.
- **"doctor shopping"** is common (simple reassurance that feared symptom is not serious is interpreted by patient as evidence that treating physician is not taking situation seriously); H: regular appointments.
- if belief becomes delusional (subtle distinction at times), then diagnosis is **DELUSIONAL DISORDER**.
- if concern is about appearance, body then diagnosis is **DYSMORPHIC DISORDER**.

Etiology:

- patients may have been raised in homes with excessive concern about illness or little parental warmth except when children were ill.
- vigilance become form of autosuggestion (fear and misperception become cyclic, self-reinforcing):
 - **normal physical sensations** (such as sweating and bowel movements) are misinterpreted.
 - **minor ailments** (such as cough or backache) are exaggerated.

Epidemiology: ≈ 1% population; **men ≈ women**; usual age of onset is 20-30 (but patients most commonly present to physician in forties ÷ fifties).

Treatment

- physician reaction is often negative (physician needs to recognize that these patients are subjectively suffering!)
- **sympathetic, educational approach** to patients is ideal.
- it may be necessary to prescribe medication; however, patients should be told that it will help but not "cure" ailment; **SSRIs** are effective.
 - PIMOZIDE** is dramatically effective in some patients with **hypochondriasis of delusional intensity**.
- **cognitive-behavioral therapy** may be helpful.

(Somatoform, s. Psychogenic) PAIN DISORDER

- **complain of pain** for which there is **no demonstrable physical cause** or pain is **excessive given known organic pathology** (i.e. *psychologic disorder is predominant influence* on pain intensity and disability degree); it is similar to conversion disorder, except that symptom is pain.

N.B. patients **truly experience pain** (i.e. pain is not factitious, and patient is not malingering).

- typical syndromes:

- 1) chronic headache
 - 2) continued low back pain
 - 3) atypical facial pain
 - 4) abdominal / pelvic pain of unknown etiology.
- pain may be acute or chronic (> 6 mo).
 - **mental factors** have dominant role in onset, severity, exacerbation, or maintenance of symptoms, but pain is not intentionally produced or feigned.
Detection of mental or social stressors may help diagnose disorder!
 - distinction between pain disorder and chronic pain itself may not be terribly useful in daily practice - accepting patient's pain is good starting place for treatment.
 - most cases lead to:
 - (1) problems with physician-patient relationship
 - (2) multiple physical examinations, unnecessary surgery
 - (3) substance abuse
 - **women** > men.

ETIOPATHOPHYSIOLOGY

Psychological factors

- patients may have learned as children to *express emotions physically instead of verbally*.
- unconscious reinforcement by **sick role**.

Physical theories

- **ENDORPHINS** (which raise pain threshold in brain) may be altered genetically, developmentally, or secondarily to stress; same is with **SEROTONIN** (involved in pain inhibitory fibers in brain stem).
- **genetic component** - increased incidence of first-degree relatives with:
 - 1) chronic pain
 - 2) depression
 - 3) alcohol dependence
 - 4) substance abuse

PROGNOSIS

- factors for poor prognosis of functional recovery:

- 1) long duration.
- 2) older patient.
- 3) reinforcement (financial, social, or otherwise); many clinicians refuse to treat patients with pending litigation because of poor outcome under these circumstances.
- 4) coexisting personality disorder.

TREATMENT

Notoriously difficult to treat! (many patients make significant improvements in functioning, but few are cured)

- thorough medical evaluation, followed by strong reassurance, may be sufficient.

Medications

- **antidepressants** may be useful.
- **analgesics** are ineffective if used alone.
- **chronic narcotic use** is not helpful* (**patients become habituated**); for minority of chronic pain patients who require chronic narcotic, long-acting preparation (such as **METHADONE**) is preferable.
*but adequate prescription of narcotics following surgery or acute physical trauma is best prevention against chronic pain development!
- **sedative-hypnotics** depress nervous system → **increase pain perceptions!!!**

Psychotherapies

- **behavioral therapy** focuses on reinforcing wellness instead of sick role behavior.
- **cognitive techniques of pain control** (e.g. relaxation training, distraction techniques, hypnosis, biofeedback).
- behavior of family members or fellow workers that reinforces pain behavior (e.g. constant inquiries about patient's health or insistence that patient perform no chores) should be discouraged.

FACTITIOUS DISORDER

- individual **intentionally produces symptoms of illness for psychologic reasons** (i.e. it is entirely mental disorder).

N.B. although such behavior is deliberate, what precipitates this behavior is not!

Examples:

- a) complains of pain when feels no pain.
 - b) adds drop of blood to urine sample to fake kidney ailment.
 - c) self-inflicted infection such as self-injection with feces or saliva.
- symptoms may be mental, physical, or both.
 - **sole unconscious goal of behavior is to be in patient role** - patients insist for hospital admission.
 - patients may have prominent histrionic or borderline personality features but are usually intelligent and resourceful.
 - medical knowledge of patients is often highly sophisticated (significant portion of patients are employed in health care field as paraprofessionals).
 - **narcotic abuse / addiction** is found in ≈ 50% patients.
 - at hospital admission, patient behavior is disruptive and demanding; symptoms change as workups prove negative; eventually, patients are confronted with evidence of faking, and they usually react angrily and leave against medical advice (AMA).

MÜNCHHAUSEN syndrome - *severe chronic form of factitious disorder* - repeated fabrication of physical illness (usually acute, dramatic, and convincing*) by person who wanders from hospital to hospital for treatment.

*patients may lie about any aspect of their history with dramatic flair (**pseudologia fantastica**)

- disorder begins in adulthood and is lifelong.
- **masochism** is important feature in patients who seek unnecessary surgery (abdominal wall may be crisscrossed by scars, or digit or limb may have been amputated).

TREATMENT

- therapeutic approach is one of *management rather than cure*, and unnecessary diagnostic procedures should be avoided.
- patients should be confronted in calm, noncondemning indirect manner; suggestion that examiner believes symptoms will soon reverse allows patient dignity to voluntarily reverse them.
- until patients are willing to face reality of psychiatric illness and agree to psychiatric treatment, prognosis is likely to be poor.

MÜNCHHAUSEN syndrome by proxy (s. factitious disorder not otherwise specified)

- adults (usually parents) intentionally produce / feign symptoms in person who is under their care (usually child).

- adult falsifies history and may injure child with drugs or other agents or add blood or bacterial contaminants to urine specimens to simulate disease.
- parent seeks medical care for child and appears to be deeply concerned and protective.

MALINGERING

- individual **intentionally produces / exaggerates symptoms of illness** with goal* that is clear to both patients and physicians, and symptoms can be stopped when they no longer serve end.

*goal is **secondary gain** (e.g. avoid work, obtain prescription for narcotics, win lawsuit); vs. in factitious disorder, goal is **to be in patient role**.

Malingering is not mental illness (vs. factitious disorder)

- because malingering is not illness, it has **no medical or psychiatric treatment**.

Malingering should be strongly suspected:

1. **Medicolegal context** of presentation (e.g. person is referred by attorney to clinician for examination)
2. Marked **discrepancy** between person's claimed **stress or disability** and **objective findings**.
3. **Lack of cooperation** during diagnostic evaluation and in complying with prescribed treatment regimen.
4. Presence of **antisocial personality disorder**.

PLACEBO RESPONSE

- any effect attributable to medication, procedure, or other form of therapy but not to specific pharmacologic property of that therapy. also see p. 907 (1) >>

- placebo response is powerful aspect of most medical care - all medical treatments can show placebo effects;
e.g. 30-40% patients in pain respond as well to placebos as they do to morphine.
- no particular personality type responds more to placebo (i.e. histrionic patient is *no more likely* to have placebo response than is any other patient).
- physicians use placebo response (mistakenly!!!) to help differentiate "real" from "psychological" symptoms.

N.B. placebo does not differentiate physical from psychological symptoms!

e.g. recent findings suggest that placebo response to pain is physiologic phenomenon! (placebo response can be blocked by NALOXONE, which suggests that analgesic effect of placebo is based on action of endorphins).

BIBLIOGRAPHY for ch. "Psychiatry" → follow this [LINK >>](#)