Psychiatric Disorders

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SECTION 4

Chapter 16

SOMATOFORM DISORDERS, FACTITIOUS DISORDERS, AND MALINGERING

The somatoform disorders are groups of disorders in which physical symptoms (pain or loss of function) are inconsistent and cannot be explained by a medical condition (Table 16-1). While transient symptoms, as "signals of distress," are responsible for up to 50% of outpatient visits in the pediatric age group, somatoform disorders represent only the severe end of this continuum. Somatization that occurs in the context of a physical illness is identified by symptoms that go beyond the expected pathophysiology, affecting the child's school, home life, and peer relationships and becoming the focus of the patient and the family's life. Somatization is often associated with psychosocial stress and often persists beyond the acute stressor, leading to the belief by the child and the family that the correct medical diagnosis has not yet been found.

A somatization disorder occurs in as many as 10% to 20% of first-degree relatives and has a higher concordance rate in monozygotic twin studies. Lifetime prevalence of somatoform disorders is 3%, and that of subclinical somatoform illness is as high as 10%. Adolescent girls tend to report nearly twice as many functional somatic symptoms as adolescent boys, whereas prior to puberty the ratio is equal.

Affected children are more likely to have difficulty expressing emotional distress, come from families with a history of marital conflict, child maltreatment (including emotional, sexual, physical abuse), or history of physical illness. In early childhood, symptoms often include recurrent abdominal pain (RAP). Later headaches, neurologic symptoms, insomnia, and fatigue are more common.

Explainable medical conditions and a somatoform disorder (e.g., seizures and pseudoseizures) can coexist in up to 50% of patients and present difficult diagnostic dilemmas. The list of systemic medical disorders that could present with unexplained physical symptoms includes chronic fatigue syndrome (CFS), multiple sclerosis, myasthenia gravis, endocrine disorders, chronic systemic infections, vocal cord dysfunction, periodic paralysis, acute intermittent porphyria, fibromyalgia, polymyositis, and other myopathies.

Depression is a common comorbid condition and frequently precedes the somatic symptoms. Anxiety disorders can present with somatic complaints.

DSM-IV classifies somatoform disorders as somatization disorder, undifferentiated somatoform disorder, somatoform disorder not otherwise specified, conversion disorder, pain disorder, body dysmorphic disorder (BDD), and hypochondriasis. The diagnostic criteria for somatoform disorders are established for adults and need additional study in pediatric populations.

Somatization disorder involves multiple unexplained physical complaints, including pain, gastrointestinal, sexual, and pseudoneurologic symptoms not caused by known mechanisms. The criteria used to diagnose this disorder are listed in Table 16-2. Given the requirement for at least one sexual or reproductive symptom, the diagnosis is unusual in children and the onset is common during adolescence. Prevalence estimates range from 0.2% to 2% in females and less than 0.2% in males. Early onset of somatization disorder is associated with poor prognosis.

Undifferentiated somatoform disorder (Table 16-3) includes one or more unexplained physical complaints accompanied by functional impairment that last for at least 6 months. Children and adolescents are more likely to meet *DSM-IV* criteria for an undifferentiated somatoform disorder than for a somatization disorder, and no evidence exists to predict which patients will go on to develop the full symptom criteria for somatization disorder.

Conversion disorder involves symptoms affecting voluntary motor or sensory function and is suggestive of a neurologic illness in the absence of a disease process (Table 16-4). Adjustment difficulties, recent family stress, unresolved grief reactions, and family psychopathology occur at a high frequency in conversion symptoms. A physical condition and a conversion disorder (e.g., epileptic and nonepileptic seizures) may coexist in the same patient. There are four subtypes of conversion disorder based on whether the symptoms presented are primarily motor, sensory, nonepileptic (seizures), or mixed.

Presenting symptoms follow the psychological stressor by hours to weeks and may cause more distress for others than for the patient. This seeming lack of concern regarding potentially serious symptoms is referred to as *la belle indifference.*