

# Differential Diagnosis: Factitious Disorders vs. Somatoform Disorders

- Somatoform Disorder (including Undifferentiated Somatoform Disorder)
  - Conversion Disorder
    - Pain Disorder
    - Hypochondriasis
  - Body Dysmorphic Disorder

# Somatization Disorder

- A. A history of many physical complaints or a belief that one is sickly beginning before age 30 and persisting for several years
- B. The physical complaint has no determined organic or patho-physiological cause or the functional effect is far beyond that that would be expected . A real pathological conditions may indeed exist but degree of impairment is in excess of actual pathology
- C. Gastrointestinal, pain, cardiopulmonary, pseudoneurological, sexual or female reproductive. Most common complaint: pain
- D. = 1-2% prevalence mostly women, 20% of 1<sup>st</sup> degree relatives.

# Somatization Disorder

- E. Masked emotional or daily living problems masked via focus on bodily sensations, the identification of the “underlying” medical problems and the seeking out of medical care.

# Hypochondriasis

- A. Preoccupation with fear of having, or belief that one has a serious disease based on person's interpretations of physical signs or sensations
- B. No physical findings that account for symptoms
- C. Fear of having or belief one's disease persists despite medical reassurance
  - diffuse complaints involving many areas of the body
  - speech is a monologue centered around symptoms and resents attempts to discuss anything else
  - well versed in medical terminology
  - very worried and anxious about condition

# Factitious Disorder by Proxy

- A. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care
- B. The motivation for the perpetrator's behavior is to assume the sick role by proxy
- C. External incentives for the behavior (such as economic gain) are absent
- D. The behavior is not better accounted for by another mental disorder

# Differential Diagnosis: Factitious Disorders vs. Somatoform Disorders

There are a number of similarities in the clinical presentation of factitious and somatoform disorders, namely:

- A) The presentation of multiple medical conditions that have elicited multiple treatment interventions via multiple treatment providers. These disorders are most often encountered in general medical settings
- B) The conditions often seem intractable or conversely, have a fluctuating or atypical clinical course with a lack of corresponding or convincing objective testing or specific laboratory findings.
- C) Somatoform disorders include:

# Differential Diagnosis: Factitious Disorders vs. Somatoform Disorders

- D) The primary distinction between somatoform conditions and factitious disorders is the degree to which the physical symptoms are **INTENTIONAL AND UNDER VOLUNTARY CONTROL**

# **Psychological characteristics of factitious somatoform disorders**

- Presentation of symptoms is elaborate
- Often exhibitionistic and preoccupied with self (or situation) at expense of others
- Skilled at manipulating family, friends, and others
- History of involvement with multiple physicians, specialists, hospitalizations, and diagnostic procedures

# Psychological characteristics of factitious somatoform disorders

## Family Background

- A. Inconsistent, unreliable and emotionally unsupportive
- B. History of physical and sexual abuse
- C. Marital discord
- D. Poor work histories
- E. Relationships are shallow and/or chaotic
- F. High degree of psychopathology in 1<sup>st</sup> degree relatives
- G. Avoidance of conflict and/or responsibility via symptoms
- H. Observation of rewards by the attention or sympathy given to the patient and/or caregiver role

# **Psychosocial Characteristics commonly found in both somatoform & fictitious disorders**

- Close identification with or observation of a family role model with often, similar, physical symptoms or “sick role” behavior.
- Developmental histories of familial discord, abuse/neglect. Often one of the parents is depicted as rejecting and/or aloof.
- Developmental history of emotional dependency often encouraged by over involved or infantilizing mothers (parents) where “sick role” behavior elicits special attention, or involvement (i.e. physical or emotional symptoms are powerful “tactics” or a primary emotional organizing principle of family life or interaction

# Psychological characteristics of hypochondriasm

- Low self esteem and experiences self as worthless, inadequate, defective
- Anxiety about physical symptoms increases the intensity of the sensation (i.e. hyperfocused) and associated catastrophic
  - (i.e. anxiety) thinking further magnifies the symptomatic experience)
  - (i.e. this is the underlying mechanism in panic disorder)

# Differential Diagnosis

- The presence of personality disorders such as antisocial histrionic or borderline personality traits that are associated with pathological lying or exaggeration, problems forming close or intimate relationships with others; hostility towards those who question their behavior.
- Extensive knowledge of medical terminology and hospital procedures making it difficult for professionals to detect the “faking”. In somatoform disorder, however, the consistency between reported symptoms and alleged testing/procedures that validate symptoms do not conform to recognized or associated standards.
- Regular evidence of hostility towards staff, evasiveness and manipulateness, demanding or attention seeking behavior. Such evidences of hostility, evasiveness and manipulation increases under confrontation or scrutiny, doctor “shopping” and splitting seem to distinguish (in my clinical opinion) the factitious end of

# Differential Diagnosis of factitious by proxy (Munchausen Syndrome)

- Factitious disorders are characterized by deliberate and seemingly senseless simulation or feigning of physical or psychological illness. They are consciously producing physical or psychological symptoms.
- The caregiver(mothers) fabrication of symptoms in the child is rewarded by the attention and recognition she receives for her “caring” of the child and seeming advocacy (eg. often almost martyr like in “standing up” against the “insensitive” medical and socio-legal systems) for the child. Her identity is defined by her maternal prowess and dedication (e.g “mother of the year”) (i.e. similar to borderline personality) her “caregiving expertise” and the close relationship with medical professionals (which often polarizes into idealization or devalving

# Differential Diagnosis

- Will likely have undergone (child) multiple invasive procedures with potentially permanent scarring and or damage. In somatization disorder, multiple diagnostic procedures and exploratory surgeries may be in evidence but the procedures are organized around discovery (i.e. what's wrong) whereas in factitious disorders there is a general lack of unwillingness or protest regarding potentially harmful or painful diagnostic or treatment procedure. Parents tend to want to avoid numerous doctors or invasive procedures.

# Summary

In sum, Munchausen syndrome is a psychiatric “spectrum” condition similar to other somatoform/factitious disorders that are characterized by attitudes and behaviors that are illness amplifying and serve to

- A. To elicit attention/sympathy from others
- B. To control (i.e. define) roles and responsibilities or avoid conflict and relational difficulty
- C. To define ones identity or self worth, reason for being, a primary organizing principle of the emotional life of the individual/family