The problem of psychogenic symptoms: is the psychiatric community in denial?

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Abstract

Psychogenic symptoms are common and pose an uncomfortable challenge. Among psychogenic symptoms, psychogenic nonepileptic seizures (PNES) are common and have been extensively studied. They are unique in that, unlike most other psychogenic symptoms, they can be diagnosed with near certainty. PNES can be used as a model, as almost everything that applies to PNES applies to other psychogenic symptoms. According to DSM-IV, somatic symptoms are the main manifestation of three groups of disorders: somatoform disorders, factitious disorder, and malingering. Treatment is challenging. Unfortunately, psychogenic symptoms tend to be neglected. For example, the American Psychiatric Association has abundant written patient education material available on diverse topics, but none on somatoform disorders. Psychogenic symptoms are also not the subject of much clinical research. A search of the journal Neurology for 1994–2003 for the word psychogenic in the title found 21 articles, only 4 of which on topics other than psychogenic seizures. A similar search for original articles in the New England Journal of Medicine found no articles with psychogenic in the title and two with psychogenic in the abstract. Thus, there seems to be a severe disconnect between the frequency of the problem and the amount of attention devoted to it.

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1. Introduction

Psychogenic (nonorganic, “functional”) symptoms are unpopular with patients and health care professionals alike. Whether we like it or not, they are common in clinical practice. It is conservatively estimated that at least 10% of all medical services are provided for psychogenic symptoms [1]. Psychogenic symptoms are also common in neurology, representing about 9% of inpatient neurology admissions [2], and probably an even higher percentage of outpatient visits. In addition to being common, psychogenic symptoms pose an uncomfortable and often frustrating challenge, both in diagnosis and in management.

Among psychogenic symptoms, psychogenic seizures (psychogenic nonepileptic seizures, or PNES) are unique in several ways. They are particularly common and have been extensively studied since the advent of EEG-video monitoring. More importantly, they are unique in that, unlike most other psychogenic symptoms, they can be diagnosed with near certainty. Because almost everything that applies to PNES applies to other psychogenic symptoms, PNES provide a good framework for studying psychogenic symptoms in general.

The literature on PNES (at least the neurology or epilepsy literature) often implies that PNES represent a unique disorder. In reality, PNES are but one type of somatoform disorder. How the psychopathology is expressed (PNES, paralysis, blindness, diarrhea, or pain) differs only with respect to the diagnostic aspects. Fundamentally, the underlying psychopathology, its
prognosis, and its management are no different for PNES than for other psychogenic symptoms. Whatever the manifestations, psychogenic symptoms pose a vexing challenge both in diagnosis and in management.

This editorial discusses important features of psychogenic symptoms, using PNES as a model, and places psychogenic symptoms in the more general context of medicine.

2. Psychogenic seizures as the prototype

2.1. The misdiagnosis of epilepsy

An erroneous diagnosis of epilepsy is relatively common. About a quarter of patients previously diagnosed with epilepsy and who are not responding to drugs are found to be misdiagnosed, both in referral epilepsy clinics [3,4] and in epilepsy monitoring units [5]. Most patients misdiagnosed with epilepsy are eventually shown to have PNES [6] or (more rarely) syncope [7,8]. Occasionally other paroxysmal conditions can be misclassified as epilepsy, including complicated migraines, paroxysmal movement disorders, and sleep disorders, but PNES are far the most common conditions. Even in patients with “posttraumatic epilepsy,” the same is true: about 30% of patients with posttraumatic epilepsy turn out to have PNES when they are monitored [9]. Very often, EEGs interpreted as providing evidence of epilepsy contribute to this misdiagnosis [3,7,10]. An erroneous diagnosis of epilepsy is notoriously difficult to “undo.”

2.2. Psychogenic nonepileptic seizures

PNES are by far the most common condition misdiagnosed as epilepsy. The estimated prevalence in the general population is 2 to 33 per 100,000, making this problem nearly as common as multiple sclerosis or trigeminal neuralgia [5]. A number of “red flags,” in addition to the lack of response to antiepileptic drugs, are useful in clinical practice and should raise the suspicion that “seizures” may be psychogenic rather than epileptic [11]. Certain characteristics of motor (“convulsive”) phenomena are associated with PNES: slow or very gradual onset or termination; unusual precipitating factors; discontinuous, interrupted, and irregular or asynchronous (out-of-phase) movements. Some movements and behaviors are relatively specific to PNES: side-to-side head shaking, pelvic thrusting, opisthotonic posturing, bilateral movements with preserved awareness, stuttering, and weeping. The gold standard for diagnosis is EEG-video monitoring, with the recording of the habitual event. The principle is to record an episode and demonstrate that (1) there is no change in the EEG during the clinical event, and (2) the clinical spell is not consistent with seizure types that can be unaccompanied by EEG changes. This has to be performed by an epileptologist experienced in the procedure. It is based on combined electroclinical analysis, in which both the clinical semiology of the “ictus” and the ictal EEG findings are important. EEG-video monitoring allows the diagnosis of PNES to be made with near certainty.

3. The diagnosis of psychogenic symptoms

Psychogenic symptoms are relatively common in neurology [2]. Common symptoms that are found to be psychogenic include paralysis, mutism, visual symptoms, sensory symptoms, movement disorders, gait or balance problems, and pain [2,12,13]. For several neurologic symptoms, signs or maneuvers have been described to help differentiate organic from nonorganic symptoms. For example, limb weakness is often evaluated by Hoover’s test, for which a quantitative version has even been proposed [14]. Other examples include looking for “giveaway” weakness, and alleged blindness with preserved optokinetic nystagmus. More generally, the neurologic examination often tries to elicit symptoms or signs that do not make neuroanatomical sense, e.g., facial numbness affecting the angle of the jaw, gait with astasia–abasia or “tightroping.” Psychogenic symptoms are also common in medicine in general. Every specialty has its share of symptoms that can be psychogenic. In gastroenterology, these symptoms include vomiting, dysphagia, abdominal pain, and diarrhea. In cardiology, chest pain that is non-cardiac is traditionally referred to as “musculoskeletal” chest pain but is probably psychogenic [15]. Symptoms that can be psychogenic in other specialties include shortness of breath and cough in pulmonary medicine, psychogenic globus and dysphonia in otolaryngology, excoriations in dermatology, erectile dysfunction in urology, and blindness and convergence spasms in ophthalmology. Pain syndromes for which a psychogenic component is likely include tension headaches, chronic back pain, limb pain, rectal pain, and sexual organ pain. Of course, as pain is by definition entirely subjective, it is extremely difficult, and perhaps impossible, to ever confidently say that pain is “psychogenic.” It could even be argued that all pain is psychogenic, and thus psychogenic pain is one of the most “uncomfortable” diagnoses to make. In addition to isolated symptoms, some syndromes are considered to be at least partly psychogenic by some and possibly entirely psychogenic (i.e., without any organic basis) by others. These controversial but “fashionable” diagnoses include fibromyalgia, fibrositis, myofascial pain [16], chronic fatigue, irritable bowel syndrome, and multiple chemical sensitivity.

Despite the availability of EEG-video monitoring, which allows PNES to be diagnosed with near certainty,
the average delay in the diagnosis of PNES remains long [17], and 80% of PNES patients receive antiepileptic drugs before diagnosis [18], indicating that the index of suspicion for psychogenic symptoms may not be high enough. If this is true for PNES, it is probably even more true for other psychogenic symptoms that are diagnosed only by exclusion. Thus, psychogenic symptoms are almost certainly underdiagnosed. In most circumstances, making the diagnosis of psychogenic symptoms requires an extensive and costly diagnostic workup to exclude even the most rare zebras and unlikely conditions (“defensive medicine”). This results in a large number of tests, procedures, and treatment, increasing cost [19], and risk of complications [20]. Even when a psychogenic etiology is suspected early on, good medical practice mandates exclusion of possible organic causes, and in this situation the physician should probably be quite extensive. When all evaluations are unrevealing, and if the psychological profile fits, then a psychogenic etiology is entertained. The thorny problem is that when all tests are negative and the diagnosis of a psychogenic origin is only one of elimination, the level of certainty is relatively low (i.e., a shadow of a doubt persists: “are we missing something organic”), and therefore so is the level of comfort in communicating the diagnosis to patients and families. Unfortunately, this persisting doubt makes it impossible for treatment to be implemented, much less to be effective. Even for PNES, the most “provable” psychogenic symptom, the index of suspicion is not high enough. If 20 to 30% of patients with refractory seizures have psychogenic spells rather than epilepsy, it is likely that the same general number applies to other symptoms. For example, psychogenic pseudosyncope is underdiagnosed and is likely the explanation for the 30 to 50% of “syncope of unknown origin” reported in large series [21]. The same probably applies to other symptoms, such as dizziness and chronic pain. Unfortunately, because the psychogenic nature of these symptoms is virtually “unprovable,” they are almost certainly never diagnosed. The diagnosis of “psychogenic pain” is probably almost never made despite the fact that it is a DSM diagnosis. Instead, we use “unsupported” diagnoses such as fibromyalgia and myofascial pain [16] because they have, according to some, a component of organicity. This strategy of avoiding the word psychogenic perpetuates the problem.

4. Suggestion, placebos and quackeries

In some instances, it is helpful to use provocative techniques or “inductions,” and many epilepsy centers use such techniques to aid in the diagnosis of PNES [11,22]. When these are correctly performed and interpreted, their specificity for the diagnosis of PNES approaches 100%. Inductions have many advantages but are somewhat controversial due to ethical concerns. However, many ethical objections are circumvented by the fact that activations can be performed without the use of placebos [11,23,24].

The essential principle behind provocative techniques is suggestibility. When symptoms are caused by unconscious psychological causes, suggesting a change in symptoms may induce that change. Suggestibility is a feature of somatoform disorders at large, and for example, in psychogenic movement disorders, where the diagnosis rests solely on phenomenology (i.e., there is no equivalent of the EEG), response to placebo or suggestion is considered a diagnostic criterion for definite psychogenic mechanism [25,26]. Likewise, in most specialties, response to placebo is the only method that may allow a positive diagnosis of psychogenic symptoms, as opposed to just diagnosis of exclusion.

Suggestibility is not only useful for diagnosis; it may also be useful as a treatment. For example, the “suggestion of a cure” is often successful in acute conversion symptoms. Most psychogenic symptoms are likely misdiagnosed as organic diseases and possibly never become diagnosed as what they are (psychogenic). In neurology, multiple sclerosis is likely overdiagnosed in young adults with neurologic symptoms [27,28]. The misdiagnosis of psychogenic symptoms as organic diseases and their response to placebo are the most likely explanations for miracle cures claimed by televangelists or faith healers and practitioners of alternative medicine, e.g., reflexology, auriculotherapy, iridology, aromatherapy, chelation therapy, homeopathy, chiropractic manipulations, craniosacral therapy, and heavily advertised products that claim to cure every ailment (magnetic bracelets, etc.).

5. Psychopathology of psychogenic symptoms

According to DSM-IV, somatic symptoms are the main manifestation of three groups of disorders: somatoform disorders (of which there are five types), factitious disorder (Munchausen syndrome), and malingering. Somatic symptoms may occur in other psychiatric conditions, such as anxiety disorders, dissociative disorders, and psychotic disorders, but in these cases they are not the main manifestations.

A frequent and unfortunate misconception among health care professionals is that “psychogenic equals fake.” It is important to clarify the differences between the somatoform disorders, in which symptoms are not consciously produced (patients are not faking), and factitious disorder or malingering, in which patients are intentionally faking symptoms. The distinction between malingering and factitious (both are the conscious feigning of symptoms to deceive the physician) is that...
malingers have a clear and understandable goal for the behavior (e.g., avoiding jail, obtaining financial compensation), whereas in factitious disorder there is no such goal (they have psychopathology that leads them to assume the sick role for no understandable reason). Although this classification is simple in theory, one must keep in mind that it is nearly impossible to know if a given patient is faking. Somatoform disorders are classified into: somatization (chronic multiple symptoms), conversion (motor–sensory–convulsive), psychogenic pain, hypochondriasis, body dysmorphic disorder, and undifferentiated, each with its own set of diagnostic criteria [29].

Another factor that is thought to play a role in terms of etiology is that many patients with psychogenic symptoms have a history of abuse, including incest or rape.

6. Treatment

The first step (and perhaps the most important one) in the treatment of psychogenic symptoms is delivery of the diagnosis [30–32]. Most patients with psychogenic symptoms have first received a diagnosis of organic disease (e.g., epilepsy), so that their reactions often include disbelief and denial, as well as anger and hostility (Are you accusing me of faking? Are you saying that I am crazy?). Written information can be useful in supplementing verbal explanations, but unfortunately patient information material for psychogenic symptoms is rather scarce [30,33,34]. Remarkably, the American Psychiatric Association has abundant written patient education material available on diverse topics, but none on somatoform disorders [34], a very telling fact. Unless patients and families understand and accept the diagnosis, they will not comply with recommendations, and will not see a psychiatrist. Therefore, communicating the diagnosis is critical. This needs to be done clearly, using unambiguous terms that patients can understand, such as “psychological, stress-induced, emotional.” The physician delivering the diagnosis must be compassionate (remembering that most patients are not faking), but firm and confident (avoiding “wissy-washy” terms). This, of course, is more difficult when the level of confidence is low (diagnosis of elimination). Unfortunately, psychiatrists tend to be skeptical about the diagnosis of psychogenic symptoms, and even for PNES, where EEG-video monitoring allows a near-certain diagnosis, patients tend to not believe the diagnosis [35]. The diagnosis is too often delivered ambiguously and timidly, so that the wrong diagnosis is perpetuated. Another obstacle is that these patients likely require long-term psychotherapy, and psychotherapy is practiced by fewer and fewer mental health professionals (partly because of poor reimbursement), and is not easily available to the uninsured. It is often easier for uninsured patients to obtain medical treatment than it is to receive psychotherapy.

Psychogenic symptoms are by definition a psychiatric disease, and psychiatrists should treat it. Treatment includes psychotherapy and adjunctive medications for coexisting anxiety or depression. From a practical point of view, the role of neurologists and other medical specialists is to determine whether there is organic disease. Once the symptoms are shown to be psychogenic, the exact psychiatric diagnosis and its treatment are best handled by the psychiatrist. This can be very difficult. The consensus is that most patients with psychogenic symptoms fall under the somatoform category (unconscious production of symptoms), rather than the intentional faking type (malingering and factitious). As mentioned above, while the DSM classification is simple in theory, it is nearly impossible to know if a given patient is faking. Intentional faking can be diagnosed only by catching a person in the act of faking (e.g., self-inflicting injuries, ingesting medications or eyedrops to cause signs, putting blood in the urine to simulate hematuria). However, malingering may be underdiagnosed [1], partly because the “diagnosis” of malingering is essentially an accusation.

Along with psychiatric treatments, it is helpful for the neurologist (or other specialist) to continue following the patient. First, providing continued follow-up and support allows the patient to not feel “abandoned.” Second, unnecessary treatments can be discontinued if coexisting organic disease has been adequately excluded. For example, only 10% of patients with PNES have coexisting epilepsy [36], and antiepileptic drugs can be discontinued in most cases. Third, issues about disability or driving should be addressed by both the psychiatrist and the neurologist or other specialist.

7. Outcome

The outcome of psychogenic symptoms is extremely variable. For PNES, there is significant morbidity. About 40 to 70% become “seizure”-free [37]. The strongest predictors of outcome are the severity of the underlying psychopathology and the duration of illness as misdiagnosed [11,38–41]. In general, children and adolescents do better than adults [42].

8. Some recommendations

It is clear that psychogenic symptoms are a source of frustration for clinicians. As a result, they are generally “avoided” and somewhat taboo. Are they being shoved under the rug? Certainly, psychogenic symptoms are not the subject of much clinical research. A search of the journal Neurology for 1994–2003 for the word psycho-
genic in the title found 21 articles, only 4 of which on topics other than psychogenic seizures. A similar search for original articles in the New England Journal of Medicine found no articles with psychogenic in the title and two with psychogenic in the abstract, both related to erectile dysfunction. Similarly, the recent (2004) APA annual meeting provides a telling example. A search by title word on the program web site (at http://www.psych.org, “scientific sessions all session types”) identified ~220 sessions with the word depression, ~82 with anxiety, 70 with eating, 7 with phobia, but 2 with the word somatoform, 1 with malingering, 0 with conversion, and 0 with factitious. Thus, there seems to be a severe disconnect between the frequency of the problem and the amount of attention devoted to it. Are psychogenic symptoms being swept under the rug?

To improve the diagnosis and outcome of psychogenic symptoms, the problems discussed here need to be addressed. Instead of being relegated to last and unlikely possibilities in lists of differential diagnoses, psychogenic symptoms should be the subject of education and research in all specialties. If PNES are any indication, psychogenic symptoms are very common in patients with atypical and refractory conditions. Communication between medical specialists and mental health professionals needs to be improved so that both sides can work together for the benefit of patients. Psychogenic causes should be specifically sought and not uncomfortably avoided. Patient education material should be developed. Placebos for diagnosis (e.g., intravenous saline to induce or abort symptoms), although inherently controversial, should be developed and standardized, as they are currently the only positive method to identify psychogenic causes.

References