Chapter 19 • Somatoform and Sleep Disorders

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**DSM-IV-TR Diagnostic Criteria for Undifferentiated Somatoform Disorder**

A. One or more physical complaints (e.g., fatigue, loss of appetite, gastrointestinal or urinary complaints).

B. Either (1) or (2):
   1. after appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication).
   2. when there is a related general medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The duration of the disturbance is at least 6 months.

E. The disturbance is not better accounted for by another mental disorder (e.g., another Somatoform Disorder, Sexual Dysfunction, Mood Disorder, Anxiety Disorder, Sleep Disorder, or Psychotic Disorder).

F. The symptom is not intentionally produced or feigned (as in Factitious Disorder or Malingering).


**USING DSM-IV-TR**

Health care providers often use language unfamiliar to clients and their families. Explain the difference between a general medical condition and a somatoform disorder in terms that clients and family members can understand.

**Undifferentiated Somatoform Disorder**

In *undifferentiated somatoform disorder*, clients have multiple physical complaints of at least 6 months’ duration; extensive evaluation reveals no organic problem. When the client does have an organic disease, the complaints or impairments are grossly excessive. Remember that the symptoms experienced by an individual with this disorder are not intentionally produced. The pain, which is psychogenic in nature, is real to the client. The DSM-IV-TR Diagnostic Criteria feature above lists the diagnostic criteria for undifferentiated somatoform disorder.

**MALINGERING**

Malingering occurs when a person deliberately fakes symptoms in order to benefit. It is not considered a psychiatric disorder because it involves deliberate falsification of illness. Malingering is consciously motivated and usually results in secondary gain, which may be in the form of extra attention, relief from responsibilities, or financial rewards, as shown in the following clinical example.

**CLINICAL EXAMPLE**

Joyce is a police officer. She fakes episodes of back pain in order to avoid street patrol. Whenever she is assigned to this duty, Joyce claims to be in too much pain to work.

Malingering often occurs in young adulthood, and according to Peebles, Sabella, Franco, and Goldfarb (2005), about 5% or less of clients treated by primary care providers are either malingering or have factitious disorders such as those described in the next section. Malingering often occurs in the following situations: personal injury and workers’ compensation litigation; military service; and criminal cases.

**FACTITIOUS DISORDER**

Malingering and somatoform disorders are sometimes mistakenly confused with *factitious disorder*, in which clients intentionally produce or feign physical or psychological symptoms (American Psychiatric Association [APA], 2000). The major difference between factitious disorder and malingering is that a person with a factitious disorder has a psychological need to assume the sick role. Unlike malingering, external incentives for the behavior are absent. According to Savino and Fordtran (2006), the self-induction of disease is a conscious act but the underlying motivation is usually unconscious. The course of factitious disorder usually consists of intermittent episodes.

Factitious disorder may occur on a continuum of mild (giving a verbal list of symptoms) to moderate (simulating physical symptoms) to severe (inflicting injury). Dermatologic manifestations are very common; however, physical symptoms can include almost any disease state (Peebles, Sabella, Franco, & Goldfarb, 2005). Thelma is an example of an individual with factitious disorder.

**CLINICAL EXAMPLE**

Thelma has been admitted to the hospital after being seen in an acute care walk-in clinic with blood in her urine. The admitting physician has ordered several invasive procedures—catheterization, blood work, and cystoscopy among others. The physician does not know that Thelma has been taking anticoagulants to produce blood in her urine.

Clients with factitious disorders deliberately give false medical histories that can be quite elaborate. It can be difficult to detect a factitious disorder because clients may use