Chapter 28: Consultation-Liaison Psychiatry

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What is Consultation-Liaison Psychiatry?

Like the other subspecialities in this section, consultation-liaison (CL) psychiatry is defined by the population it serves. In this case that is patients with a medical or surgical illness, who are inpatients of the general wards of a general medical hospital or outpatients of its clinics. Not surprisingly many of the disorders reviewed in this section also present frequently to general practitioners. The speciality's rather cryptic name derives from the two ways that psychiatrists get to see these patients in the general hospital.

'Consultation' refers to the fact that most of the time CL psychiatrists are asked to see general medical patients because the doctors looking after them think that they have a psychiatric problem of some sort and want assistance with this. The 'liaison' bit refers to the other way that patients can be seen. In some branches of medicine, in some hospitals, the physicians and surgeons feel that psychological issues occur so frequently that they need a psychiatrist embedded in their team. Psychiatrists in these liaison attachments attend team meetings, do ward rounds and either see patients themselves or advise on patients discussed with them. The nature of these liaison attachments vary from institution to institution. They are common in oncology, pain medicine and transplant medicine, but can arise in any speciality,

subspecialty or service that offers a multidisciplinary approach to a particular disease – Parkinson's, HIV, multiple sclerosis and epilepsy are typical examples.

CL psychiatry is the discipline that covers this interface between the medical and the psychological - the realm between body and mind. This is a vast intellectual landscape and in this introductory chapter we can only hope to give you an overview, pointing out the major landmarks as we go. We'll start with what it's like to be a patient in hospital and the forces that shape normal and abnormal patient (and doctor) behaviour. Then we'll look at what we know about how the mind and body interact, before turning to a range of disorders at this interface. CL psychiatry also assists patients with medical conditions that present with, or that cause psychiatric symptoms. Those are beyond the scope of this chapter but appear in the earlier chapter on organic disorders.

Normal Patient Behaviour

What Is It Like to Be a Patient?

Not to put too fine a point on it, being an inpatient can be an unpleasant experience. First, of course, you only go to hospital because you are unwell and illness usually comes with a range of unpleasant symptoms, like lethargy, pain, or nausea. Second, because patients are unwell, they are also worried, because there is always a chance their illness could turn out badly. If that were not enough, they are in this unsettling and unfamiliar environment. Remember your first days of clinical placements, and how baffling the hospital seemed, that is what it's like for most of our patients, except its worse because they're not going home in the evening.

Hospitals are huge, impersonal, institutions with hundreds of unwritten and often inflexible rules. Patients are often confined to their beds and dressed in pyjamas or a hospital gown. They need to deal with a range of professionals (and students) who appear and disappear often with little or no explanation. The usual rules of modesty are apparently thrown out the window and patients are poked and prodded and pricked at all hours of the day and night.

CL psychiatry is often called in when patients' reactions to hospitalisation are out of the ordinary – usually when they get upset or angry or frustrated. When you think about it though, it's amazing how infrequently this happens. The reason that so few people get very upset, angry or frustrated, is tied up with the answer to another question.

Why Do Patients Wear Pyjamas?

When patients come into hospital they almost always get changed into pyjamas. Of course, that makes sense if they are literally confined to bed, but most patients stay in their pyjamas even when they're quite able to pop down to the hospital coffee shop. Why?

The answer lies in the fact that when patients enter hospital, they are also expected to enter a particular social role - the sick role (Parsons, 1975). The sick role is a sociological concept originally outlined in the 1950s and while there are problems with applying the model too tightly, it provides a useful heuristic to explain various aspects of patient behaviour.

The sick role has it that when people become unwell, they willingly take on a role that, on the one hand allows them some privileges but, on the other, demands some duties. The first privilege is that while sick, patients are exempt from their usual roles and responsibilities. Sick people need not go to work for example, or need not sit exams, for the period of their illness. The second privilege is that they are exempt from responsibility for their condition – it is not their fault that they can't work or do exams.

Privileges like these place a significant burden on others and some *quid pro quo* is required. That takes the form of one major duty. Whenever people assume the sick role, they must do all they can to leave it as soon as possible. In our society that means that patients must seek out medical care, regardless of any inconvenience associated with it, and then they must conform to any treatment recommendations offered.

Viewed through this lens, hospitals are large institutions that utilise the obligations of the sick role to get people back to their normal societal roles as efficiently as possible. Viewed through this lens, pyjamas play the same role in hospitals as baggy green prisoner uniforms play in gaols – they underline who's in charge. They reinforce the obligations of the sick role, and that patients must follow instructions and get well as quickly as possible.

So powerful is the sick role and, frankly, so robust are most people, that despite the worry, the pain, the nausea, the sleeplessness, the prodding and the pricking, most patients enter and leave hospital without major psychological incident. However, things can go wrong.

Abnormal Illness Behaviour

When people become unwell they exhibit a variety of illness behaviours (Mechanic, 1961). That is, they perceive, evaluate and act upon their symptoms in different ways. In 1969 a psychiatrist working at the University of Sydney, Issy Pilowsky, proposed the term "abnormal illness behaviour" to cover the situation where "the doctor does not believe that the patient's objective pathology entitles him to be placed in the type of sick role he expects, for the reasons which he claims it" (Pilowsky, 1969: 349). Defined this way, "abnormal illness behaviour" seems to give the doctor a privileged view of the patient's experience, which sits a little uncomfortably half a century later. Despite this though, the concept still provides a useful scaffold for thinking about issues that arise in this domain.

We all learn about, and are socialised into accepting, the sick role from our earliest years. Think about your experiences staying home from primary school; no school, but also no fun. Once you were well enough to get up and play, you'd be going back to school the following day.

Abnormal illness behaviour, perhaps more loosely defined than Pilowsky had it, arises when, for various reasons, patients cannot assume or positively reject the sick role and do not adhere to its strong obligations. While the overwhelming majority of patients will adhere, the reasons for a minority not doing so are myriad, and we'll only review a few here.

If a patient is going to follow, with little question or dispute, all of the directions that their doctors or nurses or physiotherapists provide them, it's going to be important that they trust that those people have their best interests at heart. Fortunately, we have also been strongly socialised to believe that doctors and other healthcare workers are extremely trustworthy, so for most people that is not an issue. However, for some people this trust breaks down for various reasons and these patients might seriously question or downright refuse to believe that what is being suggested is for their own good.

The most straightforward manifestation of his problem occurs in patients with persecutory, or other types of, delusions. If a patient feels that his doctors are all involved in an international conspiracy aimed to bring him down, or if he feels that they have been replaced by androids, it's unlikely he'll simply follow their directions. However, people don't need to be psychotic to lack trust in their doctors. A small percentage of the population have a personality style marked by an inclination to view everyone, especially those in authority with suspicion. If you've never been inclined to trust anyone, even the strong social pull of patient role may be insufficient to reassure you about your healthcare workers.

It's not only psychotic people or people with paranoid personalities that lack trust in doctors. Some of our patients have come to this country fleeing persecution. In their countries of origin, doctors may have been complicit in government sanctioned torture, so any socialised trust of doctors may have disappeared long before they reached our shores. Such people are likely to have a well-founded fear of governments as well, and their experiences in detention centres during their attempts gain asylum may have generated an arguably justified suspicion of the Australian government as well.

Even previously healthy people born and bred in Australia may lose their trust in some circumstances. One such group of patients are those for whom things have gone badly wrong. Despite our best efforts some patients suffer terrible side-effects or receive and follow advice that was clearly ill-advised in hindsight. If the outcome was bad enough, or if bad outcomes happened more than once, these patients can lose their trust in the advice of healthcare professionals and, understandably, question everything they are told.

Other people, by nature of their illness, spend months, sometimes years in hospital. In these people the sick role simply wears off with time. They become "professional patients" and the sick role is swamped by other more normal social roles that arise because they have spent so long in the ward environment. Often these people behave more like the friends or workmates of the healthcare workers they have been around for weeks and months. This is not necessarily a bad thing of course, but it does dissolve the usual patient-doctor dynamic. Just as workmates will not automatically follow the directions of other workmates, so long-stay patients will often baulk at directions that other patients would simply adopt demurely.

There is another sort of 'professional' patient that often finds it difficult to fit into the patient role – patients who are themselves health professionals. Doctors, particularly, find adoption of the patient role challenging. After all, their usual role is to be the person giving the barely questioned directions, not the person following them. Generally, they are the one's asking the nurses to do things, not vice versa and of course, they know that everything they are being told to do may not be strictly necessary. If you are likely to have an operation at 11 am you are likely to be told to fast from midnight, but a doctor will know that that is not strictly necessary. Strict hospital protocols, designed for easy universal application, are not well suited to people who have an intimate and detailed knowledge of the system. Almost all doctors who find themselves as patients (or patient's relatives) have to apply themselves to stay within the bounds of the usual patient (or relative) role. Not every doctor manages this successfully.

Whenever the sick role is eroded, the patient-doctor dyad will be impacted, and illness behaviour will become abnormal at least in the sense that it will fall outside the normal range. In most cases this can be addressed by first recognising what is going on, and then making allowances for it. Usually, when a patient's trust is gone, this will mean taking much more time than usual explaining exactly why different requests are being made and reassuring the patient of everyone's motives. On occasion, it will also require a more flexible than usual approach to normal hospital processes.

It's not only a lack of trust that may disrupt the patient role. Other examples that we lack space to examine in detail at this point include: patients who are used to prison environments, where a whole different social milieu applies that has little overlap with the patient role; patients who cope with their illness by utilising denial, so that they may show no recognition that they are ill at all; patients with borderline personality styles who might idealise some healthcare workers while demonising others, often causing a great deal of tension within the treating team.

Conditions Typically Encountered in Consultation-Liaison Psychiatry

There are a range of psychiatric conditions that are most frequently encountered in the hospital wards or clinics and therefore are sensibly dealt with in this chapter. As noted above, people with these conditions may also present to general practitioners. Many of them could also be regarded as displaying abnormal illness behaviour in Pilowsky's terms, but it is better perhaps to consider the conditions individually.

Medically Unexplained Symptoms

As the term suggests "medically unexplained symptoms" are symptoms, like those arising in the disorders discussed in this section, for which medicine has no secure explanation. It is important to understand that the term does not imply that psychiatry (as opposed to the rest of medicine) has somehow unearthed that explanation. In truth psychiatry is as much in the dark as the rest of medicine. However, psychiatry is the speciality that is happy to take conversion disorder, somatisation disorder and the rest as its own as there *might* be some psychopathological element and it is clear that the patient needs assistance.

The basic problem with all these disorders is that at this point we have no clear way of describing how the workings of the brain come to be manifest as consciousness as we all experience it. With no answer to the mind-body problem as

it applies in normal circumstances, it is hardly surprising that our understanding is so poor when the system goes awry.

We will not be forever in the dark. There is no reason to think the problem is insoluble and a great deal of research is aimed at matching neurophysiological findings to clinical findings (Feinstein, 2011), but for the time being our understanding of these syndromes is so poor that "medically unexplained symptoms" probably provides the most accurate and informative overarching heading. Note that DSM-5-TR groups these disorders together as "Somatic Symptom and Related Disorders" (American Psychiatric Association, 2022).

Conversion Disorder

In DSM-5-TR the main features of Conversion Disorder are the presence of "one or more neurological symptoms with clinical findings that provide evidence of incompatibility between the symptom and recognised neurological or medical conditions" (American Psychiatric Association, 2022).

The sorts of neurological symptoms encountered in Conversion Disorder range across the spectrum. They include: weakness or paralysis; and tremor, dystonia or gait abnormalities. There may be dysphagia, dysphonia or dysarthria or the sensation of a lump in the throat (globus). Possibly the most common are apparent seizures, without EEG change, best termed non-epileptic seizures. There may also be all manner of sensory symptoms such as anaesthesia, visual loss or diplopia.

The diagnosis should usually be made cautiously and DSM-5-TR rightly stresses that "it should not be made simply because results from investigations are normal or because the symptom is 'bizarre'" (American Psychiatric Association, 2022). It is worth remembering that all investigations have false negatives and that there are a range of explanations for a lack of positive investigations in these cases that logically include: that the right investigation has not been conducted; or that the relevant investigation has yet to be invented. In the days before the invention of the CT scanner, a diagnosis of Conversion Disorder was often proven wrong on follow-up (Slater, 1965).

Conversion Disorder provides an excellent example of how psychiatric diagnostic classification (in this case the DSM system) can shift. DSM-IV had a diagnostic criterion that disappeared with the fifth edition, namely, the "[p]sychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors" (American Psychiatric Association, 1994). The inclusion

of that criterion was consistent with the view, previously central to the diagnosis, that the underlying cause of Conversion Disorder was some sort of internal psychological conflict. The name of the syndrome derives from the notion that emotional arousal is somehow "converted" into a physical symptom, a process known in psychoanalytic literature as "primary gain". However, the authors of DSM-5 decided a change was needed. On the one hand, plenty of people with apparent Conversion Disorder did not appear to have an internal conflict and, on the other, the vicissitudes of everyday life probably made it easy for examining psychiatrists to "discover" internal conflicts where perhaps they did not exist.

As a consequence of these perceived weaknesses with the previous understanding the creators of DSM-5 demanded that the diagnosis require "clear evidence of incompatibility with neurological disease" instead. Chief among the types of evidence suggested is internal inconsistency at examination and DSM-5-TR references a range of findings on neurological examination. However, whilst some of these tests (e.g. Hoover's sign) have at least some evidence to support their usefulness in making the diagnosis (McWhirter et al., 2011), many conversion symptoms have no empirically based test to support the diagnosis and it is not clear to what extent the evolution of the DSM's characterisation of Conversion Disorder has swapped one form of uncertainty with another.

All of this simply underlines the acknowledged weaknesses of the DSM or any classification system in psychiatry (and to some extent in medicine as a whole). The first paragraph of the preface of the manual notes that "DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can *aid* in the accurate diagnosis and treatment of mental disorders. It is a *tool* for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field" (American Psychiatric Association, 2013: xli) (emphasis added). That is to say it is not, and does not try to be, the definitive arbiter of psychiatric diagnoses.

Though patients are classically said to feature *la belle indifference* – an odd sanguine acceptance of their deficit – there is no empirical data to support the sign's usefulness in making the diagnosis, and it is difficult to distinguish *la belle* from simple stoicism. Possibly more useful is the presence of a model for the symptom – for example a close relationship with an auntie say who had similar weakness after a stroke. The people most likely to experience non-epileptic seizures are people with established epilepsy and here, it is thought, they act as their own model.

Conversion Disorder is two or three times more common in females. Prevalence in the community is unknown, but in specialist neurology clinics, where it is most often encountered in practice, the diagnosis is made in around 5% of

patients. It usually has its onset before the age of forty and it is brave indeed to use the diagnosis in unexplained neurological symptoms occurring for the first time over that age.

While the majority of conversion symptoms are only short-lived and tend not to recur, in a percentage of patients, with an estimated 2-5/100,000 per year, the symptoms persist and may be associated with significant disability. As one might expect the most important differential diagnoses are those of actual neurological disease presenting somewhat atypically. Very often the clinician cannot but avoid ongoing uncertainty, but has no choice but to press on explaining the limits of our current knowledge to the patient.

Even in cases where conversion symptoms can be diagnosed with reasonable confidence, such as patients who exhibit a typical seizure which was observed whilst the patient's EEG showed no ictal phenomena, all that the clinician can say with confidence is that that particular seizure was a non-epileptic seizure. Carefully handled though, even such cautious advice can be of significant aid to the patient.

Management begins with an unavoidably lengthy explanation of an alternative underlying cause for at least some of the patient's symptoms. Oftentimes this is best expressed as "stress", since most people are happy to accept that "stress" can manifest itself physically. It's important to spontaneously declare that in hypothesizing that symptoms may not have a standard medical explanation, no one is suggesting that the deficit is all in the patient's head or that he or she is only pretending to be ill. The patient is ill. The deficits are real. It is just that it is now thought that the cause of symptoms is more likely to be related to (admittedly poorly defined) psychological factors than standard medical ones.

In a syndrome so poorly defined that is comparatively rare and which typically resolves spontaneously, there is, unsurprisingly, little or no evidence base to guide treatment (Feinstein, 2011). Beyond reassurance and education, management is usually focused on helping the patient deal with any identifiable ongoing stressors and encouraging ongoing psychological management to enable an avenue to talk about their worries. The hope is that this will provide an alternative avenue to cope with the stressors of everyday life and free patients from the disabling somatisation that has brought them to clinical attention. There is no role for medication except to treat clear comorbidities.

Somatic Symptom Disorder and Somatisation Disorder

The DSM-5-TR criteria for Somatic Symptom Disorder are outlined in the box below (American Psychiatric Association, 2022). In previous iterations of DSM and still in the ICD this disorder was known as Somatisation Disorder or Somatisation Syndrome and, in contrast to criterion A (for DSM-5-TR) below, to diagnose it the patient had to suffer a range of unexplained physical symptoms from a range of systems. In DSM-IV for example the patient needed a history of at least four pain symptoms, two gastrointestinal symptoms, one sexual symptom and one neurological symptom. This is very different from the one symptom being sufficient in DSM-5-TR.

Because Somatic Symptom Disorder is relatively new, most of the information available in the literature concerns the more elaborate (and obviously much less common) Somatisation Disorder and the rest of this section will deal with this.

Epidemiologic studies suggested a lifetime prevalence of Somatisation Disorder of somewhere between 0.2% and 2.0% in women though the figures depended enormously on how exactly it was defined (Mai, 2004). How so ever it is defined though, it is far rarer in men. Traditionally it is regarded as a disorder with a young age of onset and DSM-IV demanded that symptoms began before age 30.

Somatic Symptom Disorder

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

The aetiology of Somatisation Disorder remains unknown. Theories, none of which are entirely satisfactory, often revolve around learnt behaviour perhaps first observed by parents during childhood, or some other mechanism by which the normal acquisition of the sick role is disrupted. Other theorists cite the importance of alexithymia – a difficulty expressing one's emotions in words - and suggest that the somatic symptoms become an alternative avenue for expressing one's feelings (De Gucht and Heiser, 2003). It is quite likely that in some cases normal bodily symptoms are amplified and misinterpreted. Though not a formal part of any of the diagnostic formulations, anxiety and depression are very common in patients with these syndromes (Kirmayer et al., 1993).

Assessment of these patients begins as always with a careful history and examination. This is probably more important than usual in patients who have attracted these diagnoses as it is all too easy to assume that a diagnosis of a somatoform disorder (no matter which one) previously made is correct and then to miss an underlying medical condition. It is also important to realise that even a lifetime of suffering undisputed somatic symptoms offers no protection from developing a physical disease. Even if the patient is well known to you, take care at least to carefully enquire about new symptoms.

Utilisation of investigations represents something of a balancing act. New symptoms should be appropriately investigated but avoid repeating investigations, especially those with an associated morbidity, if they do no more than re-visit already well-trod paths.

Obviously, there is the risk that a diagnosis of Somatisation Disorder might obscure a medical diagnosis that presents with a range of physical symptoms. Diseases such as multiple sclerosis, systemic lupus erythematosus, and certain endocrine conditions should all be borne in mind when making the diagnosis. There is also considerable overlap between Somatisation Disorder (or indeed Somatic Symptom Disorder) and functional medical syndromes such as fibromyalgia, chronic fatigue, and irritable bowel syndrome, though the specifics of this are beyond the scope of this chapter. Many physicians exhibit a degree of therapeutic nihilism around patients with Somatisation Disorder, but this can only reflect an ignorance of the management of the condition (Mai, 2004).

As was the case with Conversion Disorder the first step in management is detailed feedback to the patient about what appears to be occurring, avoiding obviously, suggestions that there is nothing wrong with the patient. This done the next step is to recognise the reality of the symptoms and to bring into focus the existence of stressful life events that might also be relevant to the patient's symptomatology. After that various supportive, interpersonal or cognitive

behavioural therapeutic approaches have been utilised that continue to link the two and shift the focus to the psychosocial realm. These interventions occur in sessions that are scheduled regularly, avoiding the need for the patient to have a somatic symptom as a ticket to gain support (Guthrie et al., 1999). As time goes on the regularity of the appointments can be spaced at longer and longer intervals. There is probably no role for pharmacotherapy beyond its judicious use in clear comorbid depression.

Illness Anxiety Disorder and Hypochondriasis

The big revamp of DSM-5's somatic disorders also saw Illness Anxiety Disorder replace Hypochondriasis, though, as was the case with Somatic Symptom Disorder and Somatisation Disorder, the two syndromes only somewhat overlap.

Hypochondriasis is "preoccupation with the fear of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms or bodily functions" (American Psychiatric Association, 1994: 445). Whereas those with Somatisation Disorder (traditionally defined) would make vague complaints of multiple symptoms in multiple domains patients suffering hypochondriasis would present with a limited range of symptoms, often described in precise detail and attributed to the possibility of one or more named diseases that they feared the symptoms revealed.

In the new Illness Anxiety Disorder by contrast, while the person remains preoccupied with the possibility of having (or acquiring) a serious disease, the somatic symptoms, if present at all, are mild and the person is more generally concerned about their personal health status. As the name reflects, Illness Anxiety Disorder appears to be a variety of anxiety disorder where anxiety is generated by the possibility of ill-health. Hypochondriasis while similar is probably better conceived of as featuring a conviction (falling short of delusional intensity) that the person has already developed, or is about to develop, some sort of nasty illness, and the anxiety arises from that belief. The management of Hypochondriasis largely overlaps in its approach with the management of Somatisation Disorder (Starcevic, 2015). Once again there is little role for pharmacotherapy.

Disorders of Body Image or Perception

The commonest disorder of body image or perception encountered in psychiatry is anorexia nervosa which is covered in the eating disorders chapter. However, a number of such conditions are best placed within the Consultation-Liaison chapter because that setting is the place they are most likely to be met.

Body Dysmorphic Disorder

Body Dysmorphic Disorder (BDD), sometimes called dysmorphophobia, is often described as a disorder of "imagined ugliness" (Morselli and Jerome, 2001). Sufferers are "preoccupied with one or more perceived defects or flaws in their physical appearance, which they believe look ugly, unattractive, abnormal, or deformed" (American Psychiatric Association, 2013: 243). Most commonly the perceived defects are around the person's face, especially the nose or hairline, or involve the person's skin or genitals, but any body area may be affected. As a result of these concerns the patient may spend hours a day gazing at the affected body part in the mirror or picking at their skin. They are usually convinced that others are also appalled by their defects and may try to cover them up or avoid others entirely. Oftentimes the first clinical contact with individuals with BDD is made by plastic surgeons as they seek remedies for their problems, though often people devise their own treatments that bring them to medical attention such as efforts to bleach their skin.

DSM-5-TR has created a subclass of BDD called "muscle dysmorphia" where a sufferer, usually a male, is "preoccupied with the idea that his or her body build is too small or insufficiently muscular" (American Psychiatric Association, 2022). Whether or not this is best seen as a subcategory of BDD or its own condition is yet to be determined.

BDD, as a class, occurs in around 2% of the population with no clear sex difference (Buhlmann et al., 2010). Patients with BDD may account for up to 8-10% of patients in dermatology, cosmetic surgery, or maxillofacial clinics. BDD starts in two thirds of individuals by age 18. The disease causes significant disability as sufferers, usually still in adolescence, withdraw from friends, avoid intimate relationships and drop out of school. Depression is a frequent comorbidity and in one study over 40% of adolescents with BDD reported having attempted suicide (Phillips et al., 2006).

The causes of BDD remain obscure. It is more common in the first degree relatives of people with obsessive compulsive disorder (OCD) and like OCD, neuroimaging abnormalities in a range of areas, including the limbic system, visual processing areas, and the orbitofrontal cortex have been reported (Rossell et al., 2015). One conception of BDD has it as some middle ground between the normal concerns about appearance often expressed by individuals who may be so concerned as to seek plastic surgery, on the one hand, and psychotic concerns as experienced by those with delusional disorders on the other. Although people with BDD are not classically convinced of their concerns to a delusional degree, a number of studies have suggested that this apparent differentiation may be unusual in practice, so that some authors have suggested either including a subtype of delusional BDD as DSM-

5-TR has done (American Psychiatric Association, 2022), or to simply label all similarly affected patients as suffering BDD regardless of the apparent intensity of their beliefs (Fang et al., 2014). Eating disorders, OCD and social anxiety disorder may also present challenges in terms of differential diagnosis.

The evidence base for treatment is marred by a poverty of randomised controlled trials. The management strategy most frequently subjected to empirical analysis has been the prescription of selective serotonin reuptake inhibitors or clomipramine, where both open-label trials and some RCTs have suggested response rates from 53% to 73% (Fang et al., 2014). The same effects are not seen with other antidepressants and the evidence suggests that the doses of SSRIs need to be higher than are typically used in depression and trials need to be longer (perhaps 6-9 weeks). In keeping with the apparent blur between "delusional" and "non-delusional" BDD, there is no good evidence that "delusional BDD" responds preferentially to antipsychotics, and therefore SSRIs are seen as the first line treatment in all patients.

Several studies have provided empirical support of cognitive behavioural therapy in BDD (Veale, 2001). This might include techniques such as exposure and response prevention centred around checking one's self in the mirror. There is also indirect evidence of benefit when psychological therapies are combined with a pharmacological approach (Fang et al., 2014).

Not surprisingly very few patients with BDD who manage to obtain surgical interventions aimed at correcting their perceived abnormalities derive long-term benefit from these (Crerand et al., 2010). With or without treatment BDD tends to be a chronic disorder with low remission rates and high rates of relapse for those who do get better (Phillips et al., 2013).

Delusional Disorders – Somatic Type

Delusional disorders were touched upon in the chapter on schizophrenia (Chapter 15), and are diagnosed when patients exhibit one (or more) delusions, but do not meet criteria for schizophrenia and apart from the impact of the delusion(s) the person's functioning is not markedly impaired. The somatic subtype of delusional disorder is often encountered in the general hospital and applies when "the central theme of the delusion involves bodily functions or sensations" (American Psychiatric Association, 2013: 90). The symptoms associated with the delusion often bring people to seek medical help.

Perhaps the delusional disorder most commonly seen in consultation-liaison psychiatry is delusional parasitosis or Ekbom's syndrome. In these cases sufferers believe that insects, lice, maggots or other small vermin are living in their skin (Enoch and Ball, 2001). As is typical of delusional disorders, patients may appear

perfectly normal until the conversation turns to their delusional concerns, and classically patients exhibit the "matchbox sign" presenting with a small container that they believe demonstrates the desiccated body-parts of the infesting bug. Worryingly, patients may also present with conditions related to their attempts to remove the offending creatures, including pruritus from scratching to chemical burns from various homemade lotions. There is only weak evidence for the efficacy of antipsychotics (the recommended first-line treatment) in delusional parasitosis, though this is probably partially attributable to rarity of the disorder and partially to the difficulties associated with keeping these patients on a treatment they believe to be irrelevant to their underlying problem (Lepping and Freudenmann, 2008).

Other somatic-type delusional disorders that may fall under the care of consultation-liaison are delusions that a person emits a foul odour, or delusions that a particular body part is misshapen, though the later will usually now be classed as body dysmorphic disorder (as discussed above).

Factitious Disorders and Malingering

In factious disorder and malingering the sick role is again central, though in these states the patient *consciously* feigns illness in order to achieve a goal. Like so many of the disorders in this chapter the definitions, and even the status of these states as "disorders", is controversial (Bass and Halligan, 2014).

Factitious Disorders

Patients with factitious disorder consciously and deliberately falsify medical or psychological signs and symptoms, but do so for no "obvious external rewards" (American Psychiatric Association, 2013: 325). The methods of deception may range from simply lying, to falsifying documents, to unneeded venesection to induce anaemia, to amputating digits claiming they were lost in an accident. As opposed to the conscious deception in malingering (see below), in factitious disorder the sole aim of the fabrication appears to be to gain the role of a patient, though successfully achieving the deception may provide psychological reward in some cases.

Most commonly factitious disorder presents with the patient feigning one symptom or one disease. Patients with dermatitis artifacta, for example, who deliberately fabricate new skin lesions or worsen existing ones, do not usually move on to feign other conditions (Koblenzer, 2000). However in the most severe variant, dubbed Munchausen's syndrome after the fictional character in Raspe's 1785 book, patients typically make a career of their condition, moving from hospital to hospital, giving false names, detailing all manner of exotic conditions or injuries, and telling elaborate tales to substantiate their claims – pseudologia fantastica (Asher, 1951). The most pernicious version of the condition sees individuals not feigning illness in themselves, but in others, typically children in order apparently, to take on the role

of a parent of a sick child. Labelled "Factitious Disorder Imposed on Another" in DSM-5-TR, this is also known as "Munchausen's via proxy" or "Meadow's syndrome" and is a form of child abuse (Meadow, 1977).

The nature of factitious disorder makes valid estimates of its prevalence almost impossible. Estimates range from 0.5 to 2%, though this depends to an extent on what degree of deceit will trigger a diagnosis, given some degree of untruthfulness is almost universal. Whatever threshold is chosen though, the condition is almost certainly significantly under-recognised as doctors are poor lie detectors (Bass and Halligan, 2014). Feigned psychiatric symptoms are probably particularly difficult to detect. Milder factitious disorder is commoner in females and people with healthcare training are over-represented (Krahn et al., 2003). Munchausen's syndrome seems almost exclusively the domain of males.

Whether or not factitious disorder is properly regarded as a psychiatric disorder, there is no doubt that those who behave in this manner suffer significant disability. Even persons with milder manifestations may spend significant amounts of time in hospital and often risk actual disease or injury because of unneeded medical intervention. Young men with Munchausen's syndrome often live a peripatetic existence, seemingly cut off from any family or friends. Though numerous theories have been posited, the cause or causes of factitious disorder are unknown.

Assessment begins with an awareness that the condition exists that triggers a low level of suspicion when a patient's story is particularly dramatic or contains inconsistencies. Of course, factitious disorder is rare, so the drama in most histories will be real and the inconsistencies genuine. However, a lurking healthy scepticism, that precipitates a call to a previous treater or some double-checking of documentation will detect many such patients, who would otherwise have gone unnoticed. Once suspicions are properly aroused it will be important to carefully check the patient's history as delivered against all available medical records. If the diagnosis is strongly suspected or confirmed, there is no sense in "confronting" the patient as, in more severe cases, this can lead to a precipitous discharge with lines still *in situ*. Instead, ask for advice from the consultation-liaison team.

Little can be said with confidence regarding the management of factitious disorder, aside from taking obvious steps to minimise further unwarranted investigations. Anecdotally, milder cases respond and may even do quite well with supportive or dynamic psychotherapy. Typically, people with the more severe Munchausen's variant tend to simply move on, though as their efforts to create signs and symptoms intensify, they are often left with genuine conditions, such as bowel obstructions secondary to multiple operations. The management of "Factitious

Disorder Imposed on Another" will inevitably include the involvement of child protection services or the police.

Malingering

Malingering involves the feigned presentation of a physical or psychological illness for one or more of a range of understandable reasons. These reasons are usually regarded as straightforwardly unethical, such as efforts to gain drug or monies, or attempts to elude responsibilities such as work or court appearance. However, in some cases, easy moral characterisation is not so simple, such as attempts to elude military service or to gain accommodation when a person has none. DSM-5-TR notes that malingering is not a diagnosis, but it may nonetheless become a focus of clinical attention (American Psychiatric Association, 2022).

Even more than factitious disorder, the prevalence of malingering will depend upon the thresholds chosen to apply that label – few people would not, at some time in their lives, at least exaggerated some symptoms to escape a dreaded social event. While the detection of malingering requires the maintenance of a scepticism similar to that required for the detection of factitious disorders, in psychiatry malingering is probably over-diagnosed, as less experienced clinicians often attribute atypical or previously unseen phenomenology to feigned efforts to gain accommodation.

Even when malingering has been confidently established, clinicians need to recall that having previously pretended to have had pain, for example, does not immunise a person against all future actual discomfort. All new instances of symptoms need to be examined afresh, with past malingering considered but not determinative of a patient's ongoing care.

Further Reading

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