



DSM-IV-TR Diagnostic Criteria for Somatoform Disorder Not Otherwise Specified

This category includes disorders with somatoform symptoms that do not meet the criteria for any specific somatoform disorder. Examples include:

1. Pseudocyesis: a false belief of being pregnant that is associated with objective signs of pregnancy, which may include abdominal enlargement although the umbilicus does not become everted, reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery. Endocrine changes may be present, but the syndrome cannot be explained by a general medical condition that causes endocrine changes (e.g., a hormone-secreting tumor).
2. A disorder involving nonpsychotic hypochondriacal symptoms of less than 6 months' duration.
3. A disorder involving unexplained physical complaints (e.g., fatigue or body weakness) of less than 6 months' duration that are not due to another mental disorder.

Dissociative disorders

In DSM-IV, the essential feature of dissociative disorders is a disruption of the usually integrated functions of consciousness, memory, identity or perception. This disturbance may be sudden or gradual, transient or chronic.

Dissociative symptoms:

- Subjective numbing.
- Detachment.
- Reduced awareness of surroundings.
- Fragmentation or loss of memory.
- Derealization and depersonalization.

Classification of dissociative disorder (DSM-IV):

- Dissociative amnesia.
- Dissociative fugue.
- Dissociative identity disorder.
- Depersonalization disorder.
- Dissociative disorder not otherwise specified.

Dissociative amnesia: the essential feature is an inability to recall important personal memories, usually of a stressful nature, that is too excessive to be explained by normal forgetfulness. Dissociative amnesia must be distinguished from amnesia having a medical cause. It has been described in two forms:

- Circumscribed amnesia for a single recent traumatic event.
- Inability to recall long periods of childhood.

Dissociative fugue: is extremely rare. There is loss of memory coupled with wandering away from the person's usual surroundings. These people usually deny all memory of their whereabouts during the period of wandering, and some deny knowledge of personal identity.

Dissociative identity disorder: widely known by the ICD-10 term multiple personality disorder, there are sudden alterations between two patterns of behavior, each of which is forgotten by the patient when the other is present.



DSM-IV-TR Diagnostic Criteria for Dissociative Identity Disorder

- A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person's behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. The disturbance is not due to the direct physiologic effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). **Note:** in children, the symptoms are not attributable to imaginary playmates or other fantasy play.

Patients who meet the above criteria often meet the criteria for other diagnoses including schizophrenia, personality disorder and substance abuse.

Depersonalization disorder : is characterized by an unpleasant state in which external objects or parts of the body are experienced as changed in their quality and feel unreal or remote . the central features are a feeling of being unreal and unreal quality to perceptions . emotions seem dulled and actions feel mechanical . insight is retained into the subjective nature of their experiences. These symptoms may be intense and accompanied by déjà vu and by changes in the experience of passage of time . two thirds of the patients are women . the onset in adolescence or early adult life . the symptoms of depersonalization disorder occurs occasionally in association with other psychiatric disorders (temporal lobe epilepsy , schizophrenia , depression , obsessional disorder , conversion disorder , migraine and also associated with the use of illicit drugs .

Additional conditions that may be a focus of clinical attention :

- Malingering : is the intentional production of false or grossly exaggerated physical or psychological symptoms , motivated by external incentives such as avoiding military duty , avoiding work , obtaining financial compensation , evading criminal prosecution or obtaining drugs .

Malingering should be strongly suspected if any combination of the following is noted :

- 1- Medicolegal context of presentation .
- 2- Evident discrepancy between the individual's claimed stress or disability and the objective findings .
- 3- Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen.
- 4- The presence of antisocial personality disorder.

Factors aiding in the differentiation between malingering and conversion disorder :

- 1- Malingerers are more likely to be suspicious , uncooperative , aloof and unfriendly ; patients with conversion disorder are more likely friendly , cooperative , appealing , dependant and clinging.

- 2- Malingers may try to avoid diagnostic evaluations and refuse recommended treatments , patients with conversion disorder likely welcome evaluation and treatment .
- 3- Malingers are more likely to provide extremely detailed and exacting descriptions of events precipitating their illness ; patients with conversion disorder are more likely to report historical gaps , inaccuracies and vagaries.

Treatment : if , at the conclusion of the diagnostic evaluation , malingering seems most likely , the patient should be tactfully , but firmly confronted with the apparent outcome. Coexisting psychiatric disorders should be thoroughly assessed .

Factitious Disorders

A. Definition. Intentional report and misrepresentation of symptoms, or self-infliction of physical signs of symptoms, of medical or mental disorders. The only apparent objective is to assume the role of a patient without an external incentive. Hospitalization is often a primary objective and a way of life. The disorders have a compulsive quality, but the behaviors are deliberate and

voluntary, even if they cannot be controlled. Also known as *Munchausen syndrome*.

- B. Epidemiology.** Unknown. More common in men than in women. Usually adult onset. Factitious illness, especially feigned fever, accounts for 5% to 10% of all hospital admissions. More common in health care workers.
- C. Etiology.** Early real illness coupled with parental abuse or rejection is typical. Patient recreates illness as an adult to gain loving attention from doctors. Can also express masochistic gratification for some patients who want to undergo surgical procedures. Others identify with an important past figure who had psychological or physical illness. No genetic or biological etiological factors have been identified.
- D. Psychodynamics.** Mechanisms of repression, identification with the aggressor, regression, and symbolization may be present.
- E. Diagnosis, signs, and symptoms**
 - 1. With predominantly physical signs and symptoms.** Intentional production of physical symptoms—nausea, vomiting, pain, or seizures. Patients may intentionally put blood in feces or urine, artificially raise body temperature, or take insulin to lower blood sugar. Gridiron abdomen sign is the result of scars from multiple surgical operations.
 - 2. With predominantly psychological signs and symptoms.** Intentional production of psychiatric symptoms—hallucinations, delusions, depression, or bizarre behavior. Patients may make up a story that they suffered major life stress to account for symptoms. *Pseudologia fantastica* consists of making up extravagant lies that the patient believes. Substance abuse, especially of opioids, is common in both types.

3. **With combined physical and psychological signs and symptoms.** Intentional production of both physical and psychological symptoms.
4. **Factitious disorder not otherwise specified.** Includes disorders that do not meet criteria for factitious disorder (e.g., factitious disorder by proxy—intentionally feigning symptoms in another person who is under the person's care so as to assume the sick role indirectly). *Factitious*

disorder by proxy is most common in mothers who feign an illness in their child, but accounts for fewer than 1,000 of the almost 3 million cases of child abuse reported annually.

F. Differential diagnosis

1. **Physical illness.** Physical examination and laboratory workup should be performed; results will be negative. The nursing staff should observe carefully for deliberate elevation of temperature or alteration of body fluids.
2. **Somatoform disorder.** Symptoms are voluntary in factitious disorder and not caused by unconscious or symbolic factors. *La belle indifférence* is not present in factitious disorder. Hypochondriacs do not want to undergo extensive tests or surgery.
3. **Malingering.** Most difficult differential diagnosis to make. Malingerers have specific goals (e.g., insurance payments, avoidance of jail term). Evidence of an intrapsychic need to maintain the sick role (e.g., to satisfy dependency needs) is more characteristic of factitious disorder.
4. **Ganser's syndrome.** Found in prisoners who give approximate answers to questions and talk past the point. Classified as a dissociative disorder not otherwise specified.
5. **Personality disorder.** Antisocial personalities are manipulative but do not usually feign illness or agree to invasive procedures or hospitalization. Borderline personalities usually have more chaotic lifestyles, parasuicidal behavior, and more disturbed interpersonal relationships.

- G. **Course and prognosis.** Course is usually chronic. Begins in adulthood, but onset may be earlier. Frequent consultation with doctors and history of hospitalizations as patient seeks repeated care. High risk for substance abuse over time. Prognosis improves if associated depression or anxiety is present that responds to pharmacotherapy. Risk for death if patient undergoes multiple life-threatening surgical procedures.

H. Treatment

1. Avoid unnecessary laboratory tests or medical procedures. Confront patient with diagnosis of factitious disorder and feigned symptoms. Patients rarely enter psychotherapy because of poor motivation; however, working alliance with doctor is possible over time, and patient may gain insight into behavior. Good management, however, is more likely than a cure. A databank of patients with repeated hospitalizations for factitious illness is available in some areas of the United States.
2. Psychopharmacological therapy is useful for associated anxiety or depression. Substance abuse should be treated if present.
3. Contact child welfare services if a child is at risk (e.g., with factitious disorder by proxy).

Dr. Waleed Al-Ameedy.