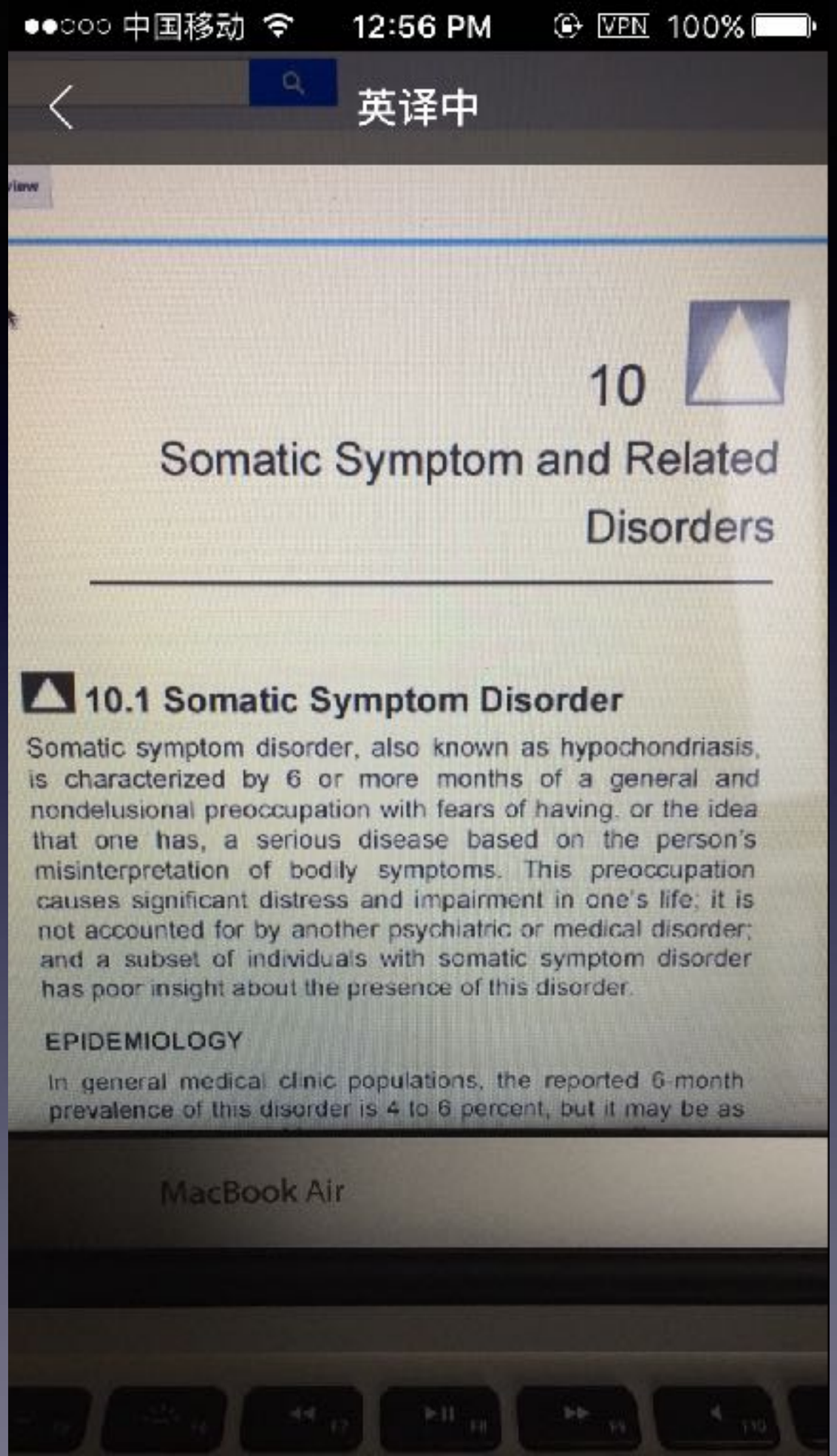
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Somatic Symptom and Related Disorders
10.1 Somatic Symptom Disorder
Somatic symptom disorder, also known as hypochondriasis, is characterized by 6 or more months of a general and nondelusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms. This preoccupation causes significant distress and impairment in one's life; it is not accounted for by another psychiatric or medical disorder; and a subset of individuals with somatic symptom disorder has poor insight about the presence of this disorder.
EPIDEMIOLOGY
In general medical clinic populations, the reported 6-month prevalence of this disorder is 4 to 6 percent, but it may be as
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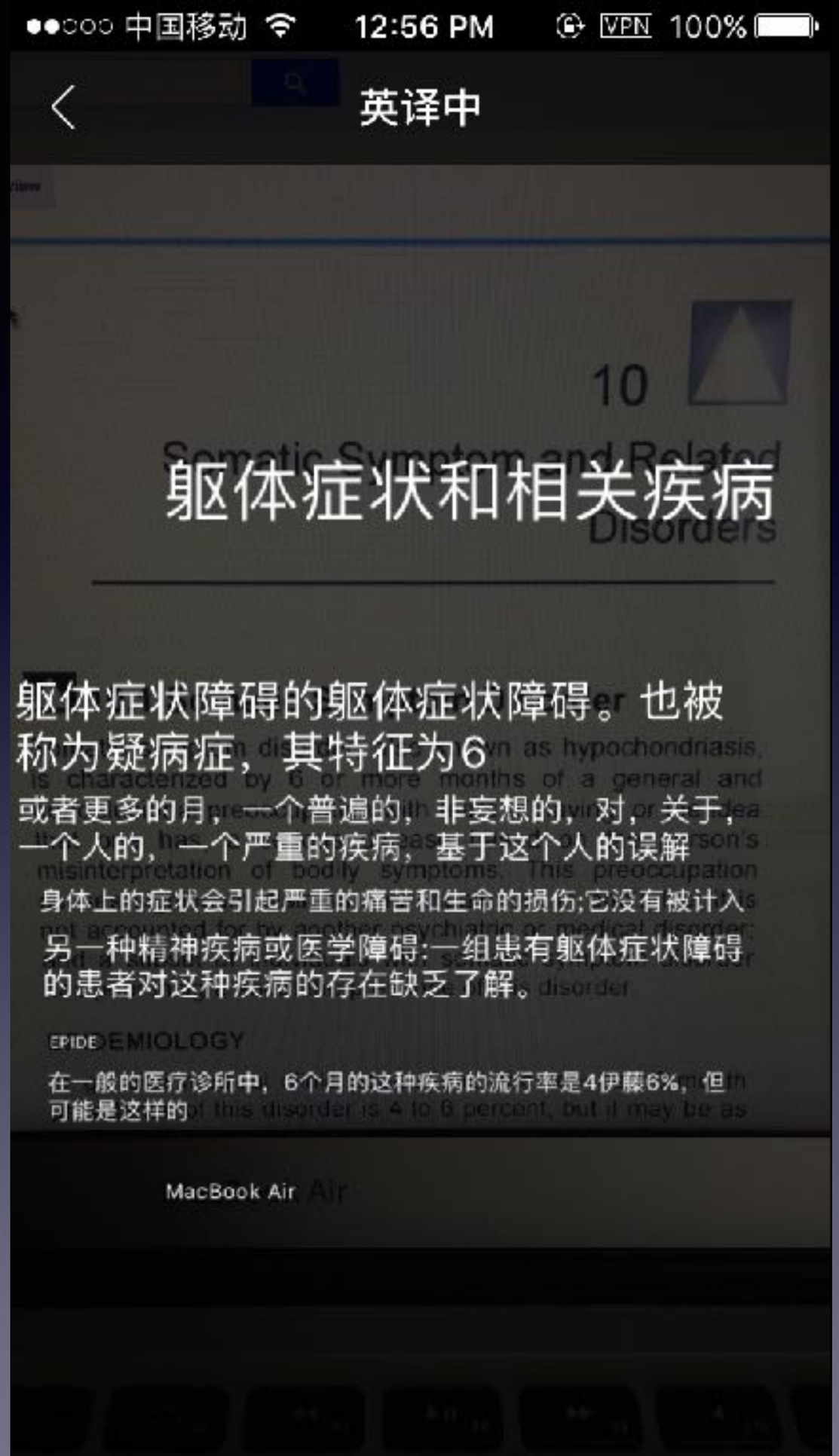
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躯体症状和相关疾病
躯体症状障碍的躯体症状障碍。也被称为疑病症，其特征为6或者更多的月，一个普遍的，非妄想的，对，关于，一个人的，一个严重的疾病，基于这个人的误解
身体上的症状会引起严重的痛苦和生命的损伤;它没有被计入另一种精神疾病或医学障碍:一组患有躯体症状障碍的患者对这种疾病的存在缺乏了解。
在一般的医疗诊所中，6个月的这种疾病的流行率是4伊藤6%，但可能是这样的
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10.1 Somatic Symptom Disorder

Somatic symptom disorder, also known as hypochondriasis, is characterized by 6 or more months of a general and nondelusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms. This preoccupation causes significant distress and impairment in one's life; it is not accounted for by another psychiatric or medical disorder; and a subset of individuals with somatic symptom disorder has poor insight about the presence of this disorder.

EPIDEMIOLOGY

In general medical clinic populations, the reported 6-month prevalence of this disorder is 4 to 6 percent, but it may be as high as 15 percent. Men and women are equally affected by this disorder. There are some reports of women having more somatic complaints than men, however. Although the onset of symptoms can occur at any age, the disorder most commonly appears in persons 20 to 30 years of age. Some evidence indicates that this diagnosis is more common among blacks than among whites, but social position, education level,

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10.1躯体症状疾病

躯体症状障碍，也被称为疑病症，其特征为6或者更多的月，一个普遍的，非妄想的，对存在的恐惧，或者一个人的想法，一个严重的疾病基于这个人对身体症状的错误理解这个bre侵占会引起严重的痛苦和生命的损害;这并不是由另一种精神疾病或医学疾病造成的，而患有躯体症状障碍的个体也对这种疾病的存在缺乏了解。

流行病学

在一般的医学诊所中，报告的6个月的患病率是4%到6%，但可能高达15%的男性和女性同样受到这种疾病的影响。然而，有报道称女性比男性更有身体上的抱怨。虽然任何年龄的症状都有可能发生，但最常见的症状是20到30岁的人。一些证据表明，这种诊断在黑人中比在白人中更为普遍，但在社会地位，教育水平上，

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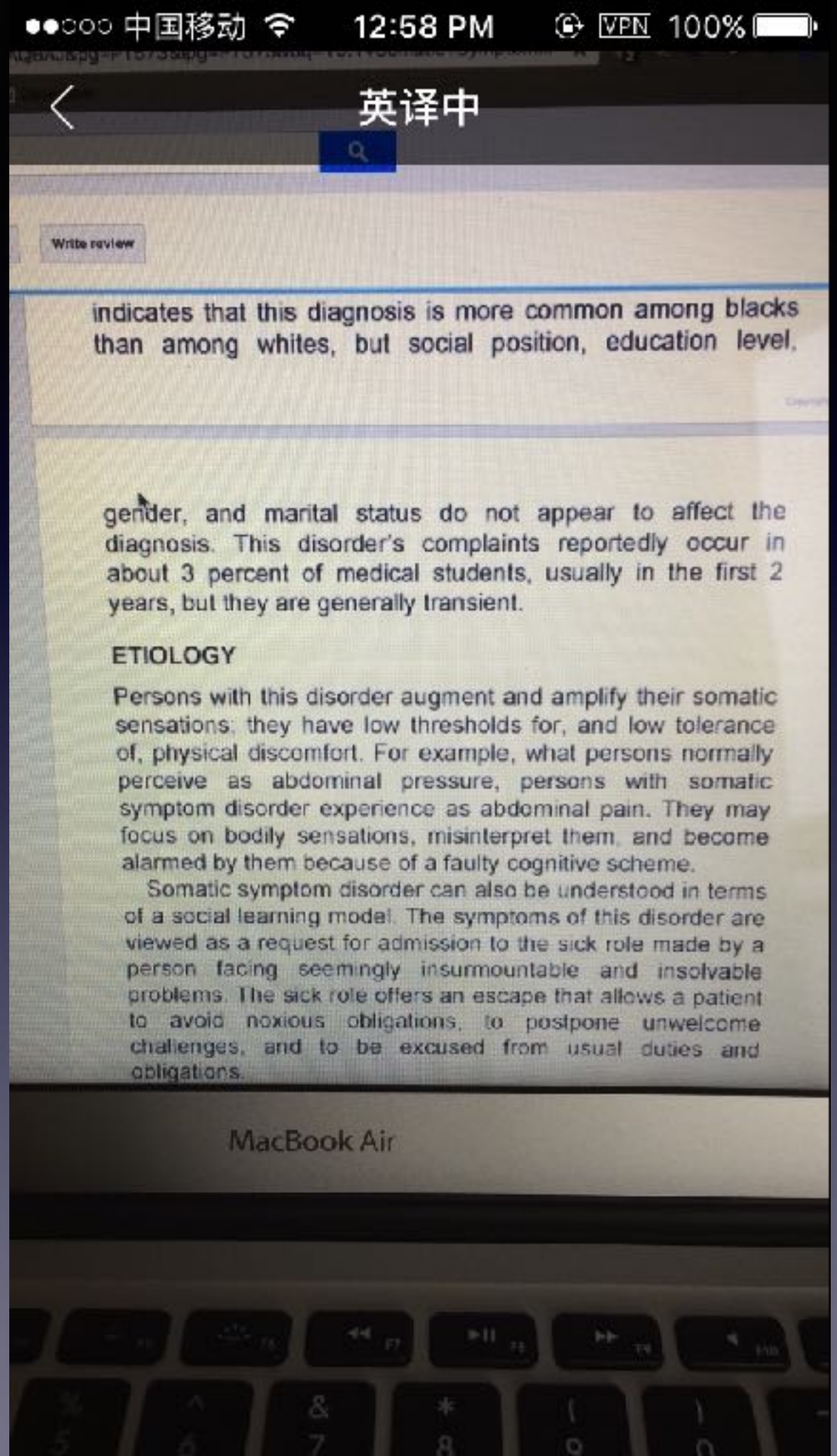
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indicates that this diagnosis is more common among blacks than among whites, but social position, education level,
gender, and marital status do not appear to affect the diagnosis. This disorder's complaints reportedly occur in about 3 percent of medical students, usually in the first 2 years, but they are generally transient.
ETIOLOGY
Persons with this disorder augment and amplify their somatic sensations; they have low thresholds for, and low tolerance of, physical discomfort. For example, what persons normally perceive as abdominal pressure, persons with somatic symptom disorder experience as abdominal pain. They may focus on bodily sensations, misinterpret them, and become alarmed by them because of a faulty cognitive scheme.
Somatic symptom disorder can also be understood in terms of a social learning model. The symptoms of this disorder are viewed as a request for admission to the sick role made by a person facing seemingly insurmountable and insolvable problems. The sick role offers an escape that allows a patient to avoid noxious obligations; to postpone unwelcome challenges, and to be excused from usual duties and obligations.
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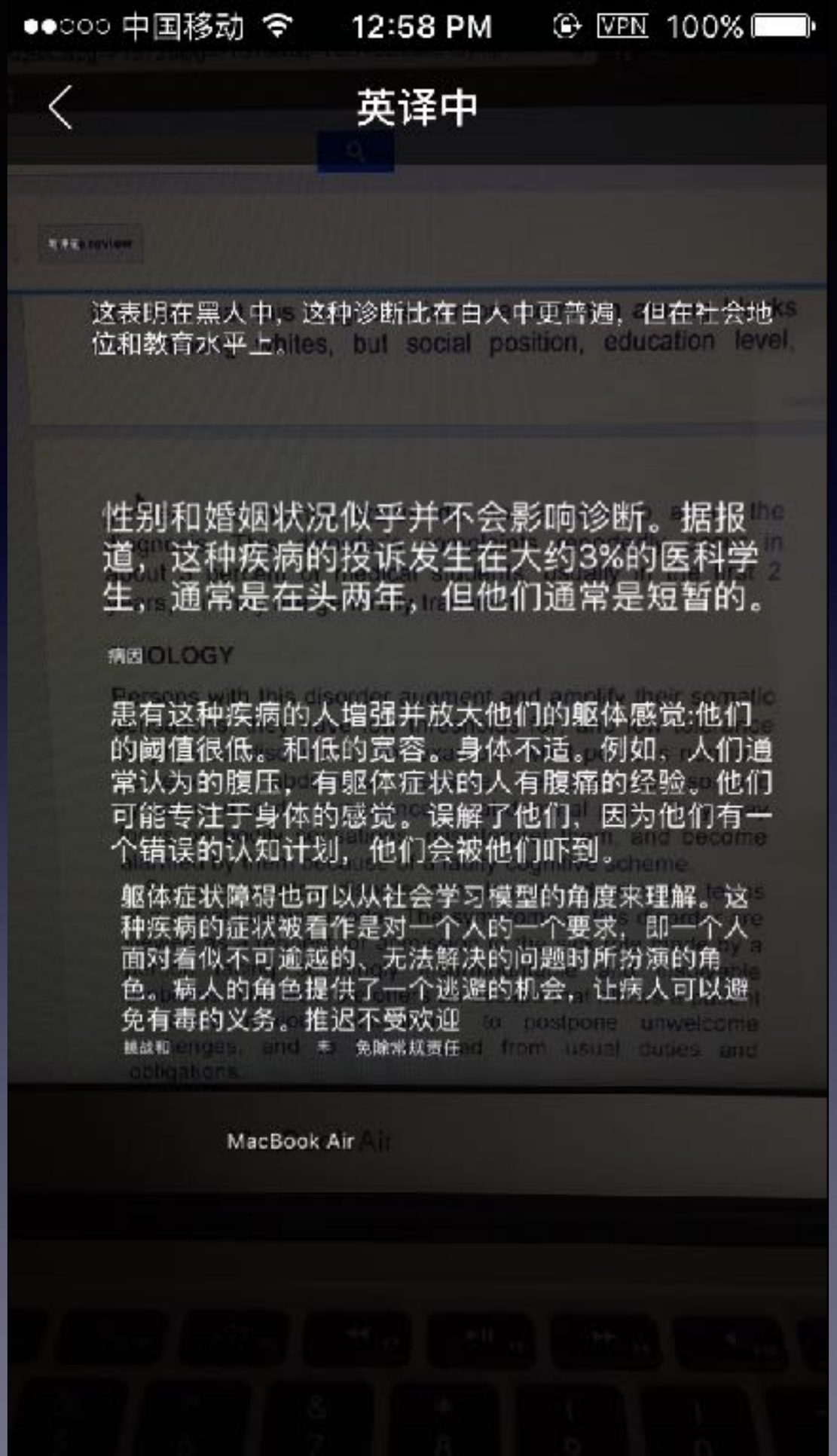
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这表明在黑人中，这种诊断比在白人中更普遍，但在社会地位和教育水平上
性别和婚姻状况似乎并不会影响诊断。据报道，这种疾病的投诉发生在大约3%的医科学生，通常是在头两年，但他们通常是短暂的。
病因OLOGY
患有这种疾病的人增强并放大他们的躯体感觉:他们的阈值很低。和低的宽容。身体不适。例如，人们通常认为的腹压，有躯体症状的人有腹痛的经验。他们可能专注于身体的感觉。误解了他们，因为他们有一个错误的认知计划，他们会被他们吓到。
躯体症状障碍也可以从社会学习模型的角度来理解。这种疾病的症状被看作是对一个人的一个要求，即一个人面对看似不可逾越的、无法解决的问题时所扮演的角色。病人的角色提供了一个逃避的机会，让病人可以避免有毒的义务。推迟不受欢迎
挑战和
免除常规责任
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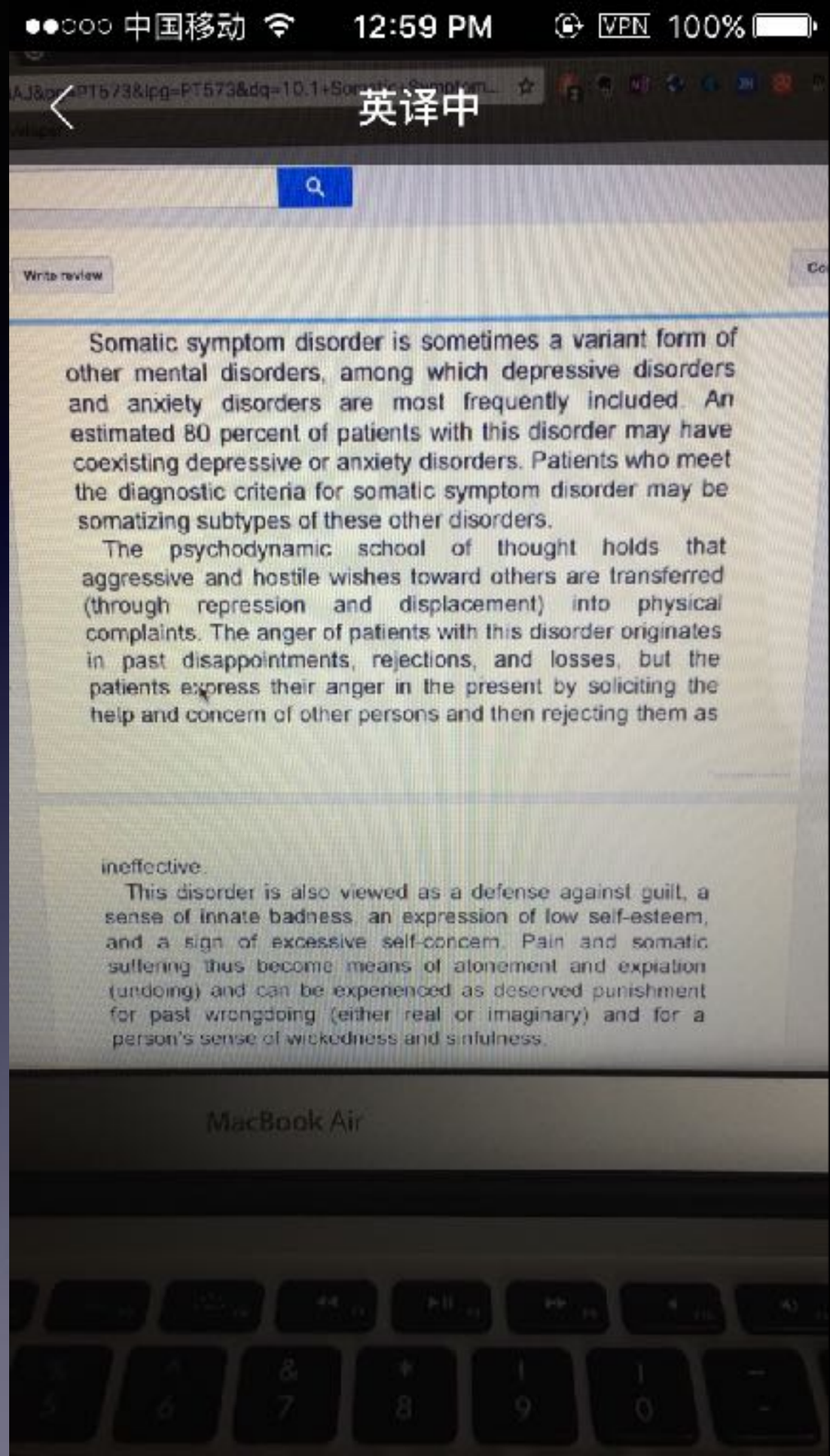
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Somatic symptom disorder is sometimes a variant form of other mental disorders, among which depressive disorders and anxiety disorders are most frequently included. An estimated 80 percent of patients with this disorder may have coexisting depressive or anxiety disorders. Patients who meet the diagnostic criteria for somatic symptom disorder may be somatizing subtypes of these other disorders.
The psychodynamic school of thought holds that aggressive and hostile wishes toward others are transferred (through repression and displacement) into physical complaints. The anger of patients with this disorder originates in past disappointments, rejections, and losses, but the patients express their anger in the present by soliciting the help and concern of other persons and then rejecting them as
ineffective.
This disorder is also viewed as a defense against guilt, a sense of innate badness, an expression of low self-esteem, and a sign of excessive self-concern. Pain and somatic suffering thus become means of atonement and expiation (undoing) and can be experienced as deserved punishment for past wrongdoing (either real or imaginary) and for a person's sense of wickedness and sinfulness.
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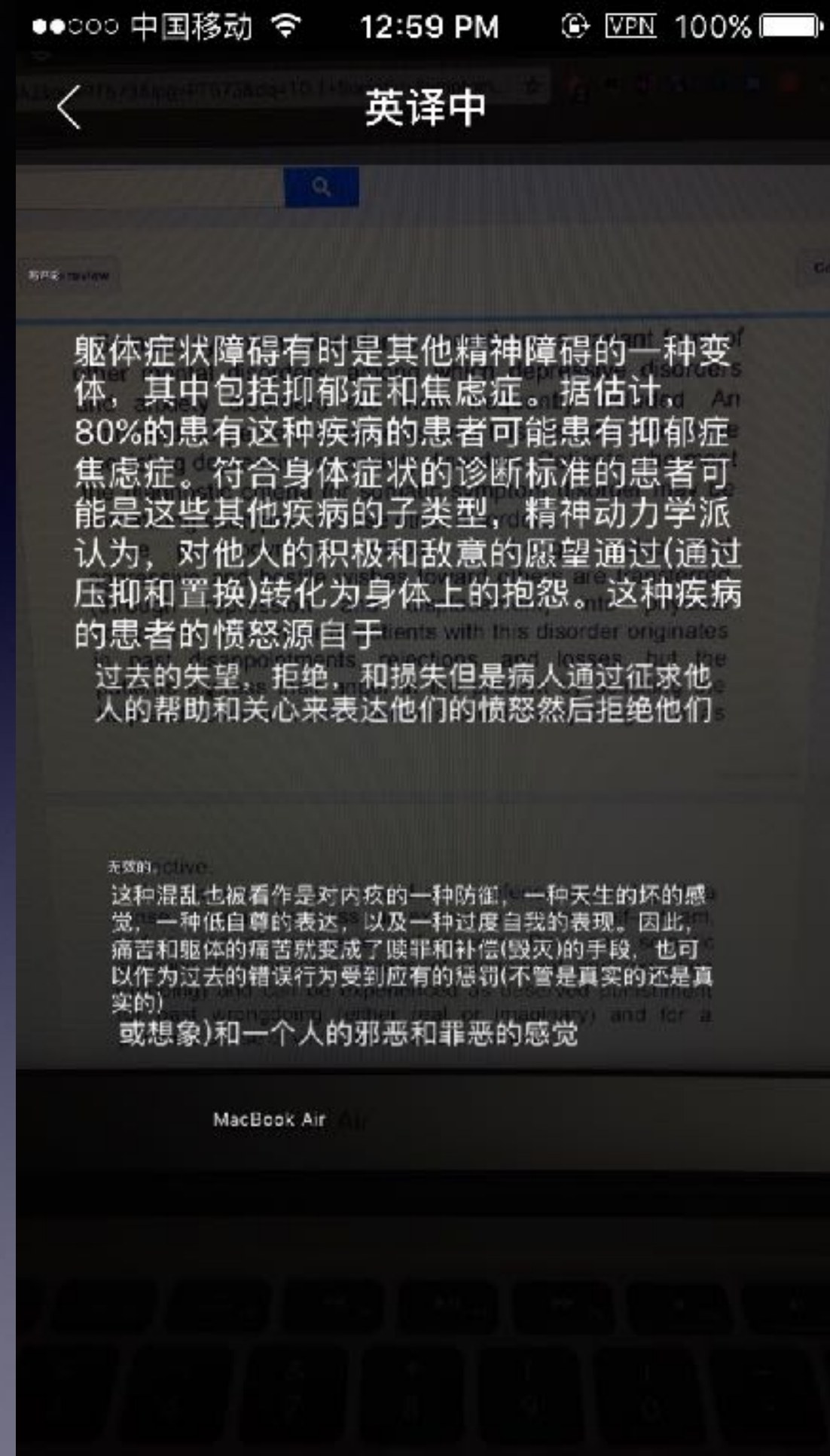
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躯体症状障碍有时是其他精神障碍的一种变体，其中包括抑郁症和焦虑症。据估计，80%的患有这种疾病的患者可能患有抑郁症焦虑症。符合身体症状的诊断标准的患者可能是这些其他疾病的子类型，精神动力学派认为，对他人的积极和敌意的愿望通过(通过压抑和置换)转化为身体上的抱怨。这种疾病的患者的愤怒源自于
过去的失望，拒绝，和损失但是病人通过征求他人的帮助和关心来表达他们的愤怒然后拒绝他们
无效的
这种混乱也被看作是对内疚的一种防御，一种天生的坏的感觉，一种低自尊的表达，以及一种过度自我的表现。因此，痛苦和躯体的痛苦就变成了赎罪和补偿(毁灭)的手段，也可以作为过去的错误行为受到应有的惩罚(不管是真实的还是真实的)
或想象)和一个人的邪恶和罪恶的感觉
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DIAGNOSIS

According to the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the diagnostic criteria for somatic symptom disorder require that patients be preoccupied with the false belief that they have a serious disease, based on their misinterpretation of physical signs or sensations the belief must last at least 6 months, despite the absence of pathological findings on medical and neurological examinations. The diagnostic criteria also require that the belief cannot have the intensity of a delusion (more appropriately diagnosed as delusional disorder) and cannot be restricted to distress about appearance (more appropriately diagnosed as body dysmorphic disorder). The symptoms of somatic symptom disorder must be sufficiently intense to cause emotional distress or impair the patient's ability to function in important areas of life. Clinicians may specify the presence of poor insight: patients do not consistently recognize that their concerns about disease are excessive.

CLINICAL FEATURES

Patients with somatic symptom disorder believe that they have a serious disease that has not yet been detected and they cannot be persuaded to the contrary. They may maintain a belief that they have a particular disease or, as time progresses, they may transfer their belief to another disease.

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诊断GNOSIS

根据第五版的《精神疾病诊断与统计手册(第五版),躯体症状的诊断标准障碍需要专注于患者错误的认为他们有一个严重的疾病,根据他们的误解的体征或感觉的信念必须至少6个月。尽管在医学和神经学检查方面没有病理发现。诊断标准还要求这种信念不能有强烈的强度

一种错觉(更恰当地诊断为妄想症),不能局限于外表的痛苦(更恰当地诊断为躯体变形障碍),躯体症状障碍的症状必须足够强烈,从而引起精神上的痛苦,或损害患者在生活中重要领域的功能。临床医生可能会指出存在的问题:患者不一致地认识到他们对疾病的关注

过度的SIVE.

临床特征AL FEATURES

患有躯体症状障碍的患者认为他们有一种尚未被发现的严重疾病,他们不能被说服相反。他们可能会认为他们有特定的疾病或者随着时间的推移他们可能会把他们的信念转移到另一种疾病上

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Their convictions persist despite negative laboratory results, the benign course of the alleged disease over time, and appropriate reassurances from physicians. Yet, their beliefs are not sufficiently fixed to be delusions. Somatic symptom disorder is often accompanied by symptoms of depression and anxiety and commonly coexists with a depressive or anxiety disorder.

A severe case of somatic symptom disorder that highlights diagnostic, prognostic, and management issues is described in the case study.

Mr. K, a white man in his mid-30s, consulted a general medicine clinic complaining of gastrointestinal problems. Major presenting symptoms were a long list of physical symptoms and concerns mostly related to the gastrointestinal system. These included abdominal pain, left lower quadrant cramps, bloating, persistent sense of fullness in stomach hours after eating, intolerance to foods, constipation, decrease in physical stamina, heart palpitations, and feelings that "skin is getting yellow" and "not getting enough oxygen." A review of systems disclosed disturbances from virtually every organ system, including tired eyes with blurred vision, sore throat and "lump" in throat, heart palpitations, irregular heartbeat, dizziness, trouble breathing, and general weakness.

The patient reported that symptoms started prior to

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他们的信念依然存在，尽管他们的实验室结果是负面的，随着时间的推移，这种疾病的良性发展，以及医生的适当保证。然而，他们的信念并没有被足够的固定，成为错觉。躯体的症状通常伴有抑郁和焦虑的症状，通常与抑郁或焦虑障碍共存。

案例研究中描述了一种严重的躯体症状障碍，它突出了诊断、预后和管理问题。

k先生是一个30多岁的白人，他咨询了一家普通的医疗诊所，抱怨肠胃问题。主要的表现症状是长时间的切片症状和主要与胃肠道有关的症状。这些包括腹痛，左侧四分之一的腹部绞痛、腹胀、持续的饱腹感、对食物的不耐受、便秘的身体耐力、心悸以及“skir正在变黄”和“没有足够的氧气”的感觉。“对系统的回顾揭示了几乎所有器官系统的干扰，包括视力模糊、喉咙痛、喉咙心悸、心律不齐、呼吸困难以及全身无力。”

病人报告 前开始出现症状

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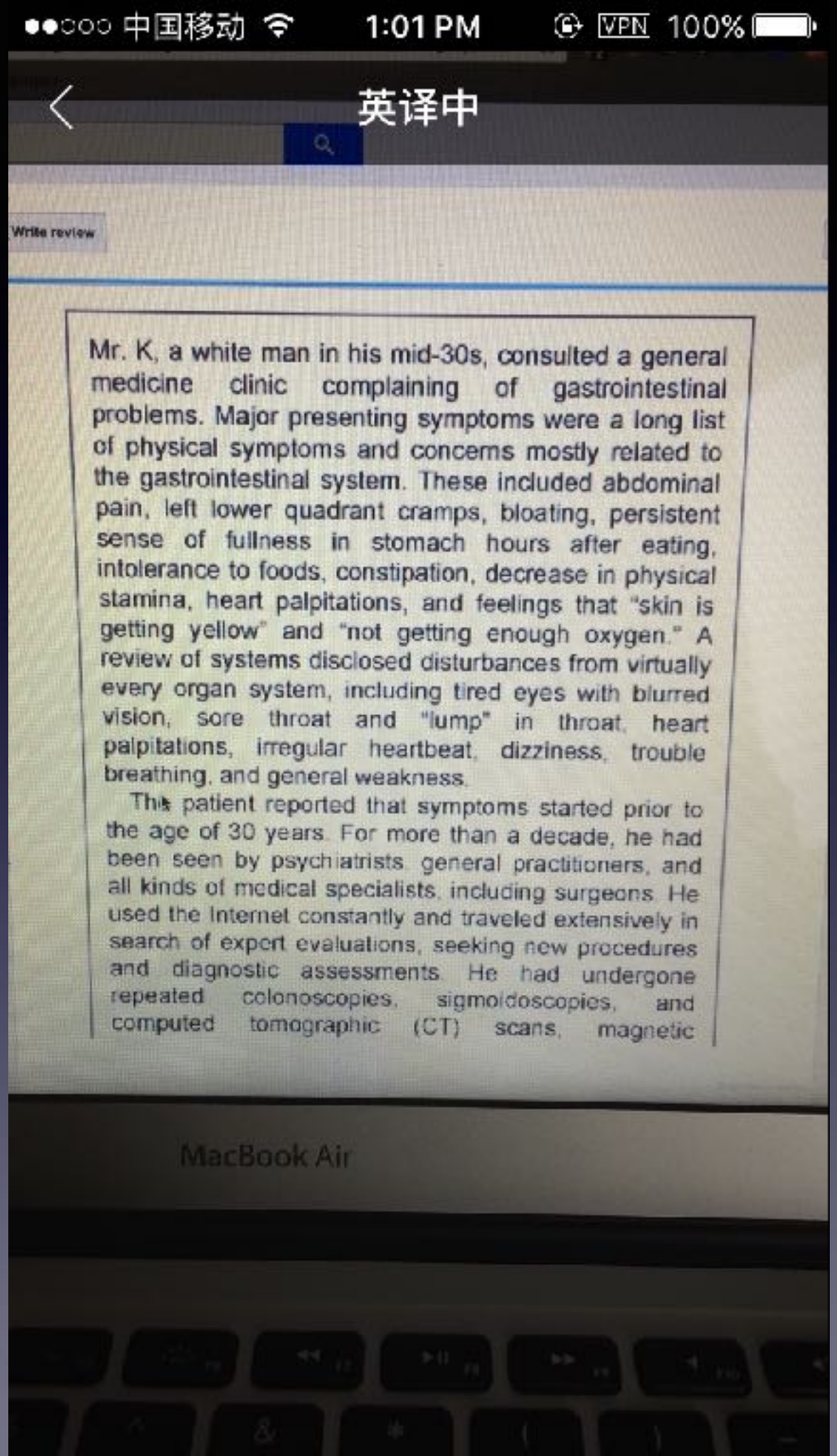
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Mr. K, a white man in his mid-30s, consulted a general medicine clinic complaining of gastrointestinal problems. Major presenting symptoms were a long list of physical symptoms and concerns mostly related to the gastrointestinal system. These included abdominal pain, left lower quadrant cramps, bloating, persistent sense of fullness in stomach hours after eating, intolerance to foods, constipation, decrease in physical stamina, heart palpitations, and feelings that "skin is getting yellow" and "not getting enough oxygen." A review of systems disclosed disturbances from virtually every organ system, including tired eyes with blurred vision, sore throat and "lump" in throat, heart palpitations, irregular heartbeat, dizziness, trouble breathing, and general weakness.
This patient reported that symptoms started prior to the age of 30 years. For more than a decade, he had been seen by psychiatrists, general practitioners, and all kinds of medical specialists, including surgeons. He used the Internet constantly and traveled extensively in search of expert evaluations, seeking new procedures and diagnostic assessments. He had undergone repeated colonoscopies, sigmoidoscopies, and computed tomographic (CT) scans, magnetic
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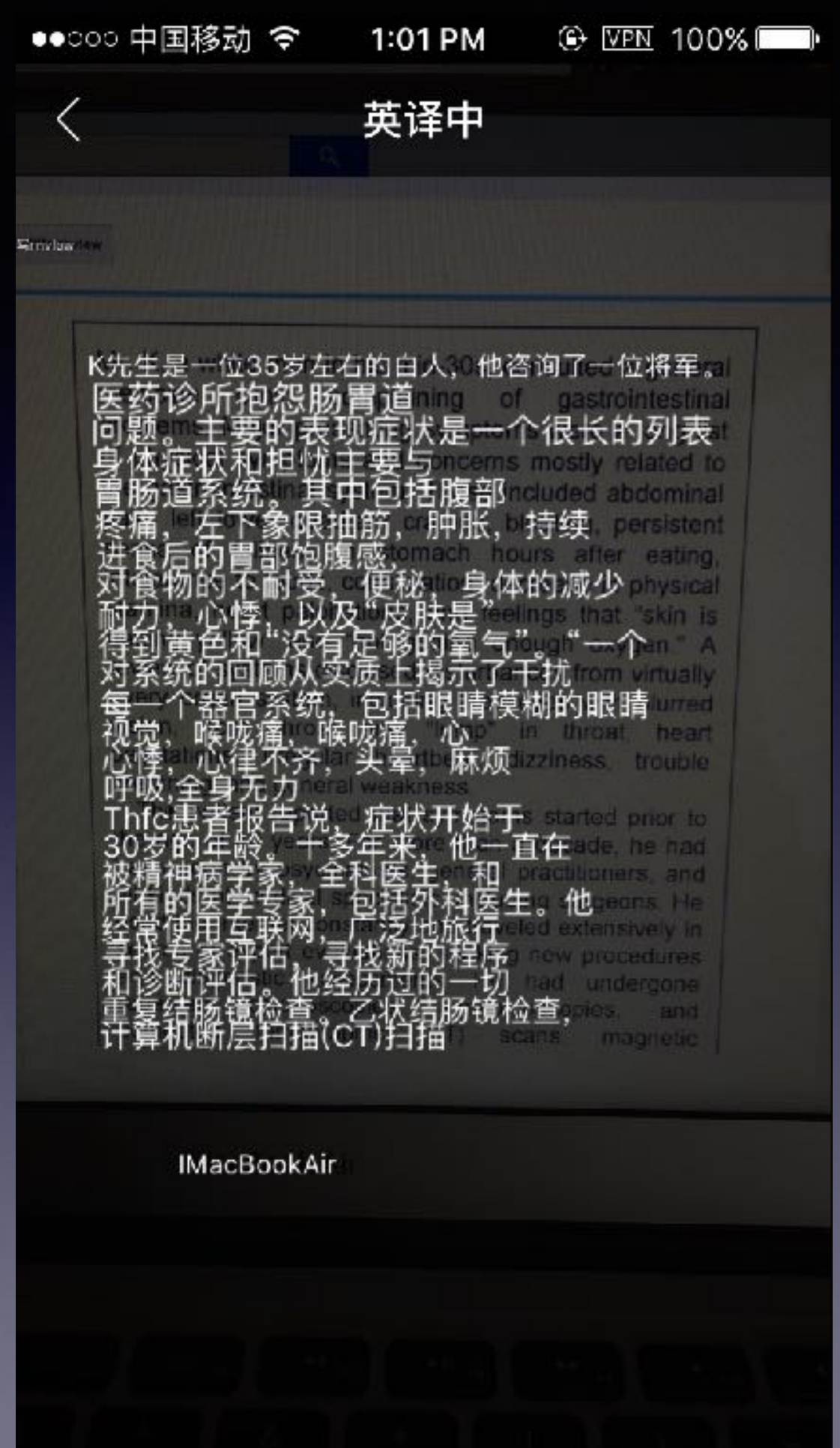
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K先生是一位35岁左右的白人，他咨询了一位将军。
医药诊所抱怨肠胃道
问题。主要的表现症状是一个很长的列表
身体症状和担忧主要与
胃肠道系统。其中包括腹部
疼痛，左下象限抽筋，肿胀，持续
进食后的胃部饱腹感，
对食物的不耐受，便秘，身体的减少
耐力，心悸，以及“皮肤是”
得到黄色和“没有足够的氧气”。“一个
对系统的回顾从实质上揭示了干扰
每一个器官系统，包括眼睛模糊的眼睛
视觉，喉咙痛，喉咙痛，心
心悸，心律不齐，头晕，麻烦
呼吸，全身无力
Thfc患者报告说，症状开始于
30岁的年龄。十多年来，他一直在
被精神病学家，全科医生，和
所有的医学专家，包括外科医生。他
经常使用互联网，广泛地旅行
寻找专家评估，寻找新的程序
和诊断评估。他经历过的一切
重复结肠镜检查，乙状结肠镜检查，
计算机断层扫描(CT)扫描
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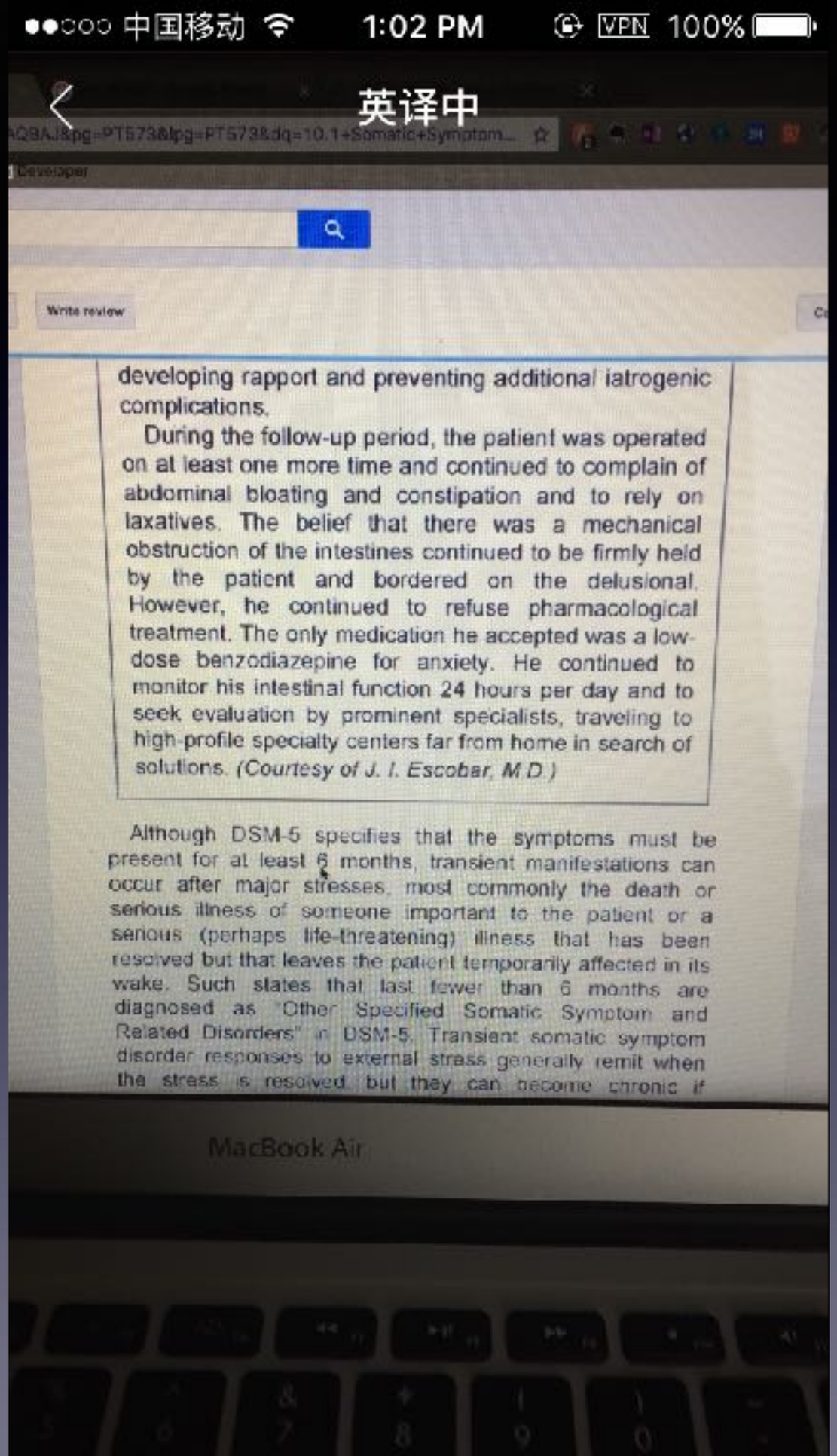
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developing rapport and preventing additional iatrogenic complications.
During the follow-up period, the patient was operated on at least one more time and continued to complain of abdominal bloating and constipation and to rely on laxatives. The belief that there was a mechanical obstruction of the intestines continued to be firmly held by the patient and bordered on the delusional. However, he continued to refuse pharmacological treatment. The only medication he accepted was a low-dose benzodiazepine for anxiety. He continued to monitor his intestinal function 24 hours per day and to seek evaluation by prominent specialists, traveling to high-profile specialty centers far from home in search of solutions. (Courtesy of J. I. Escobar, M.D.)
Although DSM-5 specifies that the symptoms must be present for at least 6 months, transient manifestations can occur after major stresses, most commonly the death or serious illness of someone important to the patient or a serious (perhaps life-threatening) illness that has been resolved but that leaves the patient temporarily affected in its wake. Such states that last fewer than 6 months are diagnosed as "Other Specified Somatic Symptom and Related Disorders" in DSM-5. Transient somatic symptom disorder responses to external stress generally remit when the stress is resolved, but they can become chronic if
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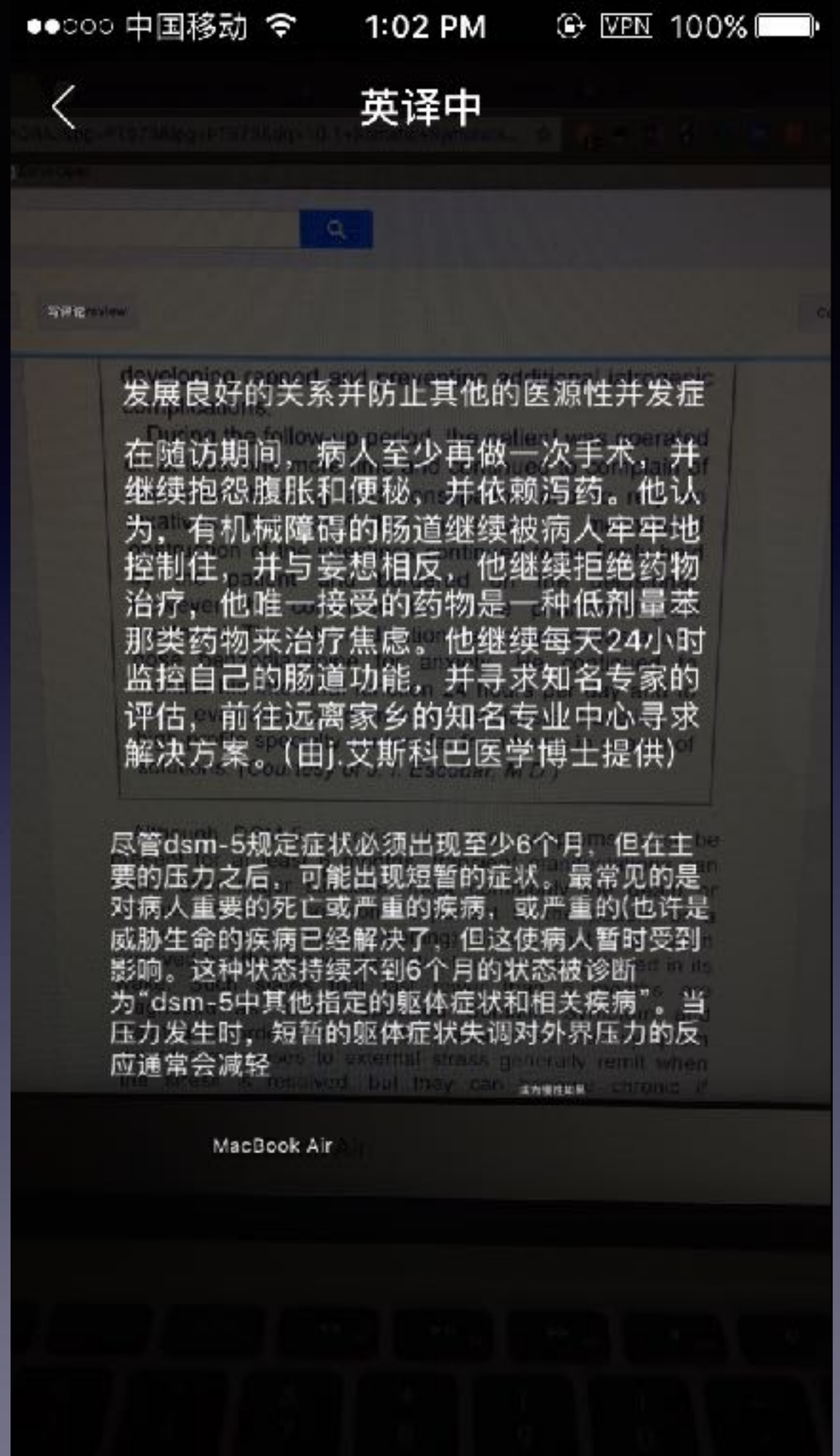
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发展良好的关系并防止其他的医源性并发症
在随访期间，病人至少再做一次手术，并继续抱怨腹胀和便秘，并依赖泻药。他认为，有机械障碍的肠道继续被病人牢牢地控制住，并与妄想相反，他继续拒绝药物治疗，他唯一接受的药物是一种低剂量苯那类药物来治疗焦虑。他继续每天24小时监控自己的肠道功能，并寻求知名专家的评估，前往远离家乡的知名专业中心寻求解决方案。(由j.艾斯科巴医学博士提供)
尽管dsm-5规定症状必须出现至少6个月，但在主要的压力之后，可能出现短暂的症状。最常见的是对病人重要的死亡或严重的疾病，或严重的(也许是威胁生命的疾病已经解决了，但这使病人暂时受到影响。这种状态持续不到6个月的状态被诊断为"dsm-5中其他指定的躯体症状和相关疾病"。当压力发生时，短暂的躯体症状失调对外界压力的反应通常会减轻
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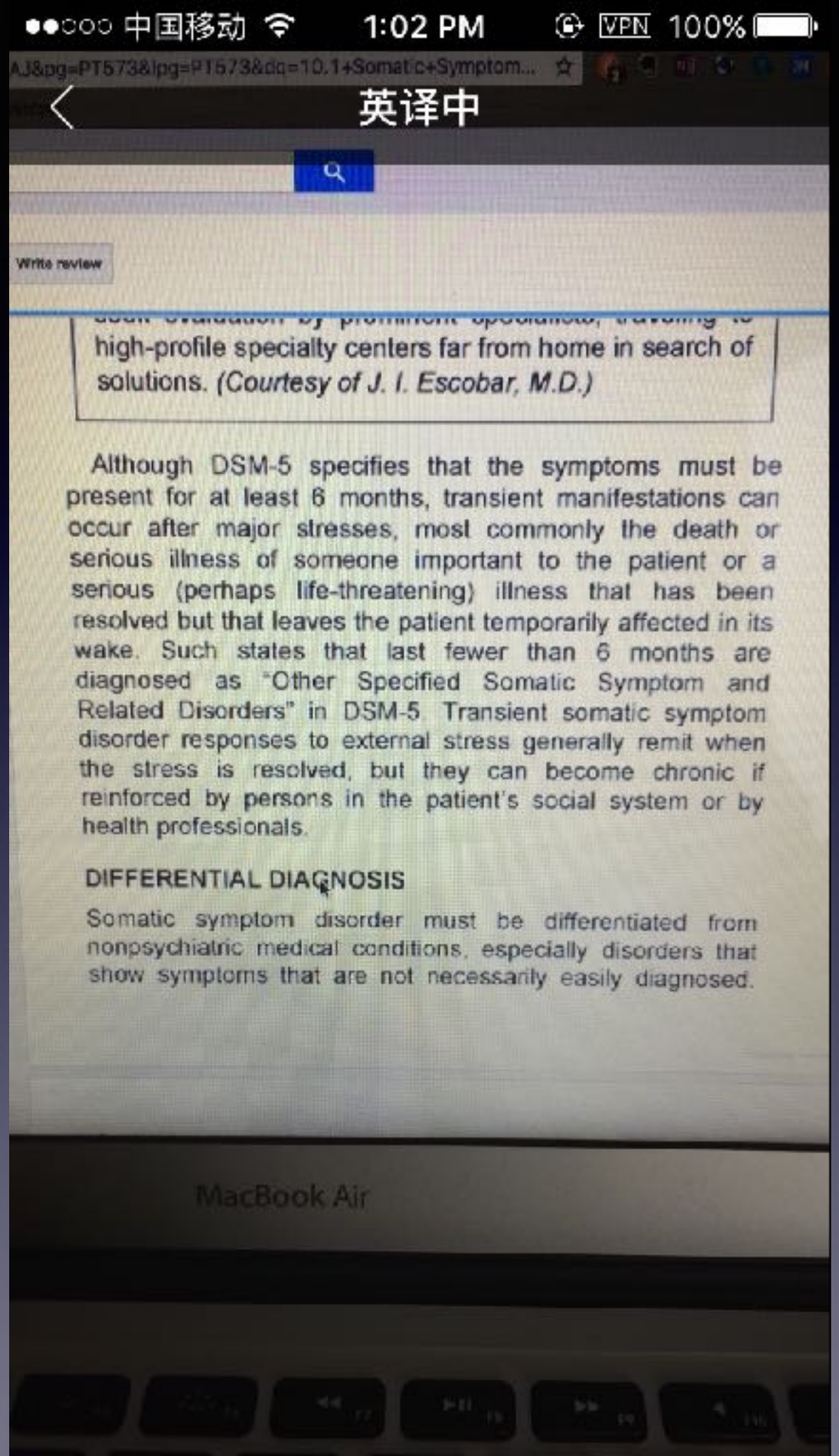
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DIFFERENTIAL DIAGNOSIS
Somatic symptom disorder must be differentiated from nonpsychiatric medical conditions, especially disorders that show symptoms that are not necessarily easily diagnosed.
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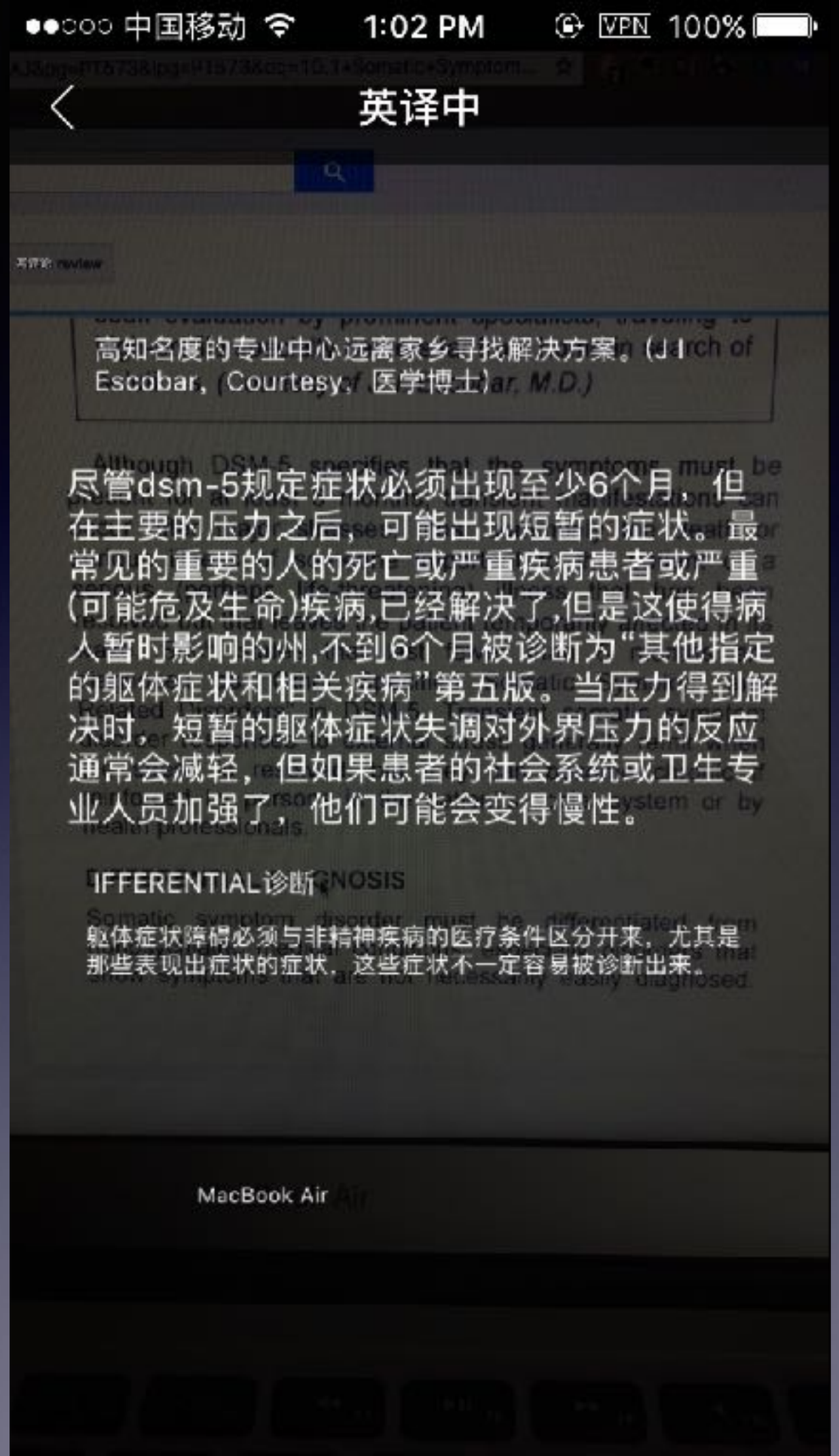
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高知名度的专业中心远离家乡寻找解决方案。(J
Escobar, (Courtesy
医学博士)
尽管dsm-5规定症状必须出现至少6个月，但在主要的压力之后，可能出现短暂的症状。最常见的重要的人的死亡或严重疾病患者或严重(可能危及生命)疾病,已经解决了,但是这使得病人暂时影响的州,不到6个月被诊断为"其他指定的躯体症状和相关疾病"第五版。当压力得到解决时，短暂的躯体症状失调对外界压力的反应通常会减轻，但如果患者的社会系统或卫生专业人员加强了，他们可能会变得慢性。
IFFERENTIAL诊断
躯体症状障碍必须与非精神疾病的医疗条件区分开来，尤其是那些表现出症状的症状，这些症状不一定容易被诊断出来。
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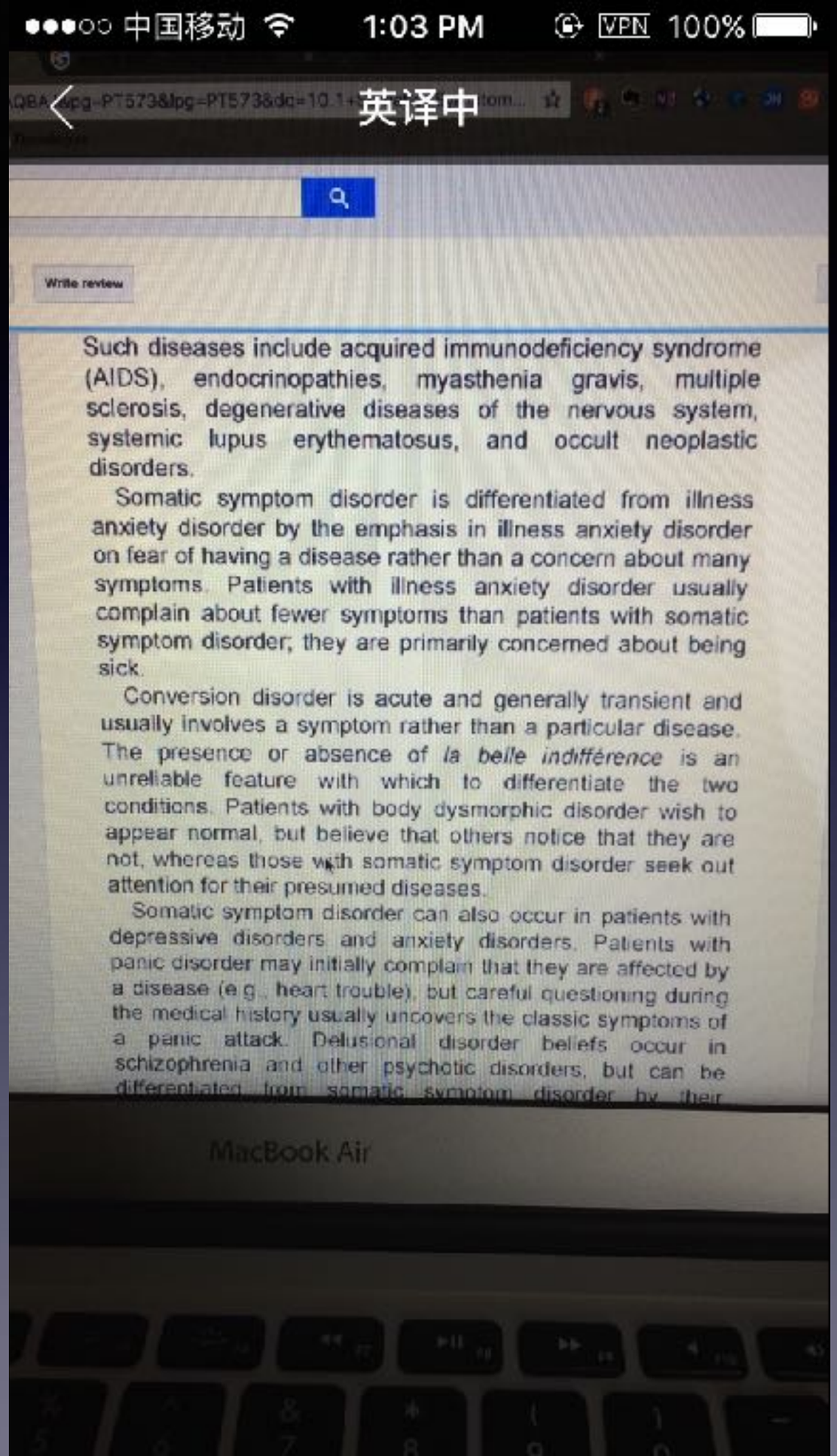
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Such diseases include acquired immunodeficiency syndrome (AIDS), endocrinopathies, myasthenia gravis, multiple sclerosis, degenerative diseases of the nervous system, systemic lupus erythematosus, and occult neoplastic disorders.
Somatic symptom disorder is differentiated from illness anxiety disorder by the emphasis in illness anxiety disorder on fear of having a disease rather than a concern about many symptoms. Patients with illness anxiety disorder usually complain about fewer symptoms than patients with somatic symptom disorder; they are primarily concerned about being sick.
Conversion disorder is acute and generally transient and usually involves a symptom rather than a particular disease. The presence or absence of la belle indifférence is an unreliable feature with which to differentiate the two conditions. Patients with body dysmorphic disorder wish to appear normal, but believe that others notice that they are not, whereas those with somatic symptom disorder seek out attention for their presumed diseases.
Somatic symptom disorder can also occur in patients with depressive disorders and anxiety disorders. Patients with panic disorder may initially complain that they are affected by a disease (e.g., heart trouble), but careful questioning during the medical history usually uncovers the classic symptoms of a panic attack. Delusional disorder beliefs occur in schizophrenia and other psychotic disorders, but can be differentiated from somatic symptom disorder by their
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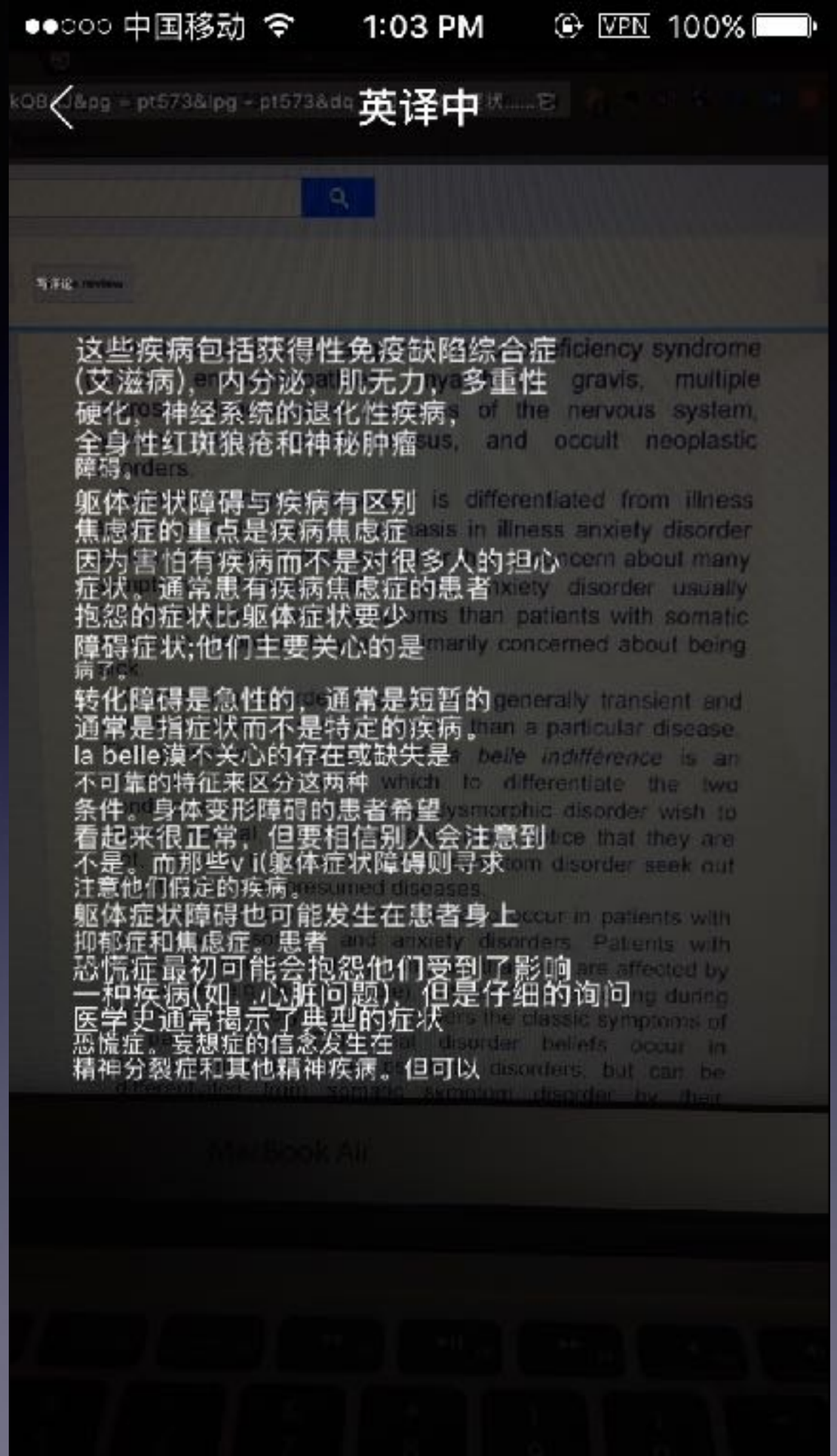
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这些疾病包括获得性免疫缺陷综合症
(艾滋病),内分泌,肌无力,多重性
硬化,神经系统的退化性疾病,
全身性红斑狼疮和神秘肿瘤
障碍
躯体症状障碍与疾病有区别
焦虑症的重点是疾病焦虑症
因为害怕有疾病而不是对很多人的担心
症状。通常患有疾病焦虑症的患者
抱怨的症状比躯体症状要少
障碍症状;他们主要关心的是
转化障碍是急性的,通常是短暂的
通常是指症状而不是特定的疾病。
la belle漠不关心的存在或缺失是
不可靠的特征来区分这两种
条件。身体变形障碍的患者希望
看起来很正常,但要相信别人会注意到
不是。而那些v i(躯体症状障碍则寻求
注意他们假定的疾病。
躯体症状障碍也可能发生在患者身上
抑郁症和焦虑症。患者
恐慌症最初可能会抱怨他们受到了影响
一种疾病(如,心脏问题),但是仔细的询问
医学史通常揭示了典型的症状
恐慌症。妄想症的信念发生在
精神分裂症和其他精神疾病。但可以

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depressive disorders and anxiety disorders. Patients with panic disorder may initially complain that they are affected by a disease (e.g., heart trouble), but careful questioning during the medical history usually uncovers the classic symptoms of a panic attack. Delusional disorder beliefs occur in schizophrenia and other psychotic disorders, but can be differentiated from somatic symptom disorder by their delusional intensity and by the presence of other psychotic symptoms. In addition, schizophrenic patients' somatic delusions tend to be bizarre, idiosyncratic, and out of keeping with their cultural milieus, as illustrated in the case below.

> A 52-year-old man complained "my guts are rotting away." Even after an extensive medical workup, he could not be reassured that he was not ill.

Somatic symptom disorder is distinguished from factitious disorder with physical symptoms and from malingering in that patients with somatic symptom disorder actually experience and do not simulate the symptoms they report.

COURSE AND PROGNOSIS

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抑郁症和焦虑症。患者
恐慌症最初可能会抱怨他们受到了影响
一种疾病(如心脏问题)，但在这期间
医学史通常揭示了典型的症状
恐慌症。妄想症的信念发生在
精神分裂症和其他精神疾病，但可以
与躯体症状障碍的区别
妄想症和其他精神病的存在
症状。另外，精神分裂患者的躯体
错觉往往是怪异的，特殊的，而且是不存在的
以他们的文化背景为例，如下面的例子所示。

> 一个52岁的男人抱怨说："我的内脏在腐烂。"
> 走了。即使在进行了大量的医疗工作之后，
> 不能放心他没有生病。

躯体症状障碍与人为因素区分开来
身体症状的障碍以及在此方面的不良反应
有躯体症状障碍的患者实际上经历过
也不要模拟他们报告的症状。

病程和预后

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COURSE AND PROGNOSIS

The course of the disorder is usually episodic; the episodes last from months to years and are separated by equally long quiescent periods. There may be an obvious association between exacerbations of somatic symptoms and psychosocial stressors. Although no well-conducted large outcome studies have been reported, an estimated one-third to one-half of all patients with somatic symptom disorder eventually improve significantly. A good prognosis is associated with high socioeconomic status, treatment-responsive anxiety or depression, sudden onset of symptoms, the absence of a personality disorder, and the absence of a related nonpsychiatric medical condition. Most children with the disorder recover by late adolescence or early adulthood.

TREATMENT

Patients with somatic symptom disorder usually resist psychiatric treatment, although some accept this treatment if it takes place in a medical setting and focuses on stress reduction and education in coping with chronic illness. Group psychotherapy often benefits such patients, in part because it provides the social support and social interaction that seem to reduce their anxiety. Other forms of psychotherapy, such as individual insight-oriented psychotherapy, behavior therapy, cognitive therapy, and hypnosis, may be useful.

Frequent, regularly scheduled physical examinations help

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病程和预后 AND PROGNOSIS

混乱的过程通常是情景性的;这几集的持续时间从几个月到几年，都是由同样长的静止期分开的。可能会有身体症状和心理压力的恶化之间有明显的联系。尽管没有得到良好的结果研究报告，但估计有三分之一到二分之一

所有患有躯体症状障碍的患者最终都会得到显著改善。A

良好的预后与

高社会经济地位，治疗反应性焦虑或抑郁突然发作症状没有人格障碍。以及没有相关的非精神疾病的医疗状况。大多数患有这种障碍的儿童在青春期后期或成年早期治疗中恢复

躯体症状障碍患者通常会抵抗

精神科的一些人接受这种治疗，如果它发生在医疗环境中，并且着重于减轻压力和治疗慢性病的教育。团体心理疗法通常对这些病人有益，部分原因是它提供了社会支持和社会互动，似乎可以减轻他们的焦虑。其他形式的心理治疗。这类个人见解导向的心理治疗。行为疗法，

认知疗法，催眠可能是有用的，有规律的定期体检帮助

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英译中

Frequent, regularly scheduled physical examinations help to reassure patients that their physicians are not abandoning

them and that their complaints are being taken seriously. Invasive diagnostic and therapeutic procedures should only be undertaken, however, when objective evidence calls for them. When possible, the clinician should refrain from treating equivocal or incidental physical examination findings.

Pharmacotherapy alleviates somatic symptom disorder only when a patient has an underlying drug-responsive condition, such as an anxiety disorder or depressive disorder. When somatic symptom disorder is secondary to another primary mental disorder, that disorder must be treated in its own right. When the disorder is a transient situational reaction, clinicians must help patients cope with the stress without reinforcing their illness behavior and their use of the sick role as a solution to their problems.

10.2 Illness Anxiety Disorder

Illness anxiety disorder is a new diagnosis in the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) that applies to those persons who are preoccupied

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经常性的定期体检帮助
向病人保证他们的医生不会放弃

他们和他们的抱怨正在被认真对待。
只有侵入性诊断和治疗程序才应该
然而，当客观证据需要时，要进行
他们。如果可能的话，临床医生应该避免治疗。
模棱两可或偶然的体检结果。
药物疗法仅能缓解躯体症状障碍
当一个病人有潜在的药物反应条件时，
比如焦虑症或抑郁症。当
躯体症状障碍是次要的
精神障碍，这种障碍必须用自己的权利来治疗。
当这种紊乱是暂时的情境反应时，临床医生
必须在不加强的情况下帮助患者的c和pe。
他们的疾病行为以及他们对病人角色的使用
解决他们的问题。

10。10的疾病焦虑症
疾病焦虑症是第五版的新诊断
精神障碍的诊断和统计手册

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10.2 Illness Anxiety Disorder

Illness anxiety disorder is a new diagnosis in the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) that applies to those persons who are preoccupied with being sick or with developing a disease of some kind. It is a variant of somatic symptom disorder (hypochondriasis). As stated in DSM-5: Most individuals with hypochondriasis are now classified as having somatic symptom disorder; however, in a minority of cases, the diagnosis of illness anxiety disorder applies instead. In describing the differential diagnosis between the two, according to DSM-5, somatic symptom disorder is diagnosed when somatic symptoms are present, whereas in illness anxiety disorder, there are few or no somatic symptoms and persons are "primarily concerned with the idea they are ill." The diagnosis may also be used for persons who do, in fact, have a medical illness but whose anxiety is out of proportion to their diagnosis and who assume the worst possible outcome imaginable.

EPIDEMIOLOGY

The prevalence of this disorder is unknown aside from using

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10。10的疾病焦虑症

疾病焦虑症是第五版的新诊断
精神障碍的诊断和统计手册 *Manual of Mental Disorders*
(dsm-5)适用于那些全神贯注的人
因为生病或患上某种疾病。它
是躯体症状障碍(疑病症)的一种变体。
正如dsm-5所述:大多数患有疑病症的患者
现在被归类为躯体症状障碍;
然而，在少数病例中，疾病的诊断
焦虑症适用。在描述微分
根据dsm-5的诊断，两者之间的诊断
症状障碍是在躯体症状出现时被诊断出来的
现在，在疾病焦虑症中，几乎没有
没有躯体症状和人"主要关注
有了这个想法，他们就生病了。"诊断也可以用于治疗。"
人做的事情。事实上，有一种疾病，但是
焦虑和他们的诊断是不相称的
最糟糕的可能是你所能想到的。

流行病学

除了使用外，这种疾病的流行程度还不清楚

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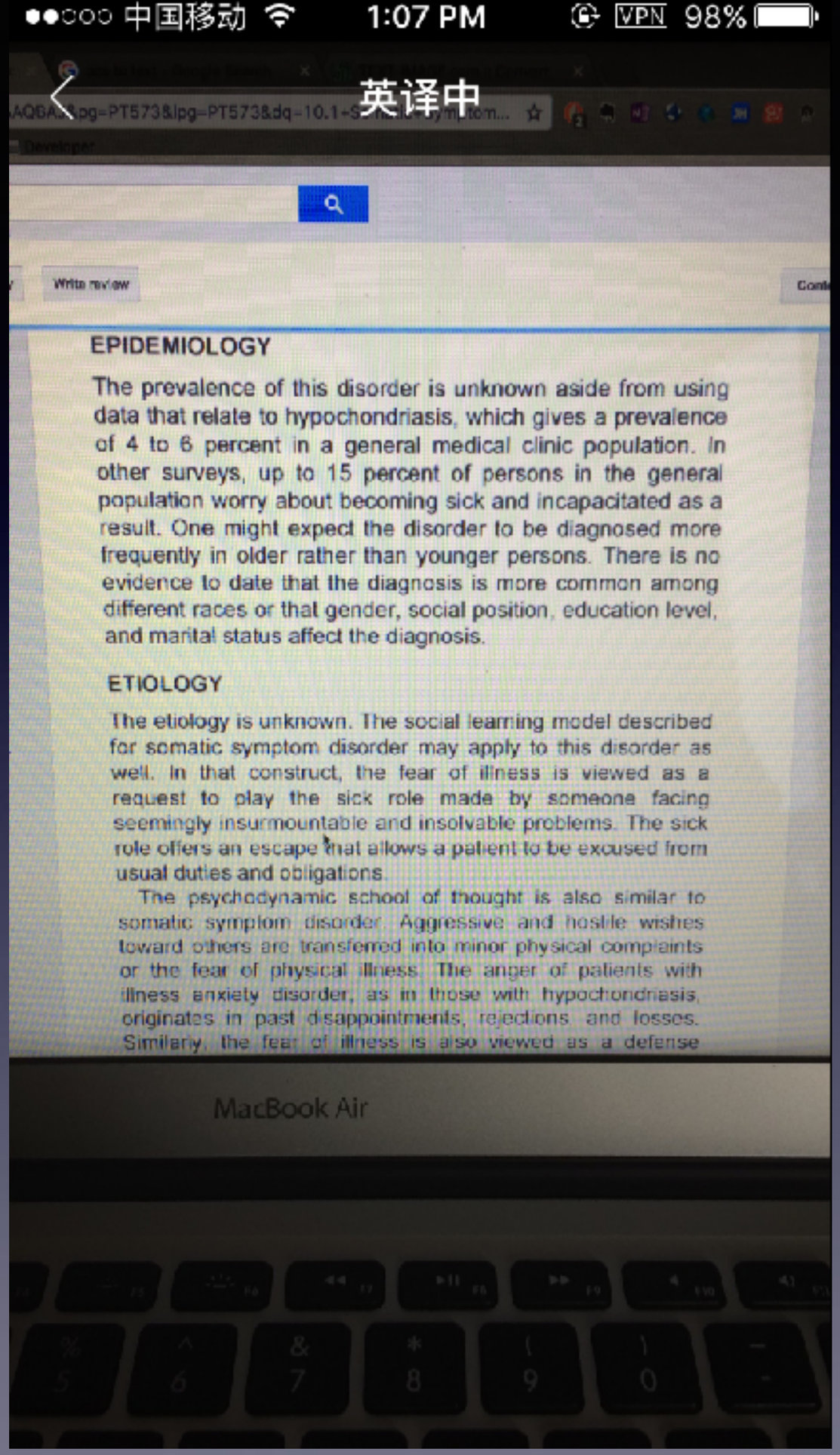
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EPIDEMIOLOGY
The prevalence of this disorder is unknown aside from using data that relate to hypochondriasis, which gives a prevalence of 4 to 6 percent in a general medical clinic population. In other surveys, up to 15 percent of persons in the general population worry about becoming sick and incapacitated as a result. One might expect the disorder to be diagnosed more frequently in older rather than younger persons. There is no evidence to date that the diagnosis is more common among different races or that gender, social position, education level, and marital status affect the diagnosis.
ETIOLOGY
The etiology is unknown. The social learning model described for somatic symptom disorder may apply to this disorder as well. In that construct, the fear of illness is viewed as a request to play the sick role made by someone facing seemingly insurmountable and insolvable problems. The sick role offers an escape that allows a patient to be excused from usual duties and obligations.
The psychodynamic school of thought is also similar to somatic symptom disorder. Aggressive and hostile wishes toward others are transferred into minor physical complaints or the fear of physical illness. The anger of patients with illness anxiety disorder, as in those with hypochondriasis, originates in past disappointments, rejections, and losses. Similarly, the fear of illness is also viewed as a defense
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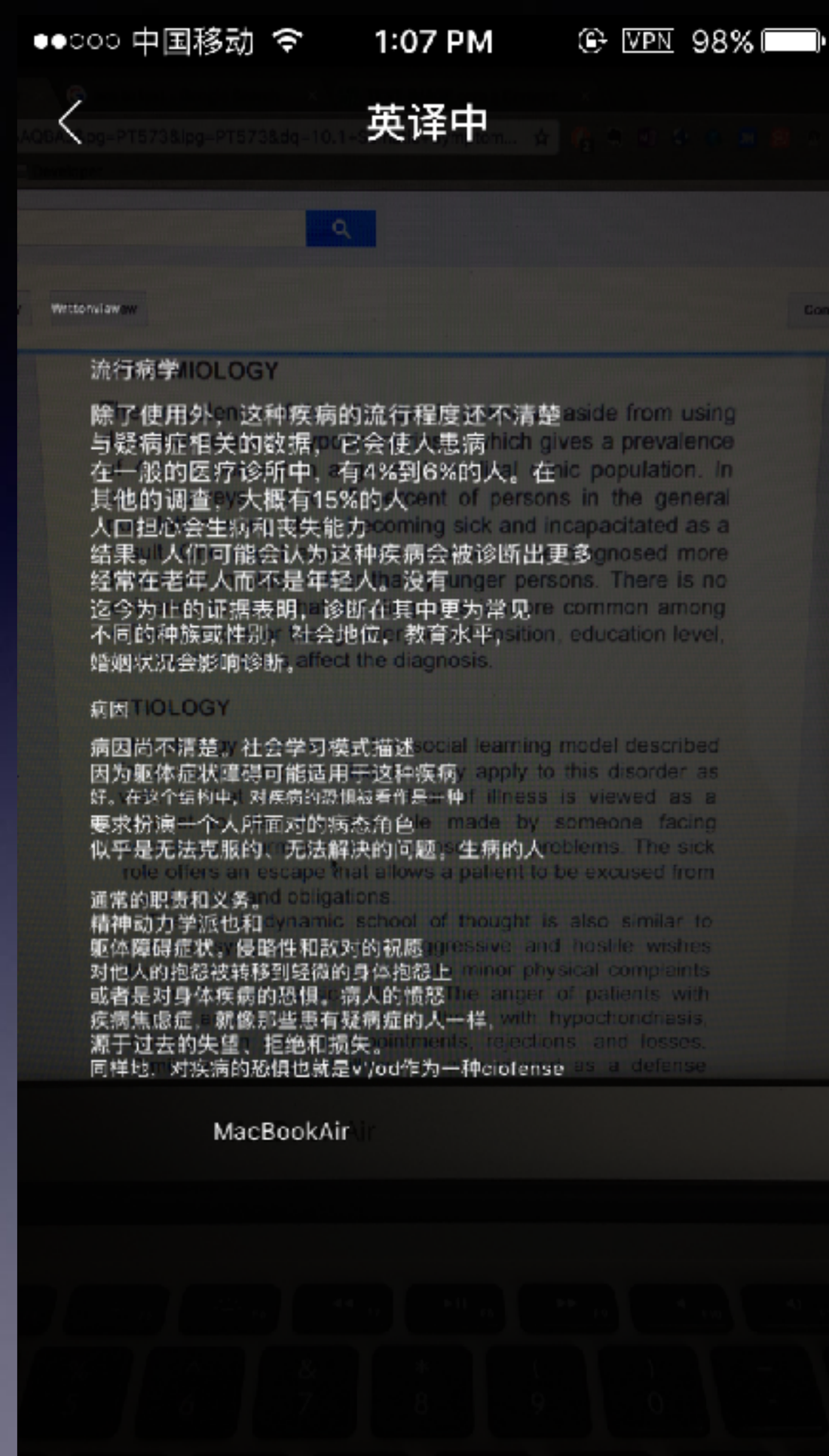
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流行病学MIOLOGY
除了使用外，这种疾病的流行程度还不清楚
与疑病症相关的数据，它会使人患病
在一般的医疗诊所中，有4%到6%的人。在
其他的调查，大概有15%的人
人口担心会生病和丧失能力
结果。人们可能会认为这种疾病会被诊断出更多
经常在老年人而不是年轻人。没有
迄今为止的证据表明，诊断在其中更为常见
不同的种族或性别，社会地位，教育水平，
婚姻状况会影响诊断。
病因TIOLOGY
病因尚不清楚。社会学习模式描述
因为躯体症状障碍可能适用于这种疾病
好。在这个结构中，对疾病的恐惧被看作是一种
要求扮演一个人所面对的病态角色
似乎是无法克服的、无法解决的问题。生病的人
通常的职责和义务。
精神动力学派也和
躯体障碍症状。侵略性和敌对的祝愿
对他人的抱怨被转移到轻微的身体抱怨上
或者是对身体疾病的恐惧。病人的愤怒
疾病焦虑症，就像那些患有疑病症的人一样，
源于过去的失望、拒绝和损失。
同样地，对疾病的恐惧也被视为一种防御
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ETIOLOGY

The etiology is unknown. The social learning model described for somatic symptom disorder may apply to this disorder as well. In that construct, the fear of illness is viewed as a request to play the sick role made by someone facing seemingly insurmountable and insolvable problems. The sick role offers an escape that allows a patient to be excused from usual duties and obligations.

The psychodynamic school of thought is also similar to somatic symptom disorder. Aggressive and hostile wishes toward others are transferred into minor physical complaints or the fear of physical illness. The anger of patients with illness anxiety disorder, as in those with hypochondriasis, originates in past disappointments, rejections, and losses. Similarly, the fear of illness is also viewed as a defense against guilt, a sense of innate badness, an expression of low self-esteem, and a sign of excessive self-concern. The feared illness may also be seen as punishment for past either real or imaginary wrongdoing. The nature of the person's relationships to significant others in his or her past life may also be significant. A parent who died from a specific illness, for example, might be the stimulus for the fear of developing that illness in the offspring of that parent. The type of the fear

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病因OLOGY

病因尚不清楚。躯体症状障碍所描述的社会学习模式也适用于这种疾病。在这个构想中，对疾病的恐惧被看作是一个要求，扮演一个面对看似无法克服且无法解决的问题的人所扮演的角色。生病的角色提供了一个逃避的机会让病人免除通常的责任和义务

心理动力学派也类似于躯体症状紊乱，对他人的敌对意愿被转移到轻微的生理疾病或对身体疾病的恐惧中。患有疑病症的患者的愤怒来自于那些患有疑病症的患者。

过去的失望被拒绝，同样地，对疾病的恐惧也被看作是对内疚的防御，一种天生的坏的感觉，一种低自尊的表达，以及一种过度自我关注的迹象。害怕的疾病也可能被视为对过去的惩罚，不管是真实的还是想象中的错误。在他或她过去的生活中，这个人与其他重要的人的关系的本质也可能是重要的RA父母死于特定的疾病，例如，可能是由于害怕在父母的后代中发展这种疾病而产生的刺激。恐惧的类型

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but there is often an obsessive quality to the patients fear.

COURSE AND PROGNOSIS

Because the disorder is only recently described, there are no reliable data about the prognosis. One may extrapolate from the course of somatic symptom disorder, which is usually episodic; the episodes last from months to years and are separated by equally long quiescent periods. As with hypochondriasis, a good prognosis is associated with high socioeconomic status, treatment-responsive anxiety or depression, sudden onset of symptoms, the absence of a personality disorder, and the absence of a related nonpsychiatric medical condition.

TREATMENT

As with somatic symptom disorder, patients with illness anxiety disorder usually resist psychiatric treatment, although some accept this treatment if it takes place in a medical setting and focuses on stress reduction and education in coping with chronic illness. Group psychotherapy may be of help especially if the group is homogeneous with patients suffering from the same disorder. Other forms of psychotherapy, such as individual insight-oriented psychotherapy, behavior therapy, cognitive therapy, and hypnosis, may be useful.

The role of frequent, regularly scheduled physical examinations is controversial. Some patients may benefit

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但是，病人的恐惧往往是一种强迫性的品质。

病程和预后AND PROGNOSIS

因为这种疾病只是最近才被描述的，没有关于预后的可靠数据。在，?可以推断躯体症状障碍的过程，通常是情景;这一集的持续时间是几个月到几年用同样长的静止时间间隔分开。与疑病症，预后良好社会经济地位，治疗反应性焦虑抑郁，突然出现的症状，没有a人格障碍，以及相关的缺失非精神疾病。

治疗REATMENT

和躯体症状障碍一样，患者也有疾病焦虑症通常会抵抗精神病治疗，尽管有些人接受这种治疗如果它发生在医学上制定和关注减轻压力和教育应对慢性疾病。团体心理治疗可能是特别是如果患者与患者是一致的患有同样的疾病。其他形式的心理疗法，比如个人的以个人为导向的心理疗法，行为疗法，认知疗法。催眠可能是有用的。

频繁的定期安排的身体的角色考试是有争议的)一些病人可能会受益

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nonpsychiatric medical condition.

TREATMENT

As with somatic symptom disorder, patients with illness anxiety disorder usually resist psychiatric treatment, although some accept this treatment if it takes place in a medical setting and focuses on stress reduction and education in coping with chronic illness. Group psychotherapy may be of help especially if the group is homogeneous with patients suffering from the same disorder. Other forms of psychotherapy, such as individual insight-oriented psychotherapy, behavior therapy, cognitive therapy, and hypnosis, may be useful.

The role of frequent, regularly scheduled physical examinations is controversial. Some patients may benefit from being reassured that their complaints are being taken seriously and that they do not have the illness of which they are afraid. Others, however, are resistant to seeing a doctor in the first place, or, if having done so, of accepting the fact that there is nothing to worry about. Invasive diagnostic and therapeutic procedures should only be undertaken when objective evidence calls for them. When possible, the clinician should refrain from treating equivocal or incidental physical

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治疗ATMENT

和躯体症状障碍一样。焦虑症患者疾病通常抗拒心理治疗,尽管一些接受这个治疗如果节拍在医疗环境和关注减压和教育在应对慢性疾病组织心理疗法可能帮助尤其是组织均匀患有同样的障碍。其他形式的个体导向心理疗法，心理疗法，诸如治疗，认知疗法和催眠等行为可能是有用的。

频繁定期的身体检查的作用是有争议的。一些病人可能会因为他们的抱怨被认真对待而感到欣慰，而他们并没有他们所害怕的疾病。别人。然而。一开始就不愿意去看医生，或者，如果这样做了，就会接受这样一个事实:没什么好担心的。只有在客观证据要求的情况下，才应该进行侵入性诊断和治疗。在可能的时候，临床医生应避免对模棱两可或偶然的身体进行治疗。

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examination findings.

Pharmacotherapy may be of help in alleviating the anxiety generated by the fear that the patient has about illness, especially if it is one that is life-threatening; but it is only ameliorative and cannot provide lasting relief. That can only come from an effective psychotherapeutic program that is acceptable to the patient and in which he or she is willing and able to participate.

10.3 Functional Neurological Symptom Disorder (Conversion Disorder)

Conversion disorder, also called functional neurological symptom disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5), is an illness of symptoms or deficits that affect voluntary motor or sensory functions, which suggest another medical condition, but that is judged to be caused by psychological factors because the illness is preceded by conflicts or other stressors. The symptoms or deficits of conversion disorder are not intentionally produced, are not caused by substance use, are not limited to pain or sexual symptoms, and the gain is primarily psychological and not social, monetary, or legal.

The syndrome currently known as *conversion disorder* was originally combined with the syndrome known as *somatization disorder* and was referred to as hysteria, conversion reaction, or dissociative reaction. Paul Briquet and Jean-Martin Charcot contributed to the development of the concept of

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检查发现。
药物疗法可能有助于缓解焦虑
由于害怕病人有疾病，
特别是如果它是危及生命的;但这只是
改善，不能提供持久的缓解。这只会
来自一个有效的心理治疗项目
病人可以接受的，他或她愿意的
能够参与。

e - 310.3功能神经症状
障碍(转换障碍)

转化障碍，也叫功能性神经学
诊断和统计手册中的症状障碍
精神障碍，第五版(dsm-5)。是一种疾病
影响自主运动或感觉的症状或缺陷
功能，暗示了另一种医疗条件，但是
被认为是由心理因素引起的
疾病是由冲突或其他压力造成的。
转化障碍的症状或缺陷不是
故意制造，不是由物质使用造成的，
不局限于疼痛或性症状，而获得的好处是
主要是心理上的，而不是社会的，货币的或法律的。
目前被称为转化障碍的综合症是
最初与被称为躯体化的综合症合并在一起
紊乱，被称为歇斯底里，转化反应，
或者是Paul Briquet和让-马丁的分离反应

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Write review

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The syndrome currently known as *conversion disorder* was originally combined with the syndrome known as *somatization disorder* and was referred to as hysteria, conversion reaction, or dissociative reaction. Paul Briquet and Jean-Martin Charcot contributed to the development of the concept of conversion disorder by noting the influence of heredity on the symptom and the common association with a traumatic event. The term conversion was introduced by Sigmund Freud, who, based on his work with Anna O, hypothesized that the symptoms of conversion disorder reflect unconscious conflicts.

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103个功能性神经症状

障碍(转换障碍)

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影响自主运动或感觉的症状或缺陷
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被认为是由心理因素引起的
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主要是心理上的，而不是sodal的。货币,或法律。
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最初与被称为躯体化的综合症合并在一起
紊乱，被称为歇斯底里，转化反应，
或离解反应。保罗煤砖,让
Charcot对这一概念的发展做出了贡献
转化障碍通过注意遗传对其的影响
症状和与创伤事件的共同联系。
这个词是由Sigmund Freud提出的，
根据他与安娜O的工作，假设
转化障碍的症状反映了无意识
冲突。

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EPIDEMIOLOGY

Some symptoms of conversion disorder that are not sufficiently severe to warrant the diagnosis may occur in up to one-third of the general population sometime during their lives. Reported rates of conversion disorder vary from 11 of 100,000 to 300 of 100,000 in general population samples. Among specific populations, the occurrence of conversion disorder may be even higher than that, perhaps making conversion disorder the most common somatoform disorder in some populations. Several studies have reported that 5 to 15 percent of psychiatric consultations in a general hospital and 25 to 30 percent of admissions to a Veterans Administration hospital involve patients with conversion disorder diagnoses.

The ratio of women to men among adult patients is at least 2 to 1 and as much as 10 to 1; among children, an even higher predominance is seen in girls. Symptoms are more common on the left than on the right side of the body in women. Women who present with conversion symptoms are more likely subsequently to develop somatization disorder than women who have not had conversion symptoms. An association exists between conversion disorder and antisocial personality disorder in men. Men with conversion disorder have often been involved in occupational or military accidents. The onset of conversion disorder is generally from late childhood to early adulthood and is rare before 10 years of age or after 35 years of age, but onset as late as the ninth

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流行病学

一些转化障碍的症状是没有的足够严重的情况下，诊断可能会出现在有1/3的普通人口的生活。报告的转化障碍率从11个10万到300万的普通人口样本。在特定人群中，转化的发生障碍可能比这更高，也许是转化障碍最常见的躯体形式障碍在一些人口。有几项研究报告说一般医院的精神病咨询的15%25到30岁的退伍军人都是退伍军人管理医院涉及到患者的转化疾病的诊断。

成年患者中女性与男性的比例至少是2比1，也就是10比1;儿童,甚至一个在吉拉，我们看到了更高的优势。症状更左边的是普通的，而不是右边的女性。有转化症状的妇女更有可能发展成躯体化障碍比没有转化症状的女性要多。一个在转化障碍和反社会之间存在联系人格障碍的人。转换障碍的男性经常涉及到职业或军事事故。转化障碍的发作通常来自于童年晚期到成年早期，在10岁之前是罕见的年龄或阿夫特克35岁。但是cnsct-t-lhy-9

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accidents. The onset of conversion disorder is generally from late childhood to early adulthood and is rare before 10 years of age or after 35 years of age, but onset as late as the ninth decade of life has been reported. When symptoms suggest a conversion disorder onset in middle or old age, the probability of an occult neurological or other medical condition is high. Conversion symptoms in children younger than 10 years of age are usually limited to gait problems or seizures.

Data indicate that conversion disorder is most common among rural populations, persons with little education, those with low intelligence quotients, those in low socioeconomic

groups, and military personnel who have been exposed to combat situations. Conversion disorder is commonly associated with comorbid diagnoses of major depressive disorder, anxiety disorders, and schizophrenia and shows an increased frequency in relatives of probands with conversion disorder. Limited data suggest that conversion symptoms are more frequent in relatives of people with conversion disorder. An increased risk of conversion disorder in monozygotic, but not dizygotic, twin pairs has been reported.

COMORBIDITY

Medical and especially neurological disorders occur

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事故。转换障碍的发病通常从童年到成年早期和后期是罕见的在10岁之前或之后35岁,但开始直到第九十年据报道当症状表明转换障碍发病中年或老年时,一个神秘的神经或其他医疗条件的概率很高。

10岁以下儿童的转化症状通常局限于步态问题或癫痫发作数据表明在农村人口中，转化障碍是最常见的，受教育程度低的人，智力低的人，低社会经济的人

团体和军事人员都暴露在战斗环境中。“转换”通常与主要抑郁症、焦虑症的共病诊断相关联。精神分裂，并显示在有转化障碍的原带的亲属中有更多的频率。有限的数据表明，在患有转化障碍的人的亲属中，转化症状更为频繁。

在单合子中增加了转化障碍的风险，但不是双卵双胞胎，据报道。

伴随疾病

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COMORBIDITY

Medical and, especially, neurological disorders occur frequently among patients with conversion disorders. What is typically seen in these comorbid neurological or medical conditions is an elaboration of symptoms stemming from the original organic lesion.

Depressive disorders, anxiety disorders, and somatization disorders are especially noted for their association with conversion disorder. Conversion disorder in schizophrenia is reported, but it is uncommon. Studies of patients admitted to a psychiatric hospital for conversion disorder reveal, on further study, that one-quarter to one-half have a clinically significant mood disorder or schizophrenia.

Personality disorders also frequently accompany conversion disorder, especially the histrionic type (in 5 to 21 percent of cases) and the passive-dependent type (9 to 40 percent of cases). Conversion disorders can occur, however, in persons with no predisposing medical, neurological, or psychiatric disorder.

ETIOLOGY

Psychoanalytic Factors

According to psychoanalytic theory, conversion disorder is caused by repression of unconscious intrapsychic conflict and

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伴随疾病RBIDITY

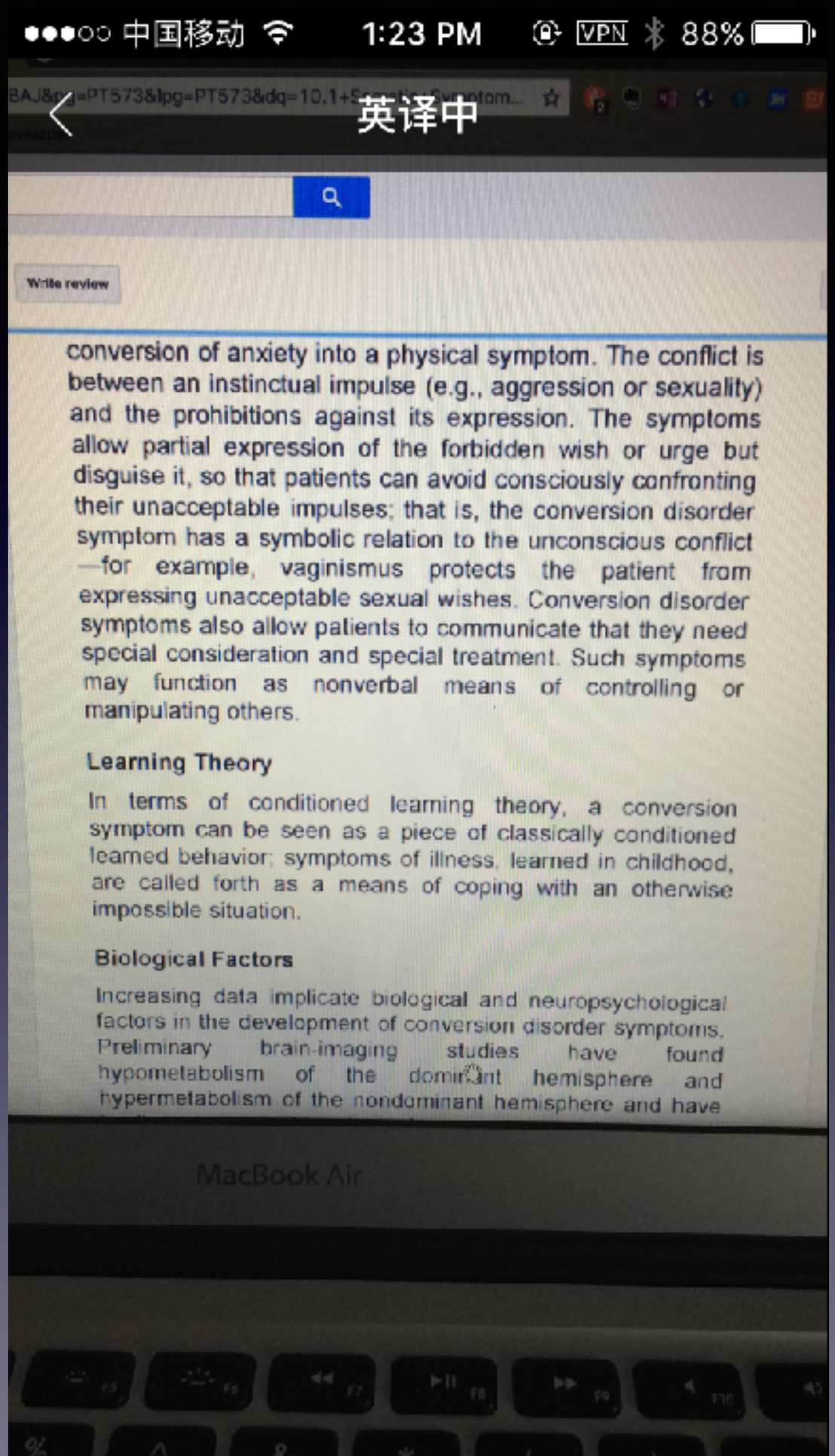
医疗和。特别是，神经障碍经常发生在有转化障碍的患者中。在这些共病神经或医疗条件下通常会出现的症状是由最初的有机病变引起的症状

抑郁障碍。焦虑症和躯体化障碍尤其因其与转化障碍的联系而被特别注意。精神分裂症的转化障碍是报告的，但对于入院治疗的患者来说，在进一步的研究中发现，四分之一到一半的患者有临床显著的心境障碍或精神分裂症的人格障碍也经常伴随转化障碍。特别是有组织的类型(在5%到21%的病例中)和被动依赖型(9%到40%的病例)。然而，转化障碍可能会发生。在没有预先治疗的病人中。神经系统或精神障碍

病因OLOGY

精神分析的因素ic Factors

根据精神分析理论，转化障碍是由于对无意识的内在冲突的压抑造成的。ed by repression of unconscious intrapsychic conflict and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conversion of anxiety into a physical symptom. The conflict is between an instinctual impulse (e.g., aggression or sexuality) and the prohibitions against its expression. The symptoms allow partial expression of the forbidden wish or urge but disguise it, so that patients can avoid consciously confronting their unacceptable impulses; that is, the conversion disorder symptom has a symbolic relation to the unconscious conflict —for example, vaginismus protects the patient from expressing unacceptable sexual wishes. Conversion disorder symptoms also allow patients to communicate that they need special consideration and special treatment. Such symptoms may function as nonverbal means of controlling or manipulating others.
Learning Theory
In terms of conditioned learning theory, a conversion symptom can be seen as a piece of classically conditioned learned behavior; symptoms of illness, learned in childhood, are called forth as a means of coping with an otherwise impossible situation.
Biological Factors
Increasing data implicate biological and neuropsychological factors in the development of conversion disorder symptoms. Preliminary brain-imaging studies have found hypometabolism of the dominant hemisphere and hypermetabolism of the nondominant hemisphere and have
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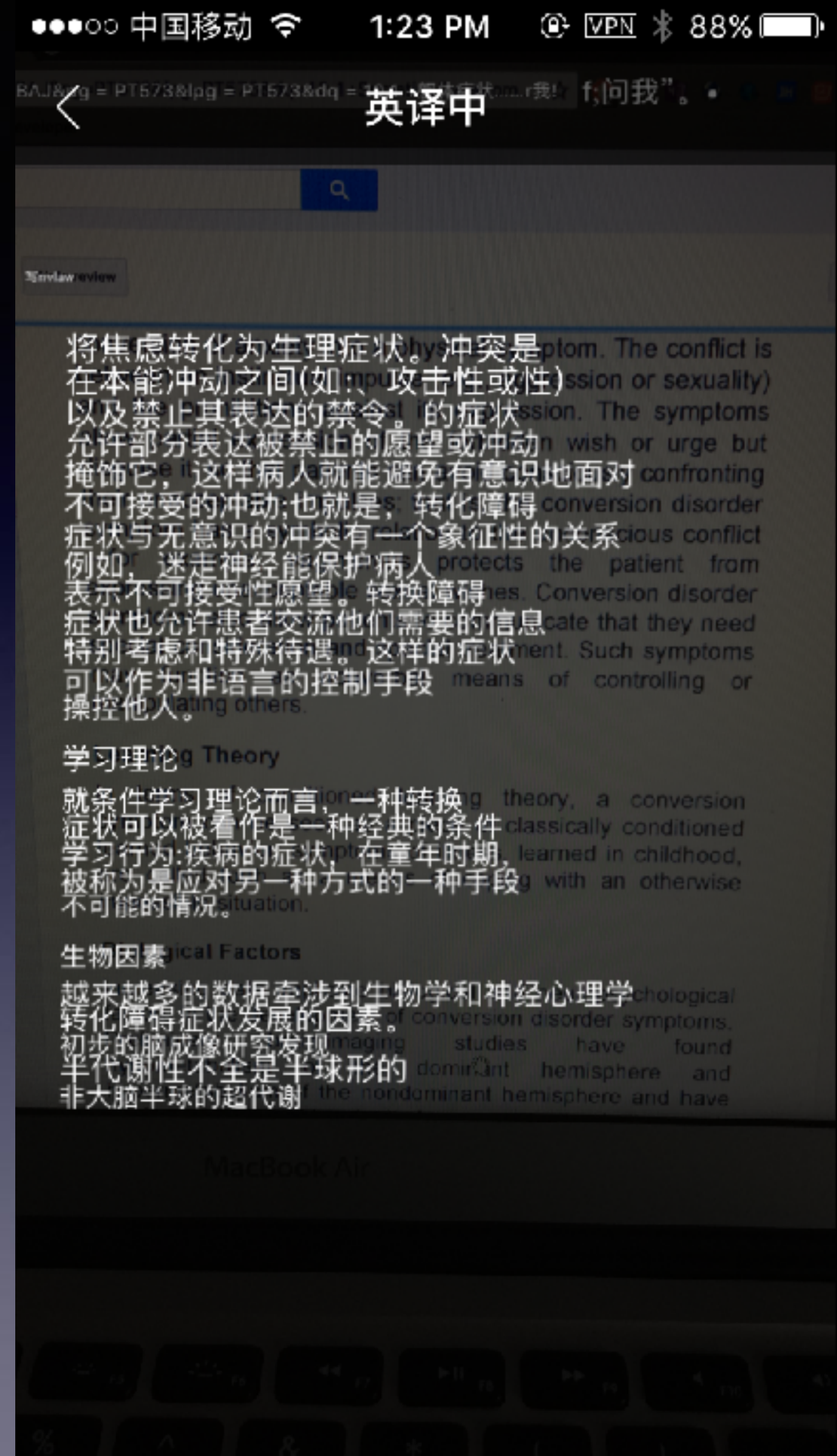
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将焦虑转化为生理症状。冲突是
在本能冲动之间(如：攻击性或性)
以及禁止其表达的禁令。的症状
允许部分表达被禁止的愿望或冲动
掩饰它，这样病人就能避免有意识地面对
不可接受的冲动;也就是，转化障碍
症状与无意识的冲突有一个象征性的关系
例如，迷走神经能保护病人
表示不可接受性愿望。转换障碍
症状也允许患者交流他们需要的信息
特别考虑和特殊待遇。这样的症状
可以作为非语言的控制手段
操控他人。
学习理论
就条件学习理论而言，一种转换
症状可以被看作是一种经典的条件
学习行为:疾病的症状，在童年时期，
被称为是应对另一种方式的一种手段
不可能的情况。
生物因素
越来越多的数据牵涉到生物学和神经心理学
转化障碍症状发展的因素。
初步的脑成像研究发现
半代谢性不全是半球形的
非大脑半球的超代谢

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may function as nonverbal means of controlling or manipulating others.

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Biological Factors

Increasing data implicate biological and neuropsychological factors in the development of conversion disorder symptoms. Preliminary brain-imaging studies have found hypometabolism of the dominant hemisphere and hypermetabolism of the nondominant hemisphere and have implicated impaired hemispheric communication in the cause of conversion disorder. The symptoms may be caused by an excessive cortical arousal that sets off negative feedback loops between the cerebral cortex and the brainstem reticular formation. Elevated levels of corticofugal output, in turn, inhibit the patient's awareness of bodily sensation, which may explain the observed sensory deficits in some patients with conversion disorder. Neuropsychological tests sometimes

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可以作为控制或操纵他人的非语言手段。

学习理论 Theory

在条件学习理论中，一个转化症状可以被看作是一种经典的、有条件的行为;儿童时期的疾病症状被称为应对不可能的情况的一种手段。

生物因素cal Factors

越来越多的数据暗示了生物和神经心理因素在转化障碍症状的发展。

初步的脑成像研究发现，低代谢非主脑半球的主导半球和超代谢，并与脑半球的沟通障碍有关。这些症状可能是由过度的皮质性兴奋引起的，它在大脑皮层和脑干网状结构之间引发了负反馈回路。而肾上腺皮质激素水平的升高反过来又抑制了病人对身体感觉的感知，这可能解释了一些患有转化障碍神经心理测试的患者的观察到的感觉缺陷。

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been shy as an adolescent, particularly around athletic participation. He had never had another episode of visual loss. He did recount feeling anxious and sometimes not feeling well in his body during athletic activities.

Discussion with the patient at the mental health center focused on the potential role of psychological and social factors in acute vision loss. The patient was somewhat perplexed by this but was also amenable to discussion. He stated that he clearly recognized that he began seeing and feeling better when his father pulled off to the side of the road and discussed things with him. Doctors admitted that they did not know the cause of the vision loss and that it would likely not return. The patient and his father were satisfied with the medical and psychiatric evaluation and agreed to return for care if there were any further symptoms. The patient was appointed a follow-up time at the outpatient psychiatric clinic. *(Courtesy of Michael A. Hollifield, M.D.)*

Sensory Symptoms

In conversion disorder, anesthesia and paresthesia are common, especially of the extremities. All sensory modalities can be involved, and the distribution of the disturbance is usually inconsistent with either central or peripheral neurological disease. Thus, clinicians may see the

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青少年时期就很害羞，尤其是在运动方面
参与。他从未有过另一集
视觉的损失。他重新叙述了他的焦虑
有时在运动时身体不舒服
活动。

与患者讨论心理健康问题
研究中心关注心理的潜在作用
以及急性视力丧失的社会因素。病人
有点不知所措，但也很容易接受
讨论。他说他很清楚地认识到
他的父亲拉着他的父亲，开始看他，感觉好多了。
在路的一边，讨论了一些事情
他。医生承认他们不知道原因
在视力丧失的情况下，它很可能不会返回。那
病人和他的父亲对医疗感到满意
以及精神病评估并同意返回治疗
如果有进一步的症状。病人
指定了门诊精神病患者的随访时间
我的诊所。(Michael A Hollifield，医学博士)

感觉症状

在转化障碍中，麻醉和感觉异常
常见的，尤其是四肢的。所有的感觉形式
可以参与进来，干扰的分布是
通常与cenlial或外围不一致
神经系统疾病。因此，临床医生可能会看到

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Sensory Symptoms

In conversion disorder, anesthesia and paresthesia are common, especially of the extremities. All sensory modalities can be involved, and the distribution of the disturbance is usually inconsistent with either central or peripheral neurological disease. Thus, clinicians may see the characteristic stocking-and-glove anesthesia of the hands or feet or the hemianesthesia of the body beginning precisely along the midline.

Conversion disorder symptoms may involve the organs of special sense and can produce deafness, blindness, and tunnel vision. These symptoms can be unilateral or bilateral, but neurological evaluation reveals intact sensory pathways. In conversion disorder blindness, for example, patients walk around without collisions or self-injury, their pupils react to light, and their cortical evoked potentials are normal.

Motor Symptoms

The motor symptoms of conversion disorder include abnormal movements, gait disturbance, weakness, and paralysis. Gross rhythmical tremors, choreiform movements, tics, and

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感觉症状 Symptoms

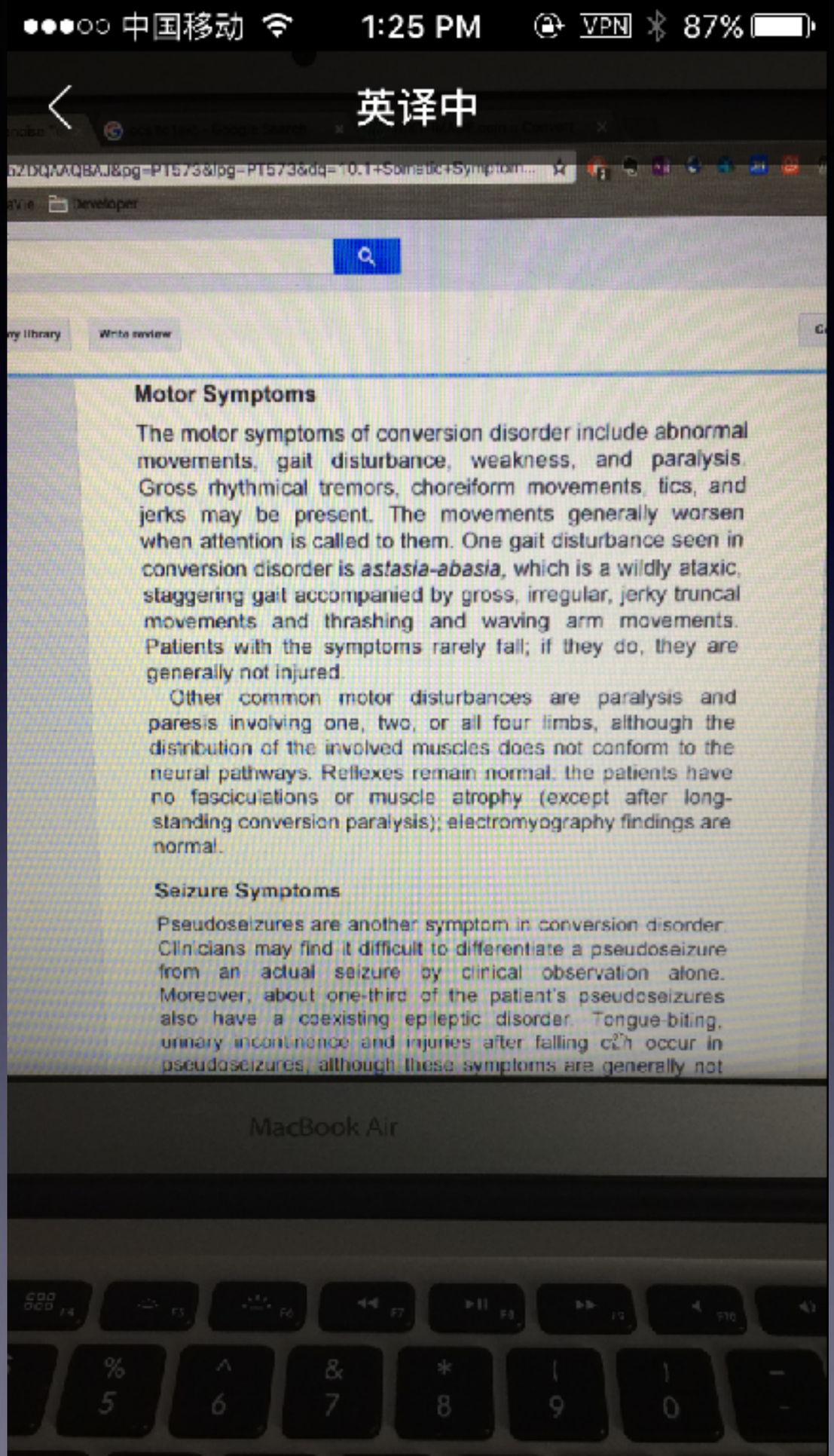
转换障碍。麻醉和感觉异常是常见的，尤其是在四肢所有感觉形态都可以参与其中。这种干扰的分布通常与中枢神经疾病或周围神经系统疾病不一致。因此，临床医生可能会看到，在足部的半麻醉状态下，他们的手在脚上的麻木和戈夫的麻醉。

转换障碍的症状可能包括特殊感觉器官，并可产生耳聋，失明，视野狭窄。这些症状在双边上是单边的，但神经系统的评估揭示了完整的感觉途径。例如，在转化障碍盲症中，患者行走

在没有碰撞或自我伤害的情况下，他们的瞳孔会对光线做出反应，而他们的皮质诱发电位是正常的

运动症状 ymptoms

转化障碍的运动症状包括异常运动aait障碍和“麻痹性心律失常的运动抽搐”。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Motor Symptoms
The motor symptoms of conversion disorder include abnormal movements, gait disturbance, weakness, and paralysis. Gross rhythmical tremors, choreiform movements, tics, and jerks may be present. The movements generally worsen when attention is called to them. One gait disturbance seen in conversion disorder is astasia-abasia, which is a wildly ataxic, staggering gait accompanied by gross, irregular, jerky truncal movements and thrashing and waving arm movements. Patients with the symptoms rarely fall; if they do, they are generally not injured.
Other common motor disturbances are paralysis and paresis involving one, two, or all four limbs, although the distribution of the involved muscles does not conform to the neural pathways. Reflexes remain normal; the patients have no fasciculations or muscle atrophy (except after long-standing conversion paralysis); electromyography findings are normal.
Seizure Symptoms
Pseudoseizures are another symptom in conversion disorder. Clinicians may find it difficult to differentiate a pseudoseizure from an actual seizure by clinical observation alone. Moreover, about one-third of the patient's pseudoseizures also have a coexisting epileptic disorder. Tongue-biting, urinary incontinence and injuries after falling occur in pseudoseizures, although these symptoms are generally not
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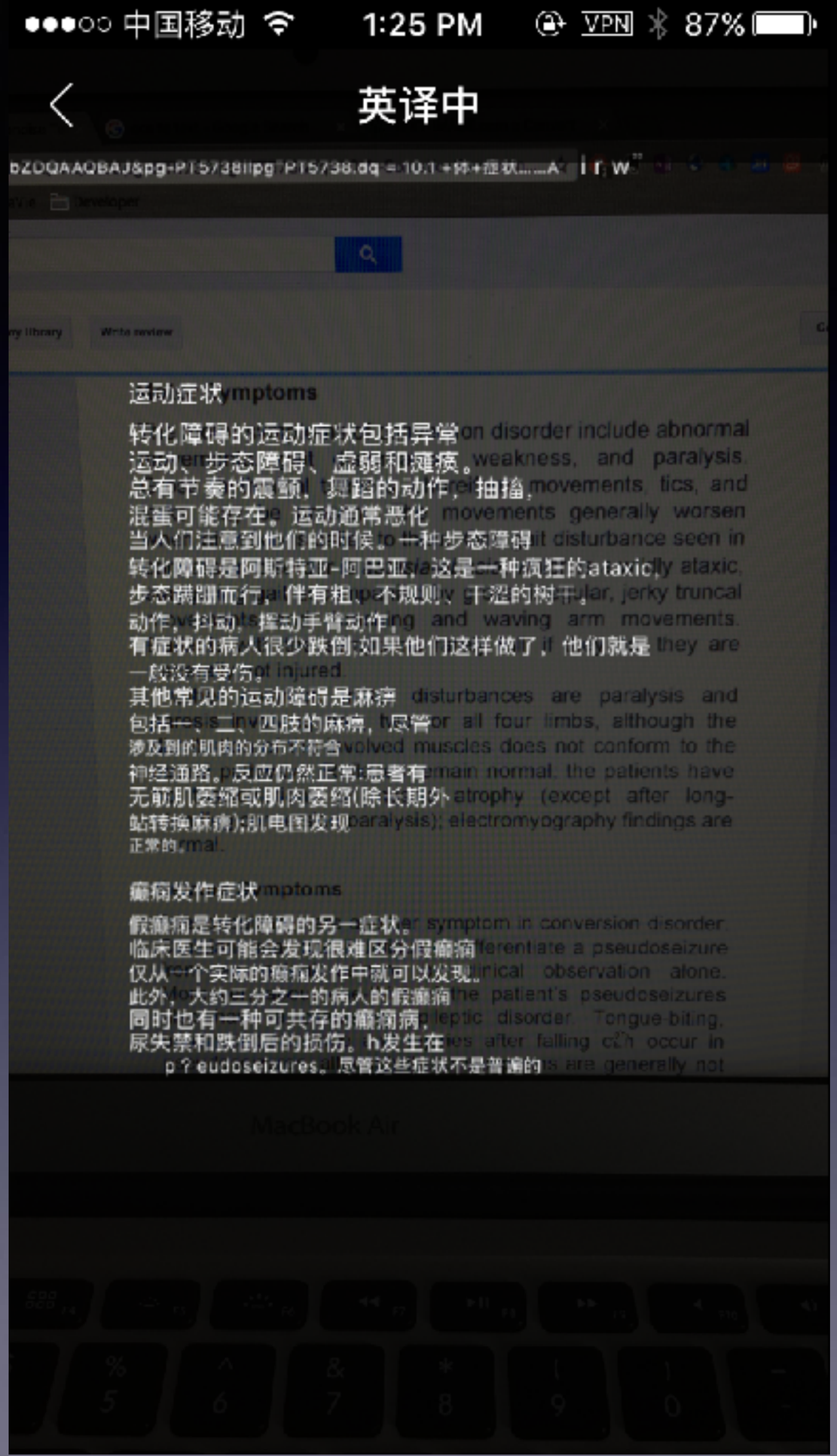
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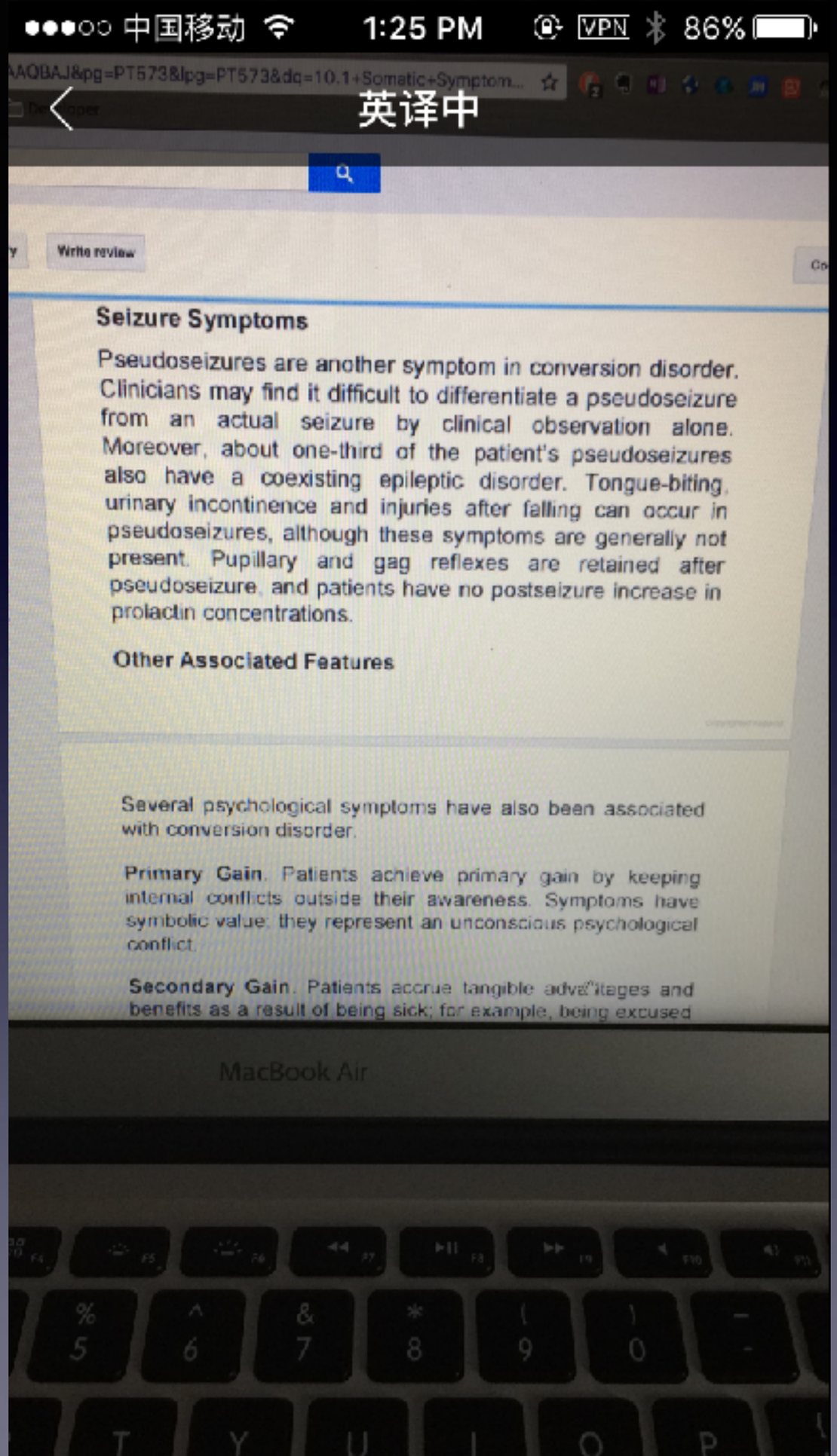
运动症状
转化障碍的运动症状包括异常运动、步态障碍、虚弱和瘫痪。总有节奏的震颤、舞蹈的动作、抽搐、混蛋可能存在。运动通常恶化当人们注意到他们的时候。一种步态障碍转化障碍是阿斯特亚-阿巴亚，这是一种疯狂的ataxic步态蹒跚而行，伴有粗、不规则、干涩的树干动作，抖动，挥动手臂动作。有症状的病人很少跌倒;如果他们这样做了，他们就是一般没有受伤。
其他常见的运动障碍是麻痹包括一、二、四肢的麻痹，尽管涉及到的肌肉的分布不符合神经通路。反应仍然正常;患者有无前肌萎缩或肌肉萎缩(除长期外站转换麻痹);肌电图发现正常的
癫痫发作症状
假癫痫是转化障碍的另一症状。临床医生可能会发现很难区分假癫痫仅从一个实际的癫痫发作中就可以发现。此外，大约三分之一的病人的假癫痫同时也有一种可共存的癫痫病，尿失禁和跌倒后的损伤。h发生在p？eudoseizures。尽管这些症状不是普遍的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Seizure Symptoms
Pseudoseizures are another symptom in conversion disorder. Clinicians may find it difficult to differentiate a pseudoseizure from an actual seizure by clinical observation alone. Moreover, about one-third of the patient's pseudoseizures also have a coexisting epileptic disorder. Tongue-biting, urinary incontinence and injuries after falling can occur in pseudoseizures, although these symptoms are generally not present. Pupillary and gag reflexes are retained after pseudoseizure, and patients have no postseizure increase in prolactin concentrations.
Other Associated Features
Several psychological symptoms have also been associated with conversion disorder.
Primary Gain. Patients achieve primary gain by keeping internal conflicts outside their awareness. Symptoms have symbolic value; they represent an unconscious psychological conflict.
Secondary Gain. Patients accrue tangible advantages and benefits as a result of being sick; for example, being excused
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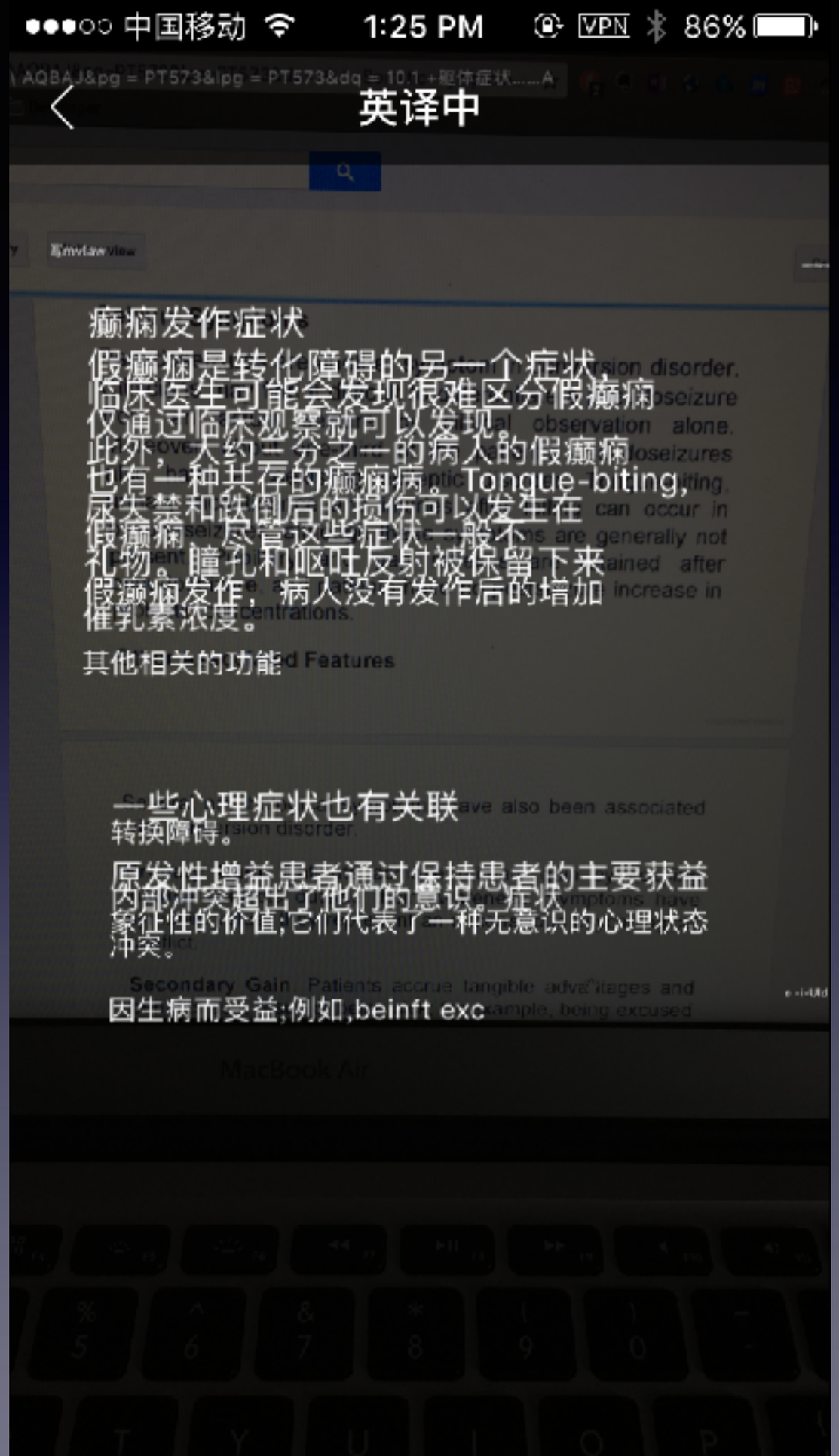
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癫痫发作症状
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也有一种共存的癫痫病。Tongue-biting,
尿失禁和跌倒后的损伤可以发生在
假癫痫，尽管这些症状一般不
在。瞳孔和呕吐反射被保留下来
假癫痫发作，病人没有发作后的增加
催乳素浓度。
其他相关的功能
一些心理症状也有关联
转换障碍。
原发性增益患者通过保持患者的主要获益
内部冲突超出了他们的意识。症状
象征性的价值;它们代表了一种无意识的心理状态
冲突。
因生病而受益;例如,beinft exc

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with conversion disorder.

Primary Gain. Patients achieve primary gain by keeping internal conflicts outside their awareness. Symptoms have symbolic value; they represent an unconscious psychological conflict.

Secondary Gain. Patients accrue tangible advantages and benefits as a result of being sick; for example, being excused from obligations and difficult life situations, receiving support and assistance that might not otherwise be forthcoming, and controlling other persons' behavior.

La Belle Indifférence. *La belle indifférence* is a patient's inappropriately cavalier attitude toward serious symptoms; that is, the patient seems to be unconcerned about what appears to be a major impairment. That bland indifference is also seen in some seriously ill medical patients who develop a stoic attitude. The presence or absence of *la belle indifférence* is not pathognomonic of conversion disorder, but it is often associated with the condition.

Identification. Patients with conversion disorder may unconsciously model their symptoms on those of someone important to them. For example, a parent or a person who has recently died may serve as a model for conversion disorder. During pathological grief reaction, bereaved persons commonly have symptoms of the deceased.

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转换障碍nversion disorder.

主要收获。患者通过保持患者的基本获益 gain by keeping
内部冲突超出了他们的意识，症状 wareness. Symptoms have
象征性的价值;它们代表了一种无意识的心理状态 ychological
冲突nflict.

二次收获。患者有明显的优势 accrue tangible advantages and
因生病而受益;例如,被原谅 eing sick; for example, being excused
从义务和艰难的生活环境中获得支持 situations, receiving support
以及其他可能不会出现的援助,以及 erwise be forthcoming, and
控制他人的行为。 ther persons' behavior.

La Belle漠不关心La Belle冷漠是一个病人 *différence* is a patient's
对严重症状不恰当的傲慢态度, attitude toward serious symptoms;
也就是说，病人似乎不关心什么 s to be unconcerned about what
appears to be a major impairment. That bland indifference is
也出现在一些病情严重的病人身上 ly ill medical patients who develop
斯多葛派的态度。la belle的存在或缺失 ce or absence of *la belle*
indifférence is not pathognomonic of conversion disorder, but
它通常与条件有关。associated with the condition.

识别。有转化障碍的患者可能 with conversion disorder may
无意识地将他们的症状反映在某人的症状上 ms on those of someone
对他们来说很重要。例如，父母或人 ple, a parent or a person who
最近去世的可能是Sonversion的一个模型 odel for conversion
障碍。悲伤在病理反应。失去亲人的人 reaction, bereaved persons
通常有死者的症状。 ave symptoms of the deceased.

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DIFFERENTIAL DIAGNOSIS

One of the major problems in diagnosing conversion disorder is the difficulty of definitively ruling out a medical disorder. Concomitant nonpsychiatric medical disorders are common in hospitalized patients with conversion disorder, and evidence

of a current or previous neurological disorder or a systemic disease affecting the brain has been reported in 18 to 64 percent of such patients. An estimated 25 to 50 percent of patients classified as having conversion disorder eventually receive diagnoses of neurological or nonpsychiatric medical disorders that could have caused their earlier symptoms. Thus, a thorough medical and neurological workup is essential in all cases. If the symptoms can be resolved by suggestion, hypnosis, or parenteral amobartital (Amytal) or lorazepam (Ativan), they are probably the result of conversion disorder.

Neurological disorders (e.g., dementia and other degenerative diseases), brain tumors, and basal ganglia disease must be considered in the differential diagnosis. For example, weakness may be confused with myasthenia gravis, polymyositis, acquired myopathies, or multiple sclerosis. Optic neuritis may be misdiagnosed as conversion disorder

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鉴别诊断

诊断转化障碍的主要问题之一
这是彻底排除一种疾病的困难。
伴随的非精神疾病的医学疾病在这方面很常见
有转化障碍的住院病人和证据

在当前或以前的神经系统疾病或系统性疾病中
据报道，18至64岁的脑部疾病已被报道
这样的患者百分比。估计有25%到50%的
最终被归为有转化障碍的患者
接受神经或非精神医学的诊断
可能引起他们早期症状的疾病。
因此，一个彻底的医学和神经病学的工作是
在所有情况下都至关重要。如果症状可以通过
建议，催眠，或肠内膜(戊巴比妥)或
劳拉西泮(Atlvan)，它们可能是转化的结果
障碍。
神经系统疾病(如，痴呆和其他
退化性疾病)，脑肿瘤和基底神经节
例如，虚弱可能与我的虚弱无力，
多肌炎，获得了肌病，或多发性硬化症。

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Neurological disorders (e.g., dementia and other degenerative diseases), brain tumors, and basal ganglia disease must be considered in the differential diagnosis. For example, weakness may be confused with myasthenia gravis, polymyositis, acquired myopathies, or multiple sclerosis. Optic neuritis may be misdiagnosed as conversion disorder blindness. Other diseases that can cause confusing symptoms are Guillain–Barré syndrome, Creutzfeldt–Jakob disease, periodic paralysis, and early neurological manifestations of acquired immunodeficiency syndrome (AIDS). Conversion disorder symptoms occur in schizophrenia, depressive disorders, and anxiety disorders, but these other disorders are associated with their own distinct symptoms that eventually make differential diagnosis possible.

Sensorimotor symptoms also occur in somatization disorder. But somatization disorder is a chronic illness that begins early in life and includes symptoms in many other organ systems. In hypochondriasis, patients have no actual loss or distortion of function; the somatic complaints are chronic and are not limited to neurological symptoms, and the characteristic hypochondriacal attitudes and beliefs are present. If the patient's symptoms are limited to pain, pain disorder can be diagnosed. Patients whose complaints are

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神经系统疾病(如、痴呆和其他退化性疾病)，脑肿瘤和基底神经节在鉴别诊断中必须考虑疾病。为例如，虚弱可能与我的虚弱无力，多肌炎，获得了肌病，或多发性硬化症。视神经炎可能被误诊为转化障碍失明。其他可能引起混淆的疾病症状是格林-巴利综合征，克雅氏病疾病，周期性麻痹，和早期神经学获得性免疫缺陷综合症的表现(艾滋病)。转化障碍症状出现精神分裂症，抑郁症和焦虑症，但是这些其他的障碍与他们自己的不同的症状最终会导致不同的诊断可能的。

感觉运动症状也出现在躯体化障碍。但躯体化障碍是一种慢性疾病在生活中开始，包括许多其他的症状器官系统。在疑病症中，患者没有实际情况功能的丧失或变形；体细胞的投诉是慢性的，不仅限于神经系统症状，还有典型的疑病症态度和信念是障碍可以诊断。病人的投诉

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limited to sexual function are classified as having a sexual dysfunction, rather than conversion disorder.

In both malingering and factitious disorder, the symptoms are under conscious, voluntary control. A malingerer's history is usually more inconsistent and contradictory than that of a patient with conversion disorder, and a malingerer's fraudulent behavior is clearly goal directed.

Table 10.3–1 lists examples of important tests that are relevant to conversion disorder symptoms.

COURSE AND PROGNOSIS

The onset of conversion disorder is usually acute, but a crescendo of symptomatology may also occur. Symptoms or deficits are usually of short duration, and approximately 95 percent of acute cases remit spontaneously, usually within 2 weeks in hospitalized patients. If symptoms have been present for 6 months or longer, the prognosis for symptom resolution is less than 50 percent and diminishes further the longer that conversion is present. Recurrence occurs in one-fifth to one-fourth of people within 1 year of the first episode. Thus, one episode is a predictor for future episodes. A good prognosis is heralded by acute onset, presence of clearly identifiable stressors at the time of onset, a short interval between onset and the institution of treatment, and above average intelligence. Paralysis, aphonia, and blindness are associated with a good prognosis, whereas tremor and seizures are poor prognostic factors.

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性功能被划分为有性行为
功能障碍，而不是转化障碍。
在两种畸形和人为的混乱中，症状
在有意识的、自愿的控制之下。他是个诈病的历史
通常比a更不一致，更矛盾
有转化障碍的病人，还有一个马林格尔人
欺诈行为显然是目标导向的。
表10.1-1列出了重要测试的例子
与转化障碍相关的症状。

病程和预后

转化障碍的发作通常是急性的，但是
症状的逐渐升高也可能发生。症状或
赤字通常是短期的，大约是95
急性病例的百分比是自发的，通常在2以内
周的住院病人。如果症状已经
6个月或更长时间，症状的预后
分辨率小于50%然后进一步降低
转换的时间越长，在一个
第一集的1年里，五分之一到四分之一的人。
因此，一集是未来剧集的预测因子。一个好的
预后预示着急性发作，清晰的出现
可识别的压力源在开始的时间，短时间间隔
在发病和治疗机构之间，以及以上
平均智商。瘫痪，失亚症和失明
与预后良好相关，而颤抖
癫痫发作是预后不良的因素。

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Table 10.3–1
Common Symptoms of Conversion Disorder

Some pages are omitted from this book preview

bank of persons who feign illness has been established to alert hospitals about such patients, many of whom travel from place to place, seek admission under different names, or simulate different illnesses.

Approximately two-thirds of patients with Munchausen syndrome are male. They tend to be white, middle-aged, unemployed, unmarried, and without significant social or family attachments. Patients diagnosed with factitious disorders with physical signs and symptoms are mostly women, who outnumber men 3 to 1. They are usually 20 to 40 years of age with a history of employment or education in nursing or a health care occupation. Factitious physical disorders usually begin for patients in their 20s or 30s.

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表10.3–1
转化障碍的常见症状

在这本书的预览中省略了一些页面

那些假装生病的人已经建立起来，向医院通知这些病人，他们中的许多人从一个地方到另一个地方，以不同的名字寻求入院。或模拟不同的疾病

大约2/3的有门查森综合征的患者是男性，他们往往是白人。中年，失业，未婚，没有明显的社会关系。被诊断为患有身体体征和症状的人为障碍的患者大多为女性。谁比男人多:3比1!。他们通常有20到40岁的年龄，有在护理或医疗行业工作的经历或教育史。F actitious物理病人。20多岁30多岁

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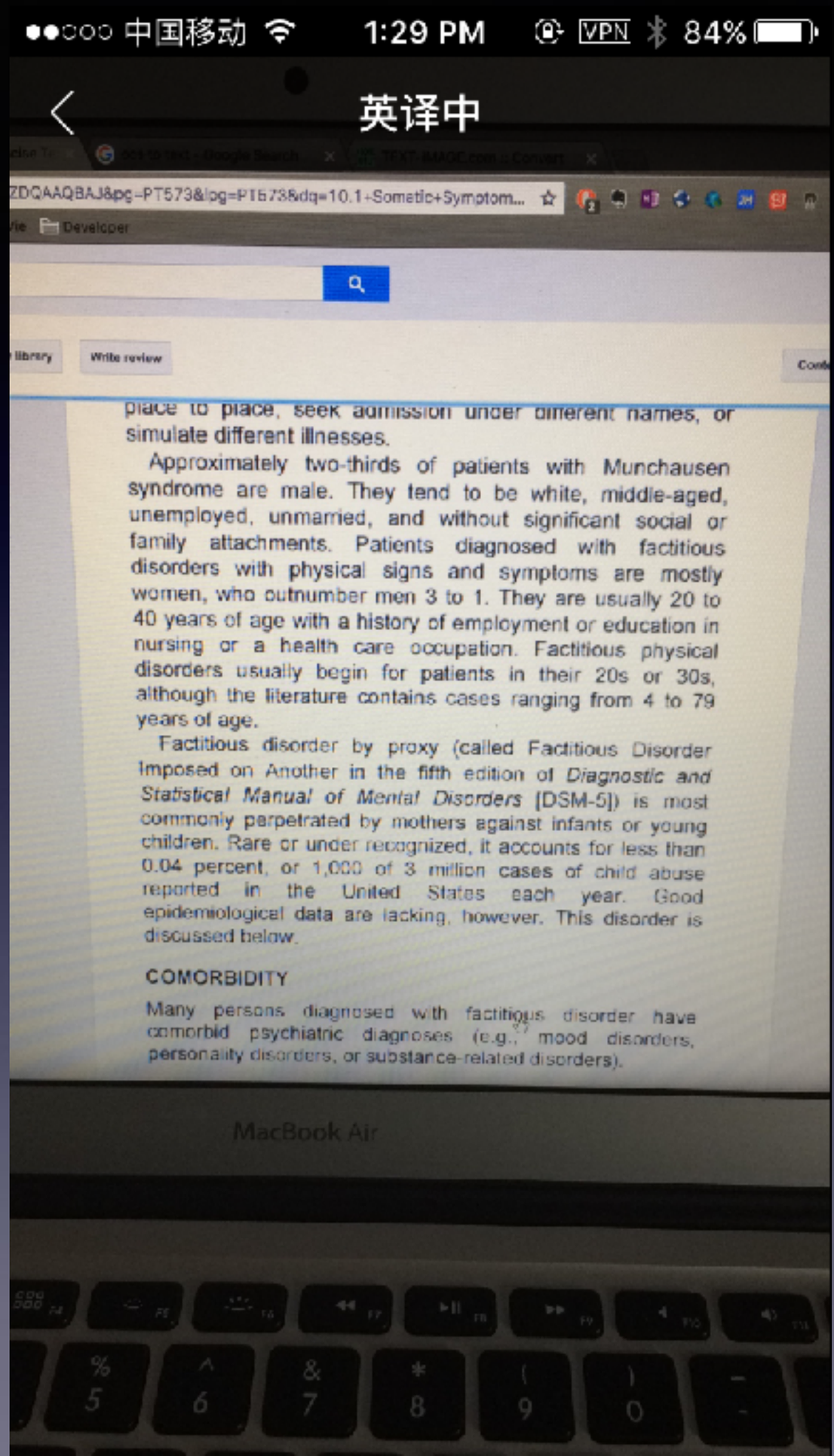
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place to place, seek admission under different names, or simulate different illnesses.
Approximately two-thirds of patients with Munchausen syndrome are male. They tend to be white, middle-aged, unemployed, unmarried, and without significant social or family attachments. Patients diagnosed with factitious disorders with physical signs and symptoms are mostly women, who outnumber men 3 to 1. They are usually 20 to 40 years of age with a history of employment or education in nursing or a health care occupation. Factitious physical disorders usually begin for patients in their 20s or 30s, although the literature contains cases ranging from 4 to 79 years of age.
Factitious disorder by proxy (called Factitious Disorder Imposed on Another in the fifth edition of Diagnostic and Statistical Manual of Mental Disorders [DSM-5]) is most commonly perpetrated by mothers against infants or young children. Rare or under recognized, it accounts for less than 0.04 percent, or 1,000 of 3 million cases of child abuse reported in the United States each year. Good epidemiological data are lacking, however. This disorder is discussed below.
COMORBIDITY
Many persons diagnosed with factitious disorder have comorbid psychiatric diagnoses (e.g., mood disorders, personality disorders, or substance-related disorders).
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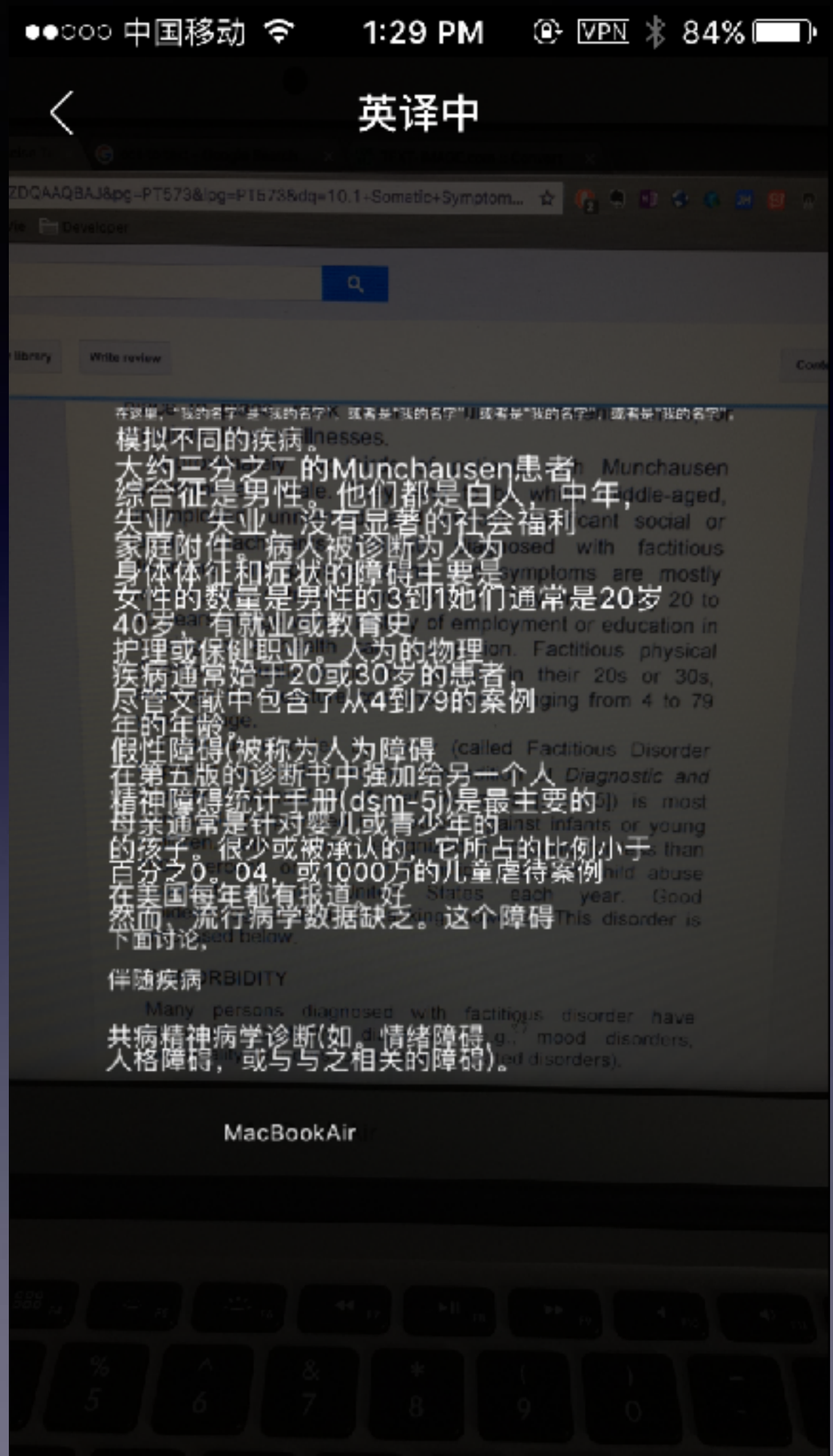
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模拟不同的疾病。
大约三分之二的Munchausen患者
综合征是男性。他们都是白人，中年，
失业，失业，没有显著的社会福利
家庭附件。病人被诊断为人为
身体体征和症状的障碍主要是
女性的数量是男性的3到1她们通常是20岁
40岁，有就业或教育史
护理或保健职业。人为的物理
疾病通常始于20或30岁的患者，
尽管文献中包含了从4到79的案例
年的年龄。
假性障碍(被称为人为障碍
在第五版的诊断书中强加给另一个人
精神障碍统计手册(dsm-5)是最主要的
母亲通常是针对婴儿或青少年的
的孩子。很少或被承认的，它所占的比例小于
百分之0。04，或1000万的儿童虐待案例
在美国每年都有报道。
然而，流行病学数据缺乏。这个障碍
下面讨论。
伴随疾病
共病精神病学诊断(如，情绪障碍，
人格障碍，或与与之相关的障碍)。
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ETIOLOGY

Psychosocial Factors

The psychodynamic underpinnings of factitious disorders are poorly understood because the patients are difficult to engage

in an exploratory psychotherapy process. They may insist that their symptoms are physical and that psychologically oriented treatment is therefore useless. Anecdotal case reports indicate that many of the patients suffered childhood abuse or deprivation, resulting in frequent hospitalizations during early development. In such circumstances, an inpatient stay may have been regarded as an escape from a traumatic home situation, and the patient may have found a series of caretakers (e.g., doctors, nurses, and hospital workers) to be loving and caring. In contrast, the patients' families of origin included a rejecting mother or an absent father. The usual history reveals that the patient perceives one or both parents as rejecting figures who are unable to form close relationships. The facsimile of genuine illness, therefore, is used to recreate the desired positive parent–child bond. The disorders are a form of repetitional compulsion, repeating the basic conflict of needing and seeking acceptance and love

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病因OLOGY

社会心理因素 Factors

人工失调的精神动力基础是 nnings of factitious disorders are
因为病人的参与很难理解 se the patients are difficult to engage

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在一个探索性的心理治疗过程中，他们可能会坚持 y insist that
他们的症状是身体上的和心理上的 that psychologically oriented
因此治疗是无用的。零星的病例报告 Anecdotal case reports
表明很多病人都遭受过童年虐待 nts suffered childhood abuse or
剥夺，导致早期住院治疗 frequent hospitalizations during early
发展。在这种情况下，住院病人可能会住院 an inpatient stay may
被视为逃离创伤家庭的一种解脱 escape from a traumatic home
情况，病人可能已经发现了一系列的 have found a series of
监护人(如：医生、护士和医院工作人员) d hospital workers) to be
爱和关怀。相比之下，病人的家属 the patients' families of origin
包括一个拒绝的母亲或一个缺席的父亲。通常的 father. The usual
历史表明，患者对父母一方或双方都有感知 s one or both parents
拒绝那些无法形成亲密关系的人 are unable to form close
的关系。因此，真正的疾病的传真是 genuine illness, therefore, is
used to recreate the desired positive parent–child bond. The
疾病是一种重复的冲动，重复着 itional compulsion, repeating the
需要和寻求接受和爱的基本冲突 and seeking acceptance and love

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in an exploratory psychotherapy process. They may insist that their symptoms are physical and that psychologically oriented treatment is therefore useless. Anecdotal case reports indicate that many of the patients suffered childhood abuse or deprivation, resulting in frequent hospitalizations during early development. In such circumstances, an inpatient stay may have been regarded as an escape from a traumatic home situation, and the patient may have found a series of caretakers (e.g., doctors, nurses, and hospital workers) to be loving and caring. In contrast, the patients' families of origin included a rejecting mother or an absent father. The usual history reveals that the patient perceives one or both parents as rejecting figures who are unable to form close relationships. The facsimile of genuine illness, therefore, is used to recreate the desired positive parent–child bond. The disorders are a form of repetitional compulsion, repeating the basic conflict of needing and seeking acceptance and love while expecting that they will not be forthcoming. Hence, the patient transforms the physicians and staff members into rejecting parents.

Patients who seek out painful procedures, such as surgical operations and invasive diagnostic tests, may have a masochistic personality makeup in which pain serves as punishment for past sins, imagined or real. Some patients may attempt to master the past and the early trauma of serious medical illness or hospitalization by assuming the role of the patient and reliving the painful and frightening experience over and over again through multiple

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在一个探索性的心理治疗过程中。他们可能会坚持
他们的症状是身体上的和心理上的
因此治疗是无用的。零星的病例报告
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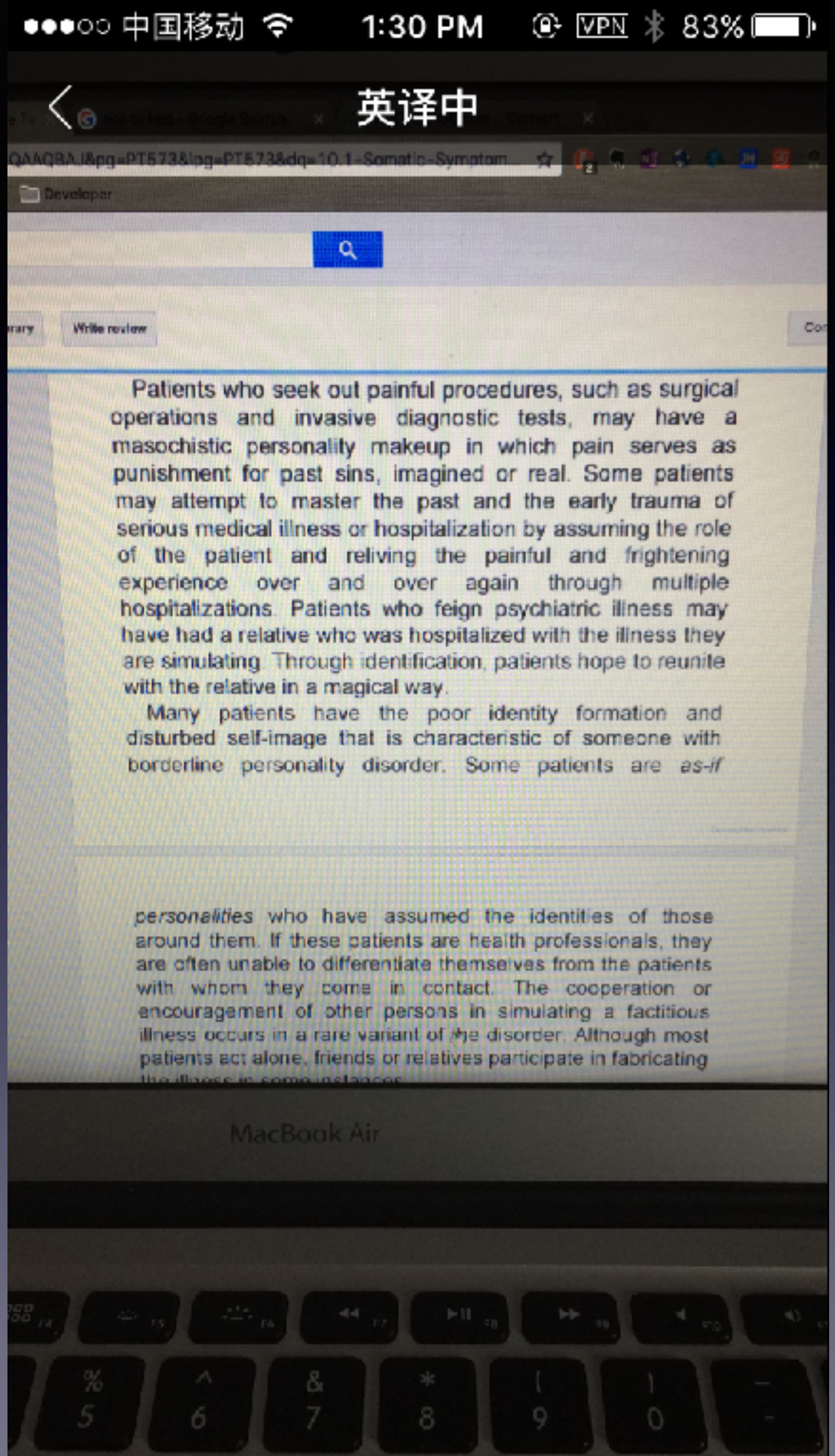
被视为逃离创伤家庭的一种解脱
情况，病人可能已经发现了一系列的
(如看护人，医生、护士和医院工作人员)
爱和关怀。相比之下，病人的家属
包括一个拒绝的母亲或一个缺席的父亲。通常的
拒绝那些无法形成亲密关系的人
的关系。因此，真正的疾病的传真是
用于重建期望的正-父-子键。那
疾病是一种重复的冲动，重复着
需要和寻求接受和爱的基本冲突
当他们期待着他们不会到来的时候，
病人将医生和工作人员转变为
拒绝父母。
那些寻求痛苦手术的病人，比如外科手术
操作和侵入性诊断测试，可能有一个
受虐狂的人格构成
对过去的罪恶，想象或现实的惩罚。一些病人
可能尝试去掌握过去和过去的创伤
严重的医疗疾病或住院治疗
病人的痛苦和痛苦的回忆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Patients who seek out painful procedures, such as surgical operations and invasive diagnostic tests, may have a masochistic personality makeup in which pain serves as punishment for past sins, imagined or real. Some patients may attempt to master the past and the early trauma of serious medical illness or hospitalization by assuming the role of the patient and reliving the painful and frightening experience over and over again through multiple hospitalizations. Patients who feign psychiatric illness may have had a relative who was hospitalized with the illness they are simulating. Through identification, patients hope to reunite with the relative in a magical way.
Many patients have the poor identity formation and disturbed self-image that is characteristic of someone with borderline personality disorder. Some patients are as-if
personalities who have assumed the identities of those around them. If these patients are health professionals, they are often unable to differentiate themselves from the patients with whom they come in contact. The cooperation or encouragement of other persons in simulating a factitious illness occurs in a rare variant of the disorder. Although most patients act alone, friends or relatives participate in fabricating
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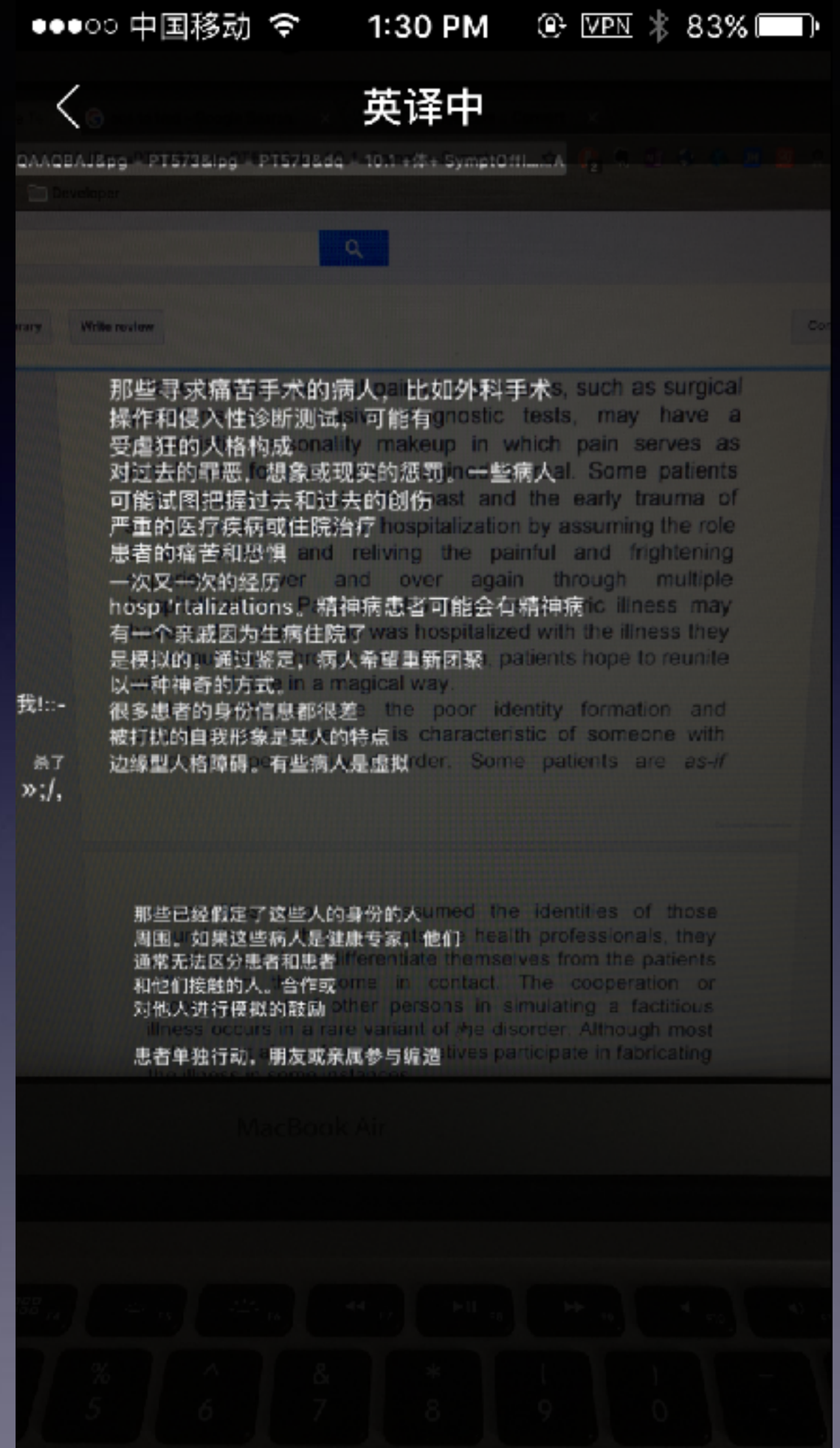
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那些寻求痛苦手术的病人，比如外科手术
操作和侵入性诊断测试，可能有
受虐狂的人格构成
对过去的罪恶，想象或现实的惩罚。一些病人
可能试图把握过去和过去的创伤
严重的医疗疾病或住院治疗
患者的痛苦和恐惧
一次又一次的经历
有一个亲戚因为生病住院了
是模拟的。通过鉴定，病人希望重新团聚
以一种神奇的方式。
很多患者的身份信息都很差
被打扰的自我形象是某人的特点
边缘型人格障碍。有些病人是虚拟
那些已经假定了这些人的身份的人
周围。如果这些病人是健康专家，他们
通常无法区分患者和患者
和他们接触的人。合作或
对他人进行模拟的鼓励
患者单独行动。朋友或亲属参与编造
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personalities who have assumed the identities of those around them. If these patients are health professionals, they are often unable to differentiate themselves from the patients with whom they come in contact. The cooperation or encouragement of other persons in simulating a factitious illness occurs in a rare variant of the disorder. Although most patients act alone, friends or relatives participate in fabricating the illness in some instances.

Significant defense mechanisms are repression, identification with the aggressor, regression, and symbolization.

Biological Factors

Some researchers have proposed that brain dysfunction may be a factor in factitious disorders. It has been hypothesized that impaired information processing contributes to the *pseudologia fantastica* and aberrant behavior of patients with Munchausen disorder; however, no genetic patterns have been established and electroencephalographic (EEG) studies noted no specific abnormalities in patients with factitious disorders.

DIAGNOSIS AND CLINICAL FEATURES

Factitious disorder is the faking of physical or psychological signs and symptoms. Clues that should trigger suspicion of the disorder are given in Table 10.4–1. The psychiatric examination should emphasize securing information from any

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那些已经假定了这些人的身份的人 the identities of those
周围。如果这些病人是健康专家，他们 ofessionals, they
通常无法区分患者和患者 ate themselves from the patients
和他们接触的人。合作或 n contact. The cooperation or
对他人进行模拟的鼓励 r persons in simulating a factitious
疾病发生在一种罕见的疾病变体中。尽管大多数 h most
患者单独行动，朋友或亲属参与编造 rticipate in fabricating
这种疾病在某些情况下。 nstances.
重要的防御机制是镇压， mechanisms are repression,
与侵略者的认同，回归，以及 ggressor, regression, and
符号化。 olization.

生物因素 ical Factors

一些研究人员提出大脑功能障碍可能会出现 dysfunction may
是人为失调的一个因素。它已经被假设 as been hypothesized
受损的信息处理导致了 mation processing contributes to the
假性福症和患者的异常行为 nd aberrant behavior of patients with
异想天开的障碍;然而，没有遗传模式 genetic patterns have
已经建立，脑电图(EEG) and electroencephalographic (EEG)
研究没有发现病人有特殊的异常 abnormalities in patients with
人为的障碍。 us disorders.

诊断和临床特征 S AND CLINICAL FEATURES

人为障碍是身体或心理的伪装 aking of physical or psychological
症状和体征。应该引起怀疑的线索 al should trigger suspicion of
这一障碍在表10-4中给出。精神病 able 10.4–1. The psychiatric
考试应该强调从任何方面获取信息 securing information from any

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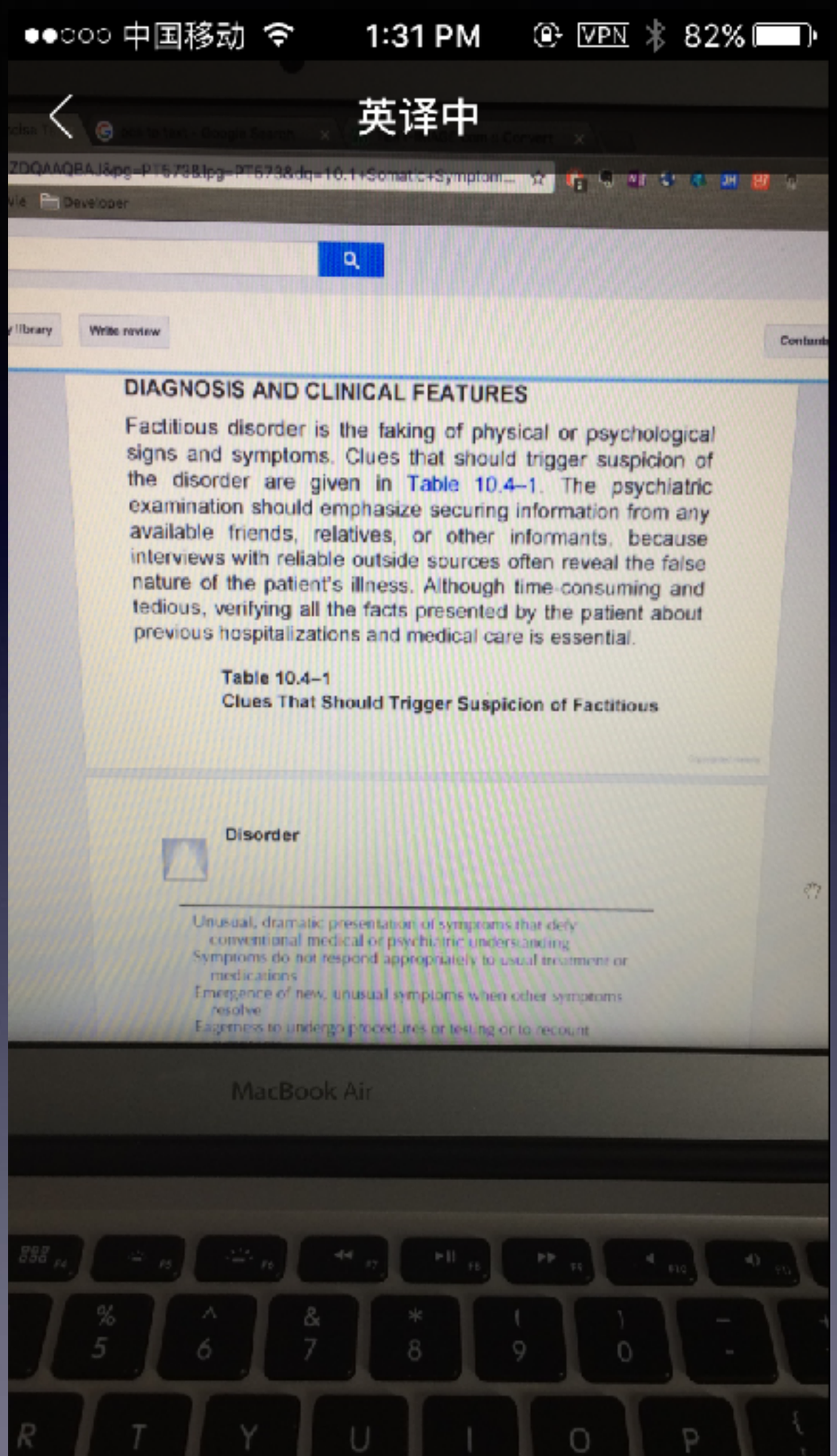
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DIAGNOSIS AND CLINICAL FEATURES
Factitious disorder is the faking of physical or psychological signs and symptoms. Clues that should trigger suspicion of the disorder are given in Table 10.4–1. The psychiatric examination should emphasize securing information from any available friends, relatives, or other informants, because interviews with reliable outside sources often reveal the false nature of the patient's illness. Although time-consuming and tedious, verifying all the facts presented by the patient about previous hospitalizations and medical care is essential.
Table 10.4–1
Clues That Should Trigger Suspicion of Factitious
Disorder
Unusual, dramatic presentation of symptoms that defy conventional medical or psychiatric understanding
Symptoms do not respond appropriately to usual treatment or medications
Emergence of new, unusual symptoms when other symptoms resolve
Eagerness to undergo procedures or testing or to recount
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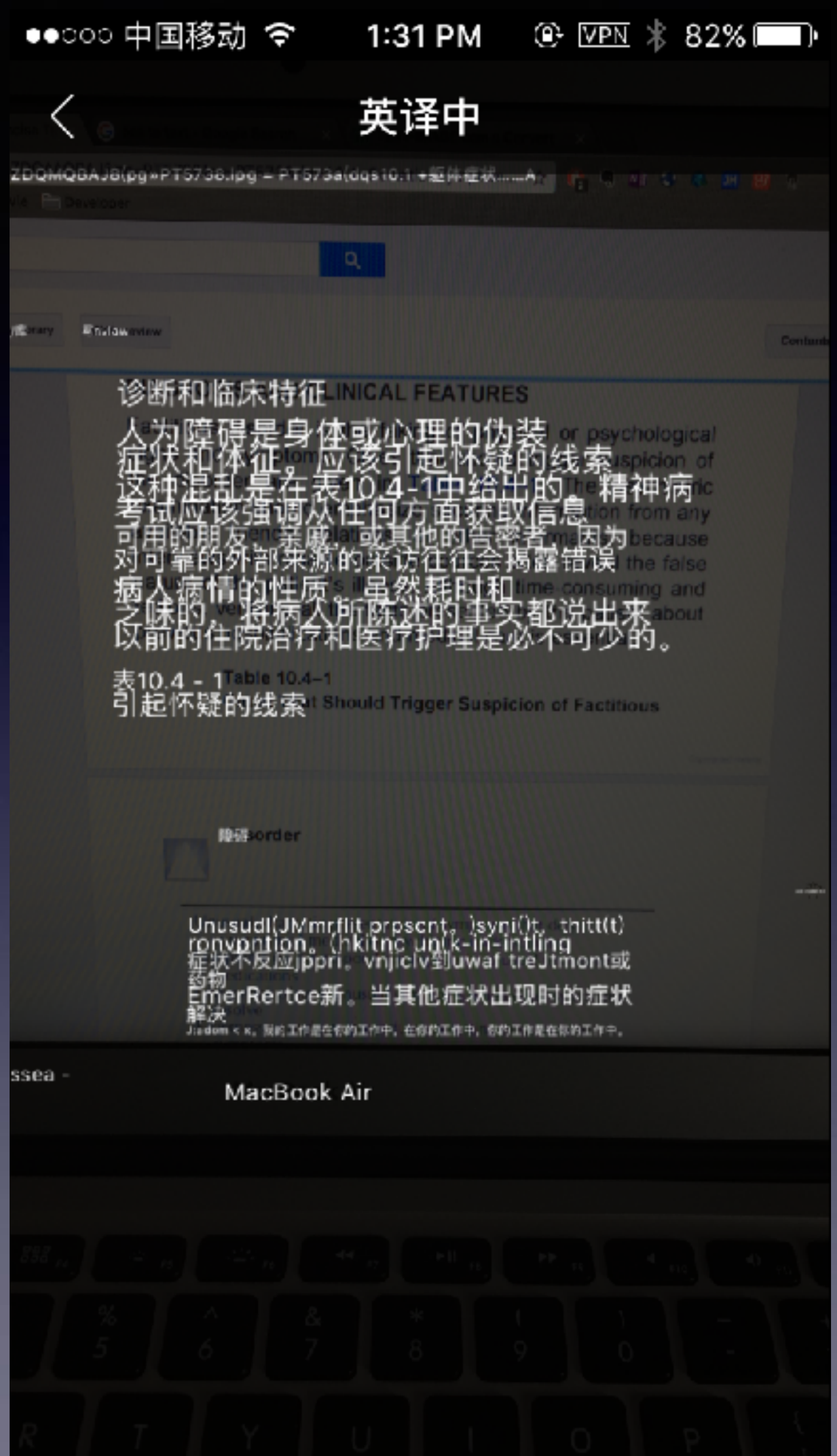
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诊断和临床特征
人为障碍是身体或心理的伪装
症状和体征，应该引起怀疑的线索
这种混乱是在表10.4-1中给出的。精神病
考试应该强调从任何方面获取信息
可用的朋友，亲戚，或其他的告密者，因为
对可靠的外部来源的采访往往会揭露错误
病人病情的性质。虽然耗时和
之味的，将病人所陈述的事实都说出来
以前的住院治疗和医疗护理是必不可少的。
表10.4 - 1
引起怀疑的线索
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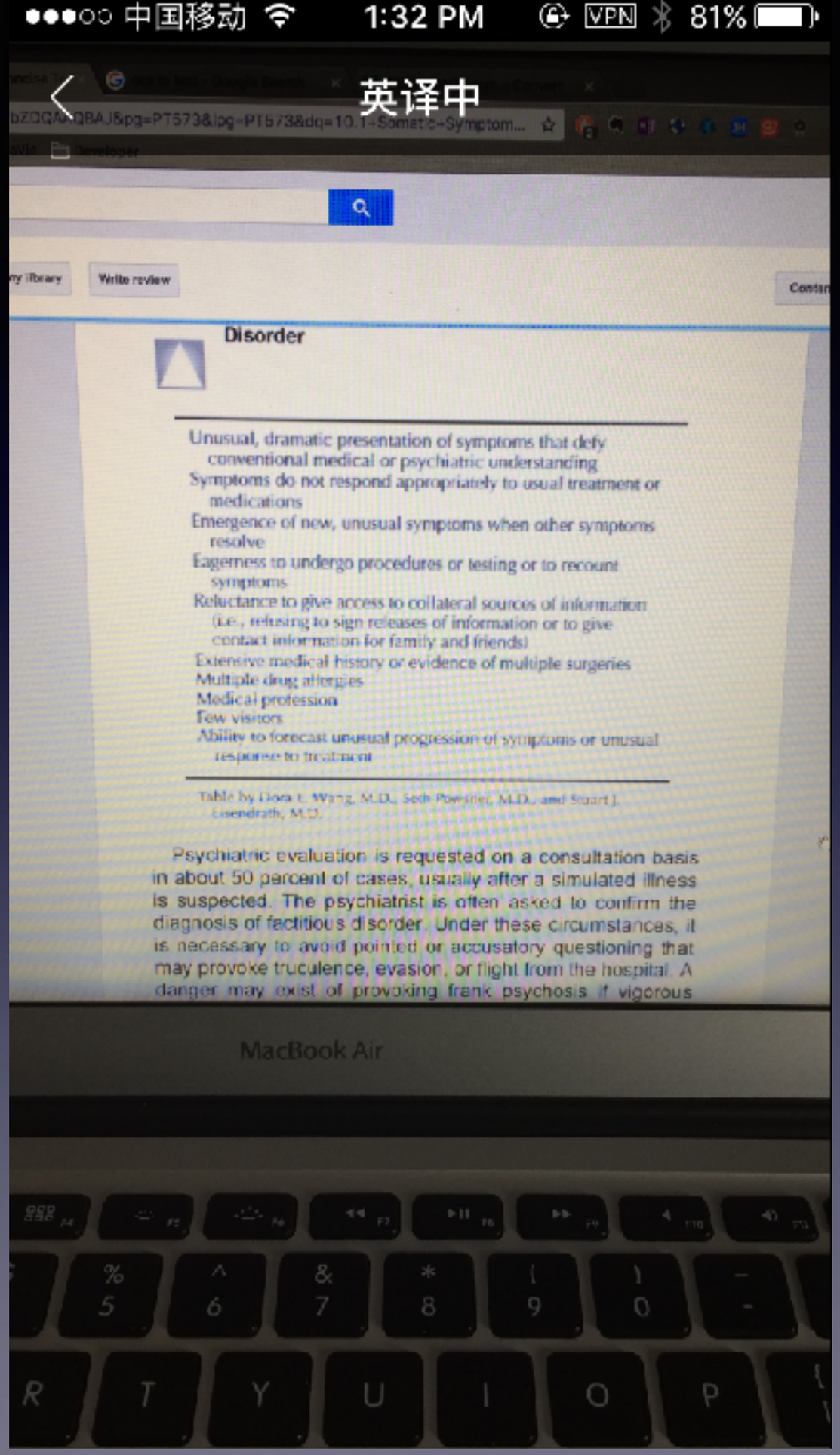
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Disorder
Unusual, dramatic presentation of symptoms that defy conventional medical or psychiatric understanding
Symptoms do not respond appropriately to usual treatment or medications
Emergence of new, unusual symptoms when other symptoms resolve
Eagerness to undergo procedures or testing or to recount symptoms
Reluctance to give access to collateral sources of information (i.e., refusing to sign releases of information or to give contact information for family and friends)
Extensive medical history or evidence of multiple surgeries
Multiple drug allergies
Medical profession
Few visitors
Ability to forecast unusual progression of symptoms or unusual response to treatment
Table by Dora L. Wang, M.D., Seth Powsner, M.D., and Stuart J. Eisendrath, M.D.
Psychiatric evaluation is requested on a consultation basis in about 50 percent of cases, usually after a simulated illness is suspected. The psychiatrist is often asked to confirm the diagnosis of factitious disorder. Under these circumstances, it is necessary to avoid pointed or accusatory questioning that may provoke truculence, evasion, or flight from the hospital. A danger may exist of provoking frank psychosis if vigorous
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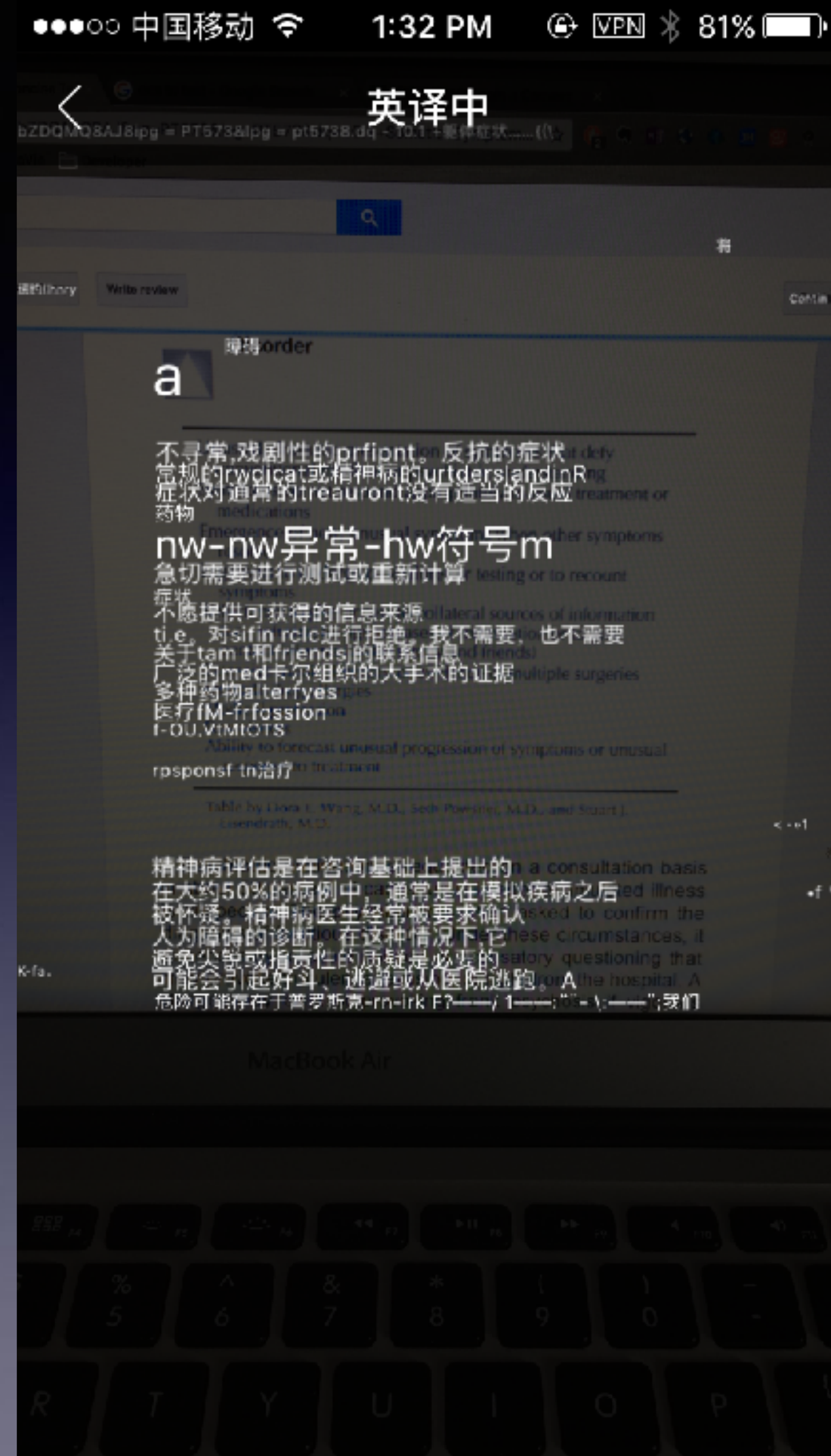
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障碍order
a
不寻常,戏剧性的prfiont。反抗的症状
常规的rwcicat或精神病的urtdersjandinR
症状对通常的treauront没有适当的反应
药物
nw-nw异常-hw符号m
急切需要进行测试或重新计算
症状
不愿提供可获得的信息来源
ti.e。对sifin rclc进行拒绝。我不需要，也不需要
关于tam t和frjends]的联系信息
广泛的med卡尔组织的大手术的证据
多种药物alterfyes
医疗fM-frfossion
rpsponsf tn治疗
精神病评估是在咨询基础上提出的
在大约50%的病例中，通常是在模拟疾病之后
被怀疑。精神病医生经常被要求确认
人为障碍的诊断。在这种情况下，它
避免尖锐或指责性的质疑是必要的
可能会引起好斗，逃避或从医院逃跑。A
危险可能存在于普罗斯克-rn-irk F?——/ 1——:"" - \:——";我们
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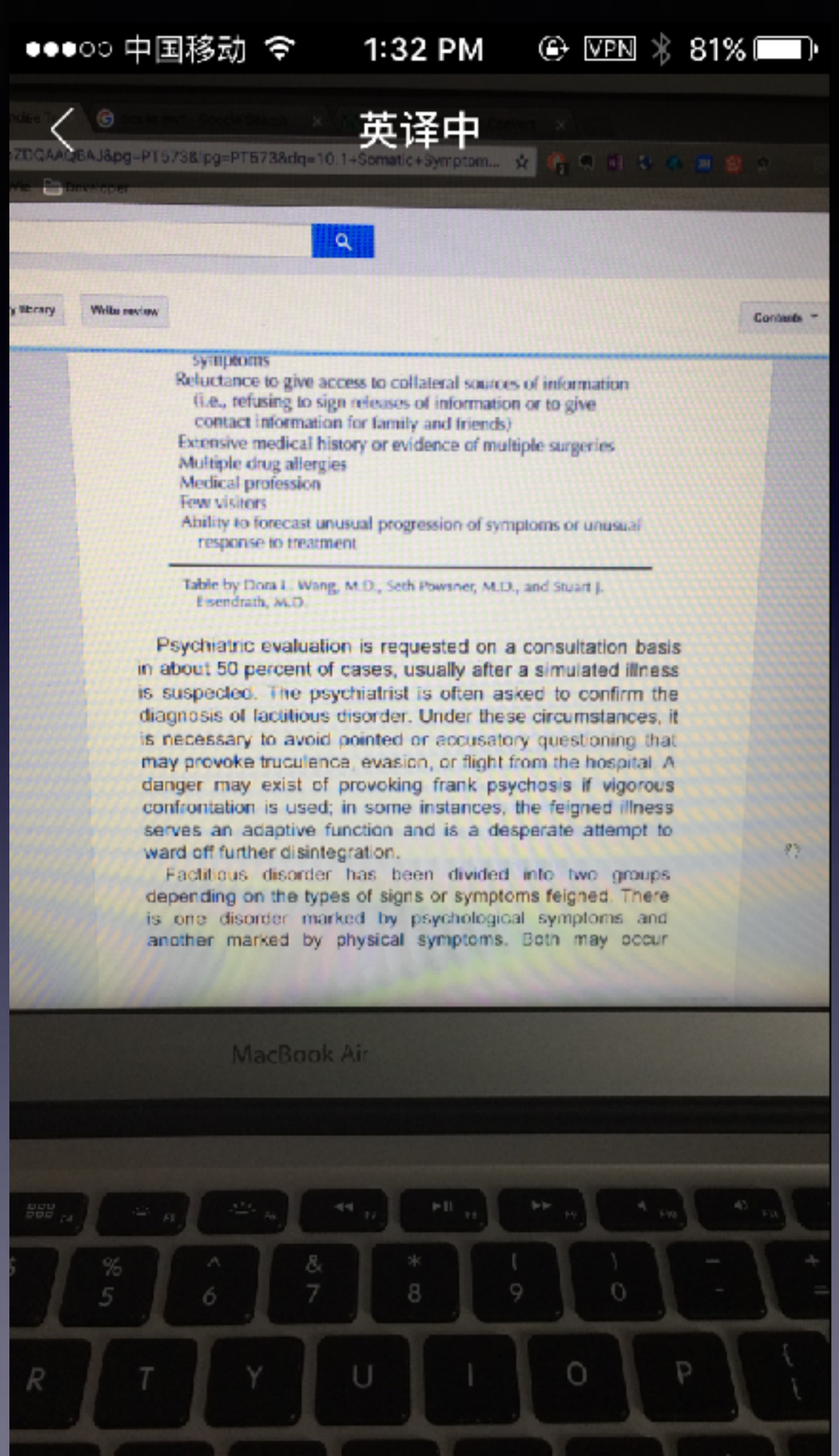
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Symptoms
Reluctance to give access to collateral sources of information (i.e., refusing to sign releases of information or to give contact information for family and friends)
Extensive medical history or evidence of multiple surgeries
Multiple drug allergies
Medical profession
Few visitors
Ability to forecast unusual progression of symptoms or unusual response to treatment
Table by Dora L. Wang, M.D., Seth Pownner, M.D., and Stuart J. Eisendrath, M.D.
Psychiatric evaluation is requested on a consultation basis in about 50 percent of cases, usually after a simulated illness is suspected. The psychiatrist is often asked to confirm the diagnosis of factitious disorder. Under these circumstances, it is necessary to avoid pointed or accusatory questioning that may provoke truculence, evasion, or flight from the hospital. A danger may exist of provoking frank psychosis if vigorous confrontation is used; in some instances, the feigned illness serves an adaptive function and is a desperate attempt to ward off further disintegration.
Factitious disorder has been divided into two groups depending on the types of signs or symptoms feigned. There is one disorder marked by psychological symptoms and another marked by physical symptoms. Both may occur
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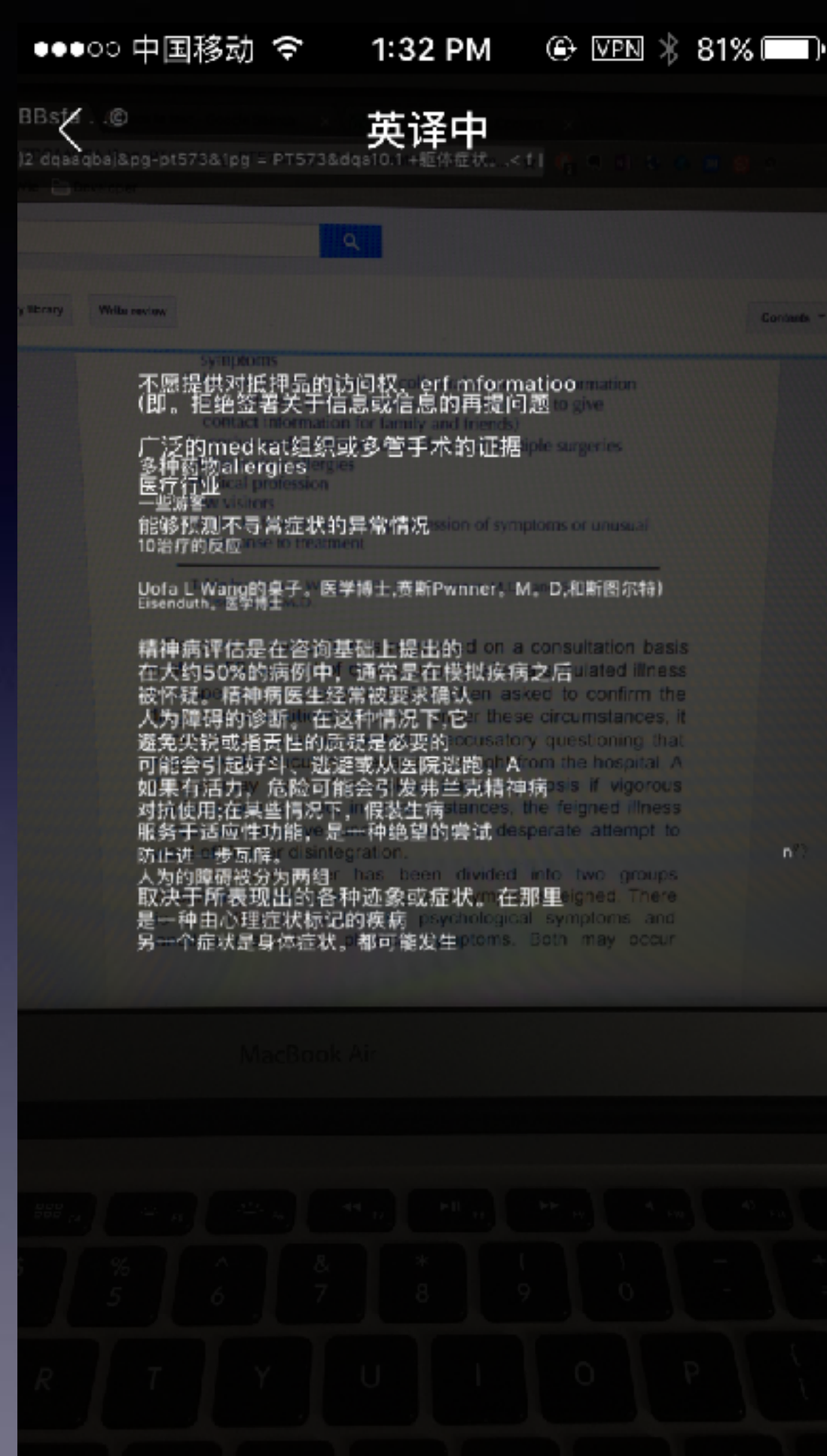
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(即。拒绝签署关于信息或信息的再提问题
广泛的medkat组织或多管手术的证据
多种药物allergies
医疗行业
能够预测不寻常症状的异常情况
10治疗的反应
Uofa L Wang的桌子。医学博士,赛斯Pwnner。M。D,和斯图尔特)
精神病评估是在咨询基础上提出的
在大约50%的病例中，通常是在模拟疾病之后
被怀疑。精神病医生经常被要求确认
人为障碍的诊断。在这种情况下,它
避免尖锐或指责性的质疑是必要的
可能会引起好斗、逃避或从医院逃跑。A
如果有活力,危险可能会引发弗兰克精神病
对抗使用;在某些情况下，假装生病
服务于适应性功能，是一种绝望的尝试
防止进一步瓦解。
人为的障碍被分为两组
取决于所表现出的各种迹象或症状。在那里
是一种由心理症状标记的疾病
另一个症状是身体症状。都可能发生
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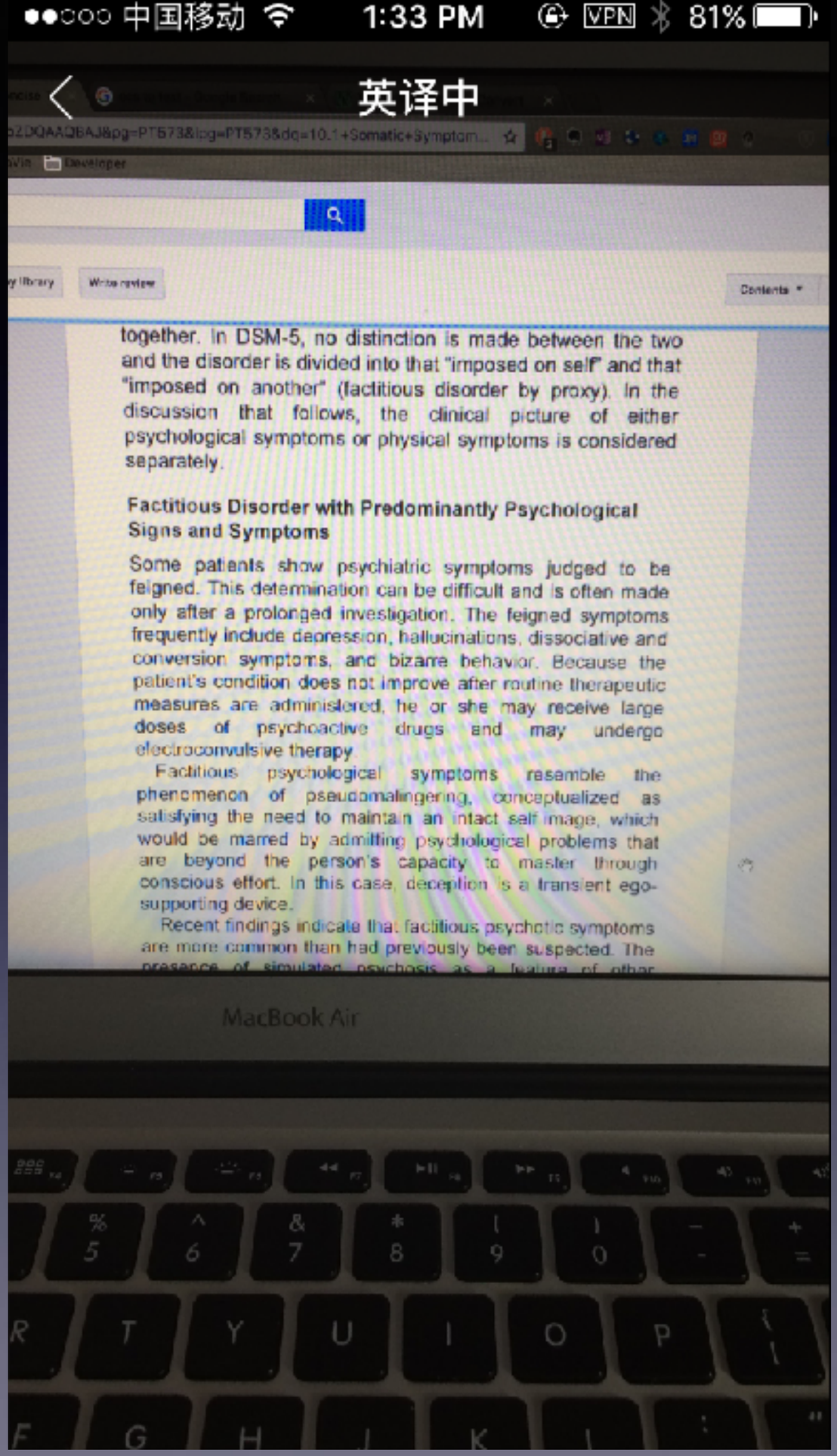
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together. In DSM-5, no distinction is made between the two and the disorder is divided into that "imposed on self" and that "imposed on another" (factitious disorder by proxy). In the discussion that follows, the clinical picture of either psychological symptoms or physical symptoms is considered separately.
Factitious Disorder with Predominantly Psychological Signs and Symptoms
Some patients show psychiatric symptoms judged to be feigned. This determination can be difficult and is often made only after a prolonged investigation. The feigned symptoms frequently include depression, hallucinations, dissociative and conversion symptoms, and bizarre behavior. Because the patient's condition does not improve after routine therapeutic measures are administered, he or she may receive large doses of psychoactive drugs and may undergo electroconvulsive therapy.
Factitious psychological symptoms resemble the phenomenon of pseudomalingering, conceptualized as satisfying the need to maintain an intact self image, which would be marred by admitting psychological problems that are beyond the person's capacity to master through conscious effort. In this case, deception is a transient ego-supporting device.
Recent findings indicate that factitious psychotic symptoms are more common than had previously been suspected. The
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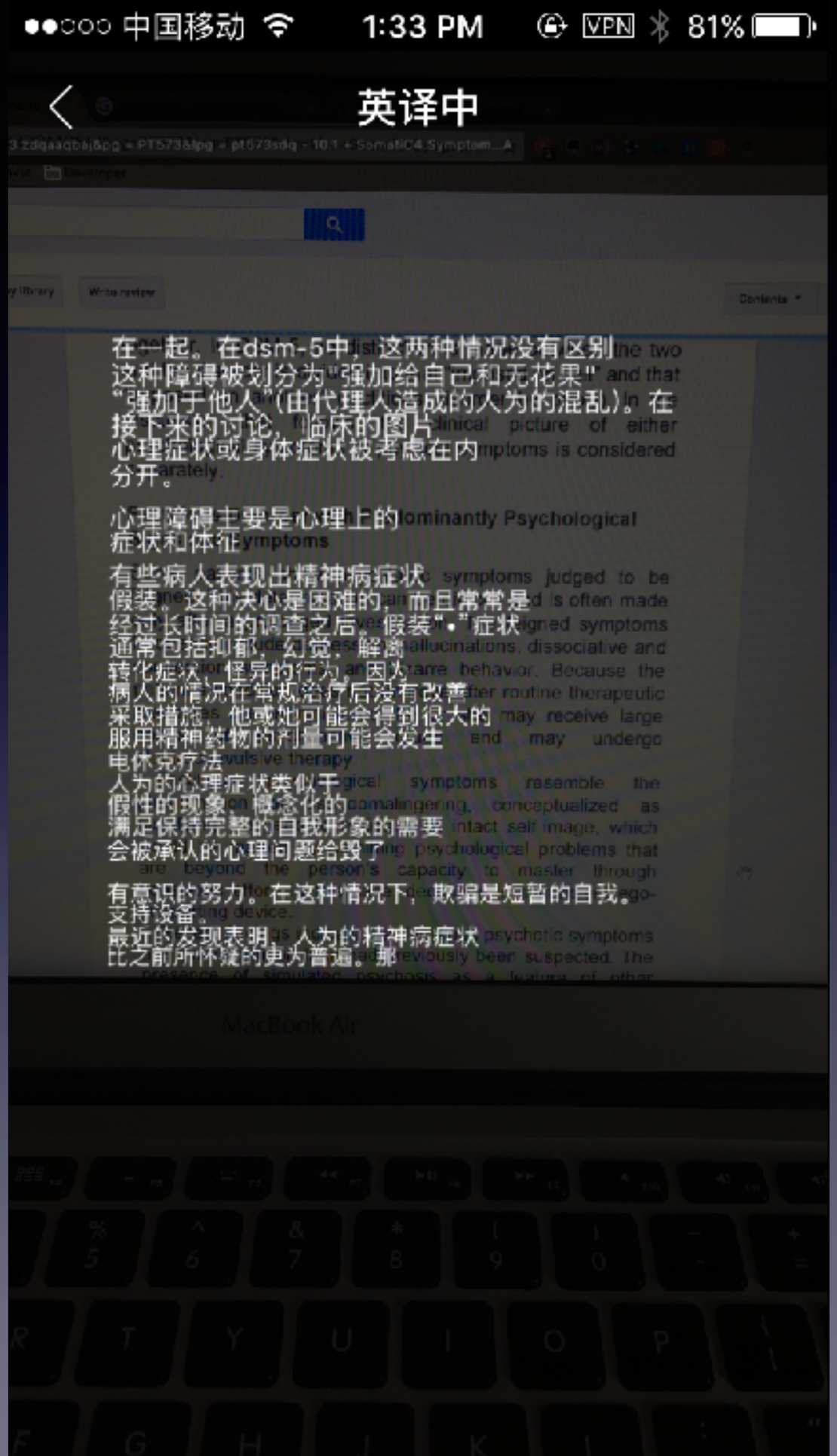
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在一起。在dsm-5中，这两种情况没有区别
这种障碍被划分为"强加给自己和无花果" and that
"强加于他人"(由代理人造成的人为的混乱)。在
接下来的讨论，临床的图片
心理症状或身体症状被考虑在内
分开。
心理障碍主要是心理上的
症状和体征
有些病人表现出精神病症状
假装。这种决心是困难的，而且常常是
经过长时间的调查之后，假装"•"症状
通常包括抑郁，幻觉，解离
转化症状，怪异的行为。因为
病人的情况在常规治疗后没有改善
采取措施，他或她可能会得到很大的
服用精神药物的剂量可能会发生
电休克疗法
人为的心理症状类似于
假性的现象，概念化的
满足保持完整的自我形象的需要
会被承认的心理问题给毁了
有意识的努力。在这种情况下，欺骗是短暂的自我。
支持设备。
最近的发现表明，人为的精神病症状
比之前所怀疑的更为普遍。那

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Recent findings indicate that factitious psychotic symptoms are more common than had previously been suspected. The presence of simulated psychosis as a feature of other disorders, such as mood disorders, indicates a poor overall prognosis.

Table 10.4–2
Presentations in Factitious Disorder with Predominantly Psychological Signs and Symptoms

Some pages are omitted from this book preview.

mild schizophrenic defect state; she takes regular depot medication but still complains of auditory hallucinations, hearing her dead sister's voice. She is a day patient. *(Courtesy of Dora Wang, M.D., Deepa N. Nadiga, M.D., and James J. Jenson, M.D.)*

Chronic Factitious Disorder with Predominantly Physical Signs and Symptoms

Factitious disorder with predominantly physical signs and

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最近的发现表明，人为的精神病症状比之前所怀疑的更为普遍。模拟精神病的出现其他疾病的特征，如情绪障碍，预示着预后不良。

表10.4 12.4–2

假性障碍的报告主要是心理症状和症状

轻度精神分裂症缺陷状态。她经常服用药物，但仍在抱怨幻听。听到她去世的姐姐的声音，她是Dora Wang，Dora Wang，Dora Wang，M.D。James J.Jenson M.D.)

慢性假性障碍主要是体征和症状

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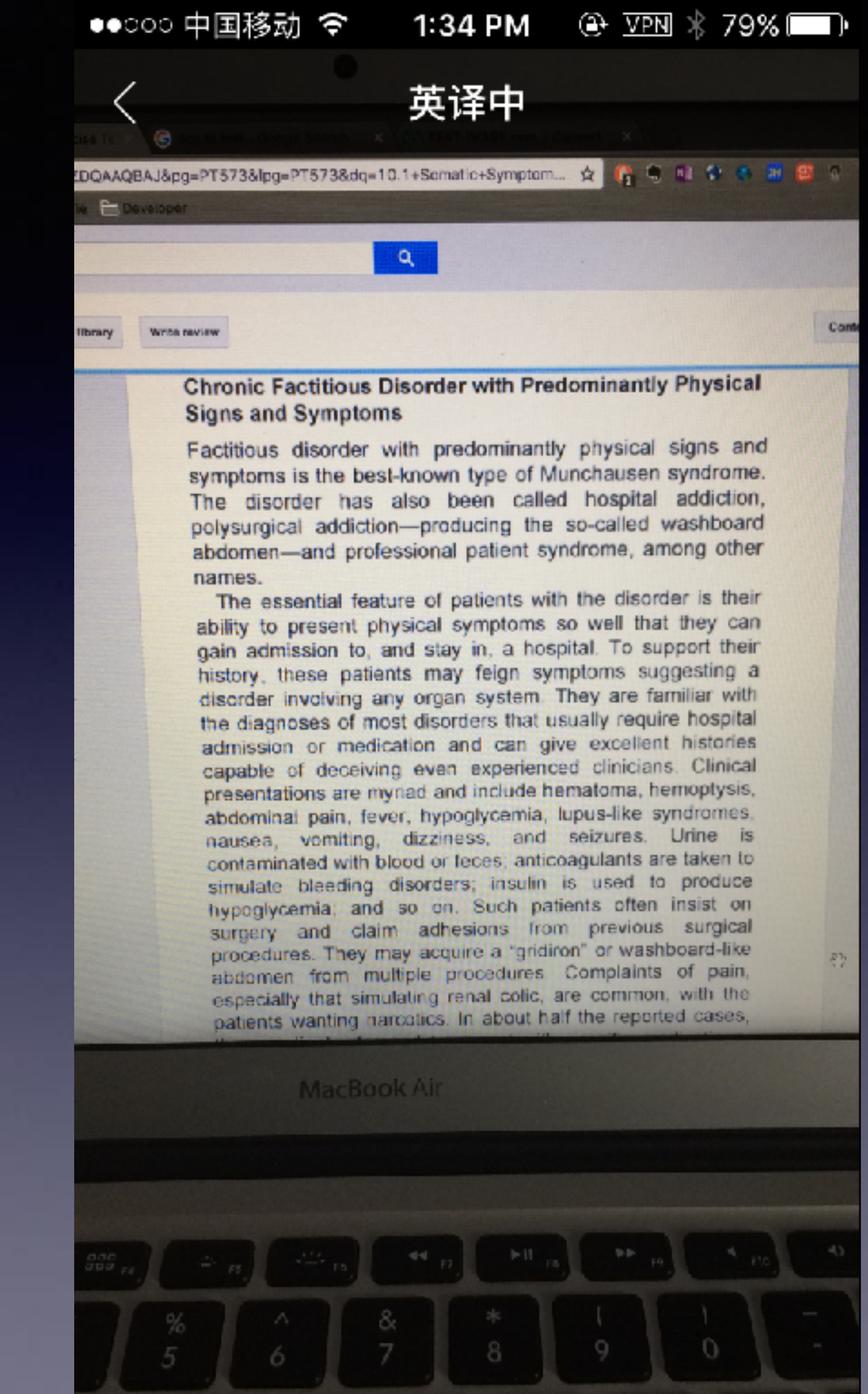
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Chronic Factitious Disorder with Predominantly Physical Signs and Symptoms
Factitious disorder with predominantly physical signs and symptoms is the best-known type of Munchausen syndrome. The disorder has also been called hospital addiction, polysurgical addiction—producing the so-called washboard abdomen—and professional patient syndrome, among other names.
The essential feature of patients with the disorder is their ability to present physical symptoms so well that they can gain admission to, and stay in, a hospital. To support their history, these patients may feign symptoms suggesting a disorder involving any organ system. They are familiar with the diagnoses of most disorders that usually require hospital admission or medication and can give excellent histories capable of deceiving even experienced clinicians. Clinical presentations are myriad and include hematoma, hemoptysis, abdominal pain, fever, hypoglycemia, lupus-like syndromes, nausea, vomiting, dizziness, and seizures. Urine is contaminated with blood or feces; anticoagulants are taken to simulate bleeding disorders; insulin is used to produce hypoglycemia; and so on. Such patients often insist on surgery and claim adhesions from previous surgical procedures. They may acquire a "gridiron" or washboard-like abdomen from multiple procedures. Complaints of pain, especially that simulating renal colic, are common, with the patients wanting narcotics. In about half the reported cases,
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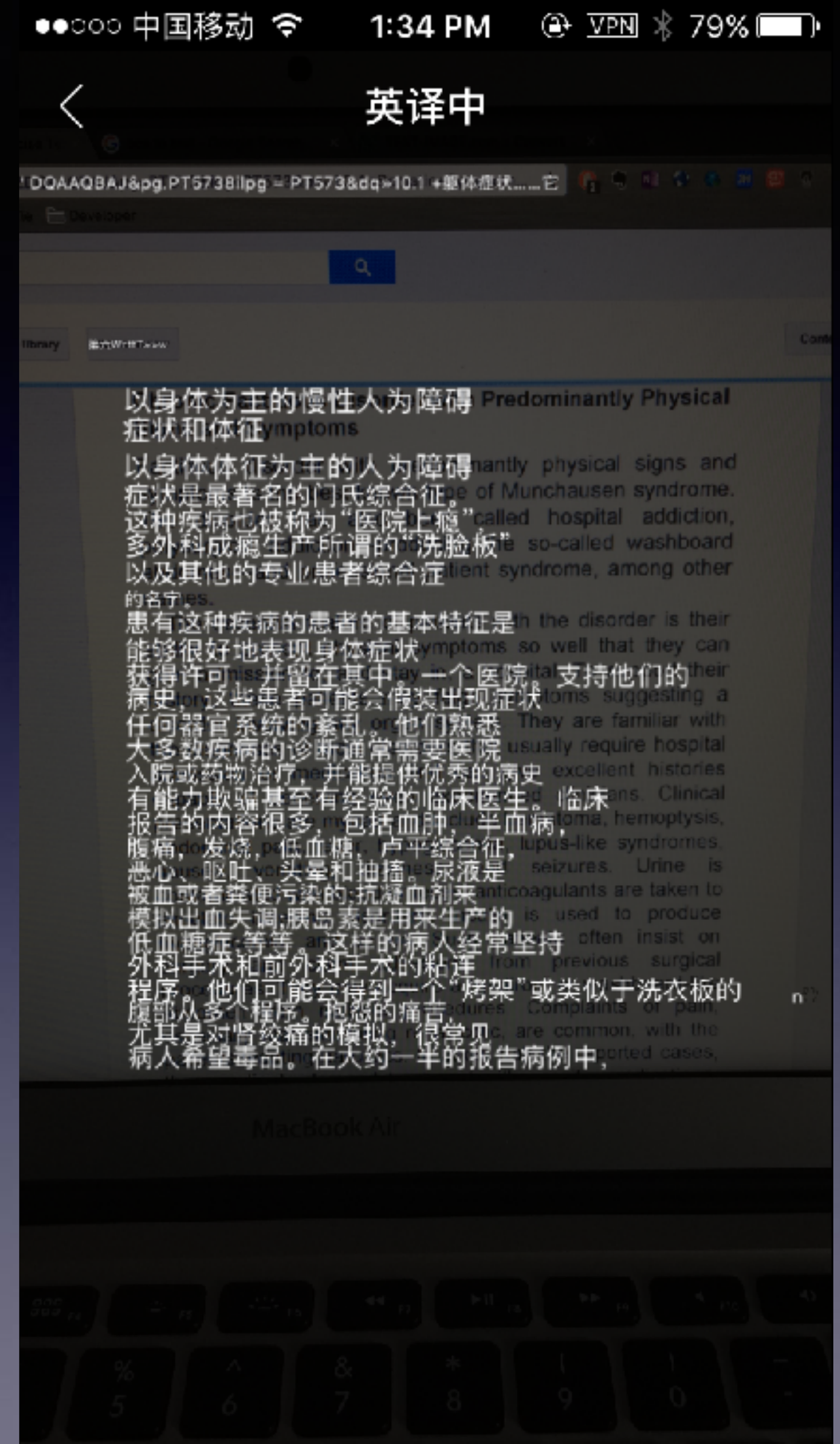
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以身体为主的慢性人为障碍
症状和体征
以身体体征为主的人为障碍
症状是最著名的闵氏综合征。
这种疾病也被称为"医院上瘾"
多外科成瘾生产所谓的"洗脸板"
以及其他的专业患者综合症
患有这种疾病的患者的基本特征是
能够很好地表现身体症状
获得许可并留在其中一个医院，支持他们的
病史，这些患者可能会假装出现症状
任何器官系统的紊乱。他们熟悉
大多数疾病的诊断通常需要医院
入院或药物治疗，并能提供优秀的病史
有能力欺骗甚至有经验的临床医生。临床
报告的内容很多，包括血肿，半血病，
腹痛，发烧，低血糖，卢平综合征，
恶心，呕吐，头晕和抽搐。尿液是
被血或者粪便污染的；抗凝血剂来
模拟出血失调；胰岛素是用来生产的
低血糖症等等。这样的病人经常坚持
外科手术和前外科手术的粘连
程序。他们可能会得到一个"烤架"或类似于洗衣板的
腹部从多个程序。抱怨的痛苦，
尤其是对肾绞痛的模拟，很常见
病人希望毒品。在大约一半的报告病例中，
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procedures. They may acquire a "gridiron" or washboard-like abdomen from multiple procedures. Complaints of pain, especially that simulating renal colic, are common, with the patients wanting narcotics. In about half the reported cases, these patients demand treatment with specific medications,

usually analgesics. Once in the hospital, they continue to be demanding and difficult. As each test is returned with a negative result, they may accuse doctors of incompetence, threaten litigation, and become generally abusive. Some may sign out abruptly shortly before they believe they are going to be confronted with their factitious behavior. They then go to another hospital in the same or another city and begin the cycle again. Specific predisposing factors are true physical disorders during childhood leading to extensive medical treatment, a grudge against the medical profession, employment as a medical paraprofessional, and an important relationship with a physician in the past.

Factitious Disorder with Combined Psychological and Physical Signs and Symptoms

In combined forms of factitious disorder, both psychological and physical signs and symptoms are present. In one

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程序。他们可能会从多个程序中获得一个“烤架”或类似于洗衣板的腹部。对疼痛的抱怨，尤其是对肾绞痛的模拟，是常见的，病人需要麻醉。在大约一半的报告病例中，这些病人需要用特定的药物治疗。

通常在医院里的止痛剂，他们会继续要求和困难。每一个测试都返回一个负面结果。他们可能会指控医生的无能威胁到诉讼，并且变得普遍的虐待一些人在他们相信自己将会面对他们的行为之前就会突然出现。然后他们去同一家或另一个城市的另一家医院，重新开始这个循环。在儿童时期，特定的易发因素是真正的身体疾病，导致广泛的医学治疗，对“na”的不满。医学专业，职业医学，职业和医生之间的重要关系

综合心理和身体体征和症状的人为障碍

综合形式的人为的混乱，Osychologica和他的身体症状和症状

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Write review

Factitious Disorder with Combined Psychological and Physical Signs and Symptoms

In combined forms of factitious disorder, both psychological and physical signs and symptoms are present. In one representative report, a patient alternated between feigned dementia, bereavement, rape, and seizures.

Table 10.4–3 provides a comprehensive overview of a variety of signs and symptoms that may be faked and mistaken for genuine illness. The table also includes the means of simulation and possible methods of detection.

Factitious Disorder by Proxy

In this diagnosis, a person intentionally produces physical signs or symptoms in another person who is under the first person's care, hence the DSM-5 diagnosis of "Factitious Disorder Imposed on Another." One apparent purpose of the behavior is for the caretaker to indirectly assume the sick role; another is to be relieved of the caretaking role by having the child hospitalized. The most common case of factitious disorder by proxy involves a mother who deceives medical personnel into believing that her child is ill. The deception may involve a false medical history, contamination of

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综合心理和身体体征和症状的人为障碍

在综合形式的人为障碍的情况下，出现了心理和生理上的症状和体征。在一份有代表性的报告中，一个病人在假装痴呆之间交替出现。丧亲之痛强奸和癫痫发作。

表10 4-3提供了一个全面的概述，包括各种各样的症状和症状，这些症状可能是伪造的，并被误认为是真正的疾病。这个表还包括了模拟的方法和可能的检测方法。

人为的障碍通过代理

在这个诊断中，一个人故意在另一个人的照料下产生身体的体征或症状。因此dsm-5被诊断为"人为的混乱强加于另一个人"。的一个明显的目的的行为是看守间接承担病人机械;另一个是松了一口气的照顾的角色让孩子住院最常见的人为障碍的情况下代理需要一个母亲,使医务人员错误地相信她的孩子生病的欺骗可能涉及一个虚假的病史,污染

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laboratory samples, alteration of records, or induction of injury and illness in the child.

BC, a 1-month-old girl, was admitted for the evaluation of fever. Psychiatric consultation was requested due to inconsistencies in the mother's reporting of medical information despite her presentation as a knowledgeable and caring mother who worked as an emergency medical technician. BC's mother reported her own diagnosis of ovarian cancer when she was 3 months pregnant with BC. She reported undergoing a hysterectomy during her cesarean section, and that she had been getting radiation therapy at a local hospital since BC's birth. The pediatrician called the local hospital with the mother's permission and learned that she had a corpus luteum cyst removed at 3 months' gestation and mild hydronephrosis but no cancer or hysterectomy. BC's mother, when confronted with this, stated only that she might need a kidney transplant for the hydronephrosis.

On further exploration, it was discovered that the mother had brought her children to multiple emergency rooms, giving inaccurate histories that prompted excessive testing. At one visit, she told clinicians that her 2-year-old son had lupus and hypergammaglobulinemia, and at another visit, that he had asthma and seizures. She also pursued a minor

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实验室样本，记录的改变，儿童受伤和疾病的归纳。

BC。一个出生的女孩，由于母亲报告的医学信息不一致，她被要求参加发烧精神病会诊，尽管她作为一名有知识和有爱心的母亲，作为一名紧急医疗技术员工作。BC的母亲在她怀孕3个月的时候报告了她自己的卵巢癌诊断，她报告说她在剖腹产期间接受了yster切除术，她从BC出生后就一直在当地医院接受放射治疗。儿科医生在母亲的许可下给当地医院打电话，得知她在妊娠3个月和轻微的肾积水中切除了一个黄体囊肿，但是没有任何癌症r子宫切除的母亲在面对这一情况时，只说她可能需要肾移植来做肾移植。

在进一步的探索中，人们发现这位母亲带着她的孩子去了多个急诊室，这些急救室的历史不准确，导致了过度的测试。在一个访问，她告诉临床医生她22岁的时候

在另一次的访问中，他患上了哮喘和癫痫。她也追求一个小的

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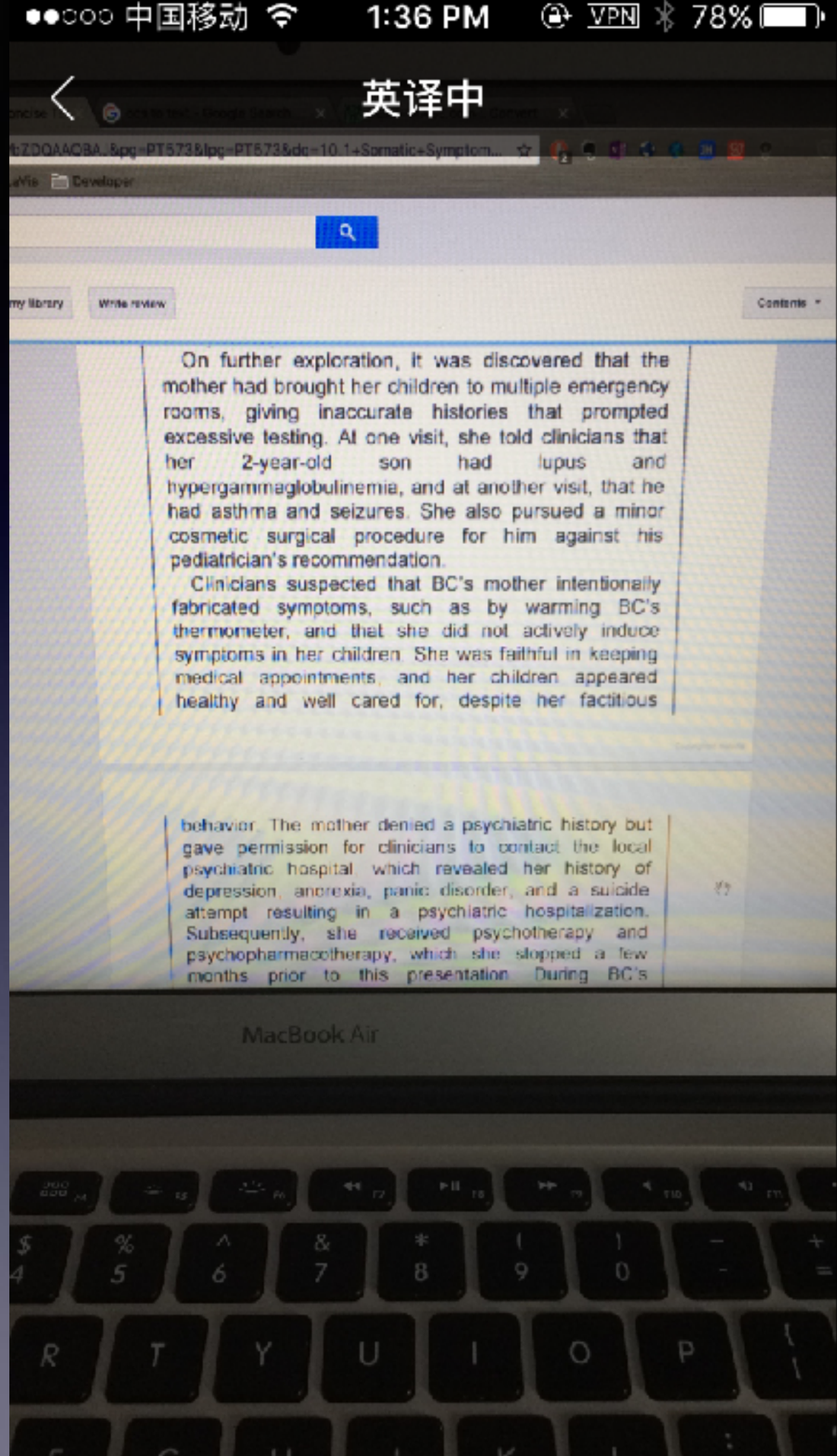
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On further exploration, it was discovered that the mother had brought her children to multiple emergency rooms, giving inaccurate histories that prompted excessive testing. At one visit, she told clinicians that her 2-year-old son had lupus and hypergammaglobulinemia, and at another visit, that he had asthma and seizures. She also pursued a minor cosmetic surgical procedure for him against his pediatrician's recommendation.
Clinicians suspected that BC's mother intentionally fabricated symptoms, such as by warming BC's thermometer, and that she did not actively induce symptoms in her children. She was faithful in keeping medical appointments, and her children appeared healthy and well cared for, despite her factitious
behavior. The mother denied a psychiatric history but gave permission for clinicians to contact the local psychiatric hospital, which revealed her history of depression, anorexia, panic disorder, and a suicide attempt resulting in a psychiatric hospitalization. Subsequently, she received psychotherapy and psychopharmacotherapy, which she stopped a few months prior to this presentation. During BC's
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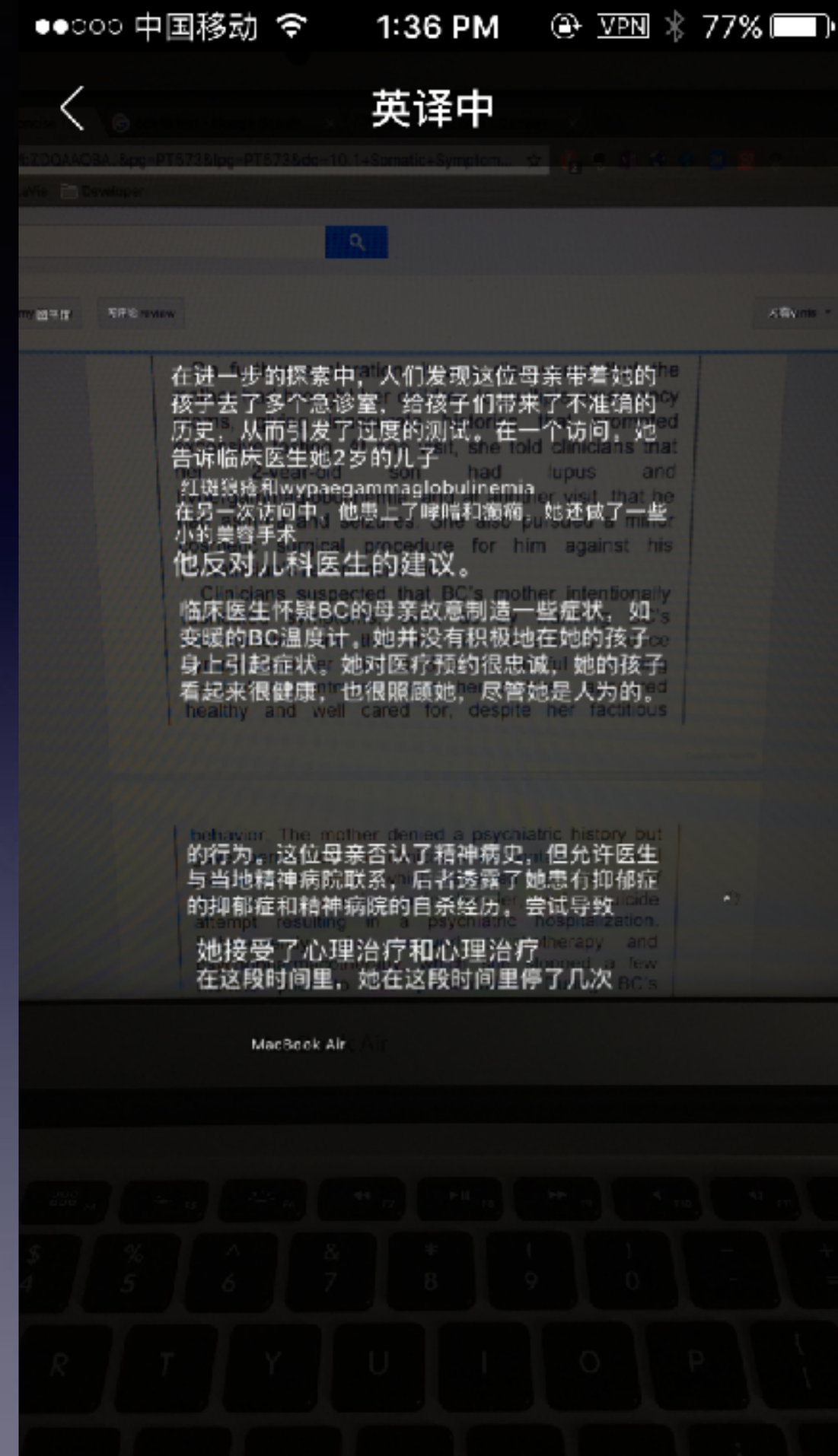
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在进一步的探索中，人们发现这位母亲带着她的孩子去了多个急诊室，给孩子们带来了不准确的历史，从而引发了过度的测试。在一个访问，她告诉临床医生她2岁的儿子
红斑狼疮和wypaegammaglobulinemia
在另一次访问中，他患上了哮喘和癫痫，她还做了一些小的美容手术
他反对儿科医生的建议。
临床医生怀疑BC的母亲故意制造一些症状，如变暖的BC温度计。她并没有积极地在她的孩子身上引起症状。她对医疗预约很忠诚，她的孩子看起来很健康，也很照顾她，尽管她是人为的。
的行为。这位母亲否认了精神病史，但允许医生与当地精神病院联系，后者透露了她患有抑郁症的抑郁症和精神病院的自杀经历，尝试导致
她接受了心理治疗和心理治疗
在这段时间里，她在这段时间里停了几次
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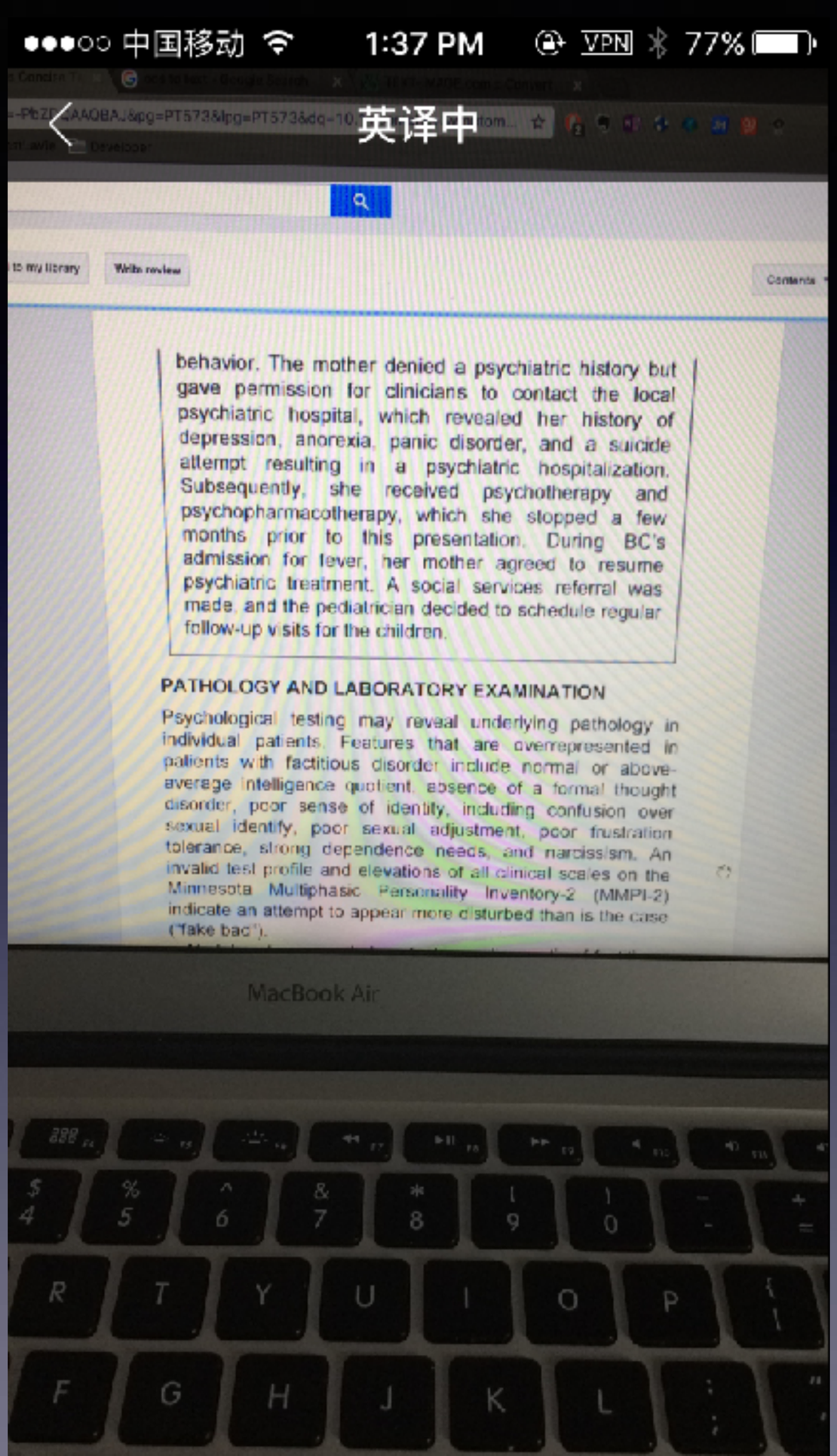
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behavior. The mother denied a psychiatric history but gave permission for clinicians to contact the local psychiatric hospital, which revealed her history of depression, anorexia, panic disorder, and a suicide attempt resulting in a psychiatric hospitalization. Subsequently, she received psychotherapy and psychopharmacotherapy, which she stopped a few months prior to this presentation. During BC's admission for fever, her mother agreed to resume psychiatric treatment. A social services referral was made, and the pediatrician decided to schedule regular follow-up visits for the children.
PATHOLOGY AND LABORATORY EXAMINATION
Psychological testing may reveal underlying pathology in individual patients. Features that are overrepresented in patients with factitious disorder include normal or above-average intelligence quotient, absence of a formal thought disorder, poor sense of identity, including confusion over sexual identify, poor sexual adjustment, poor frustration tolerance, strong dependence needs, and narcissism. An invalid test profile and elevations of all clinical scales on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) indicate an attempt to appear more disturbed than is the case ("fake bad").
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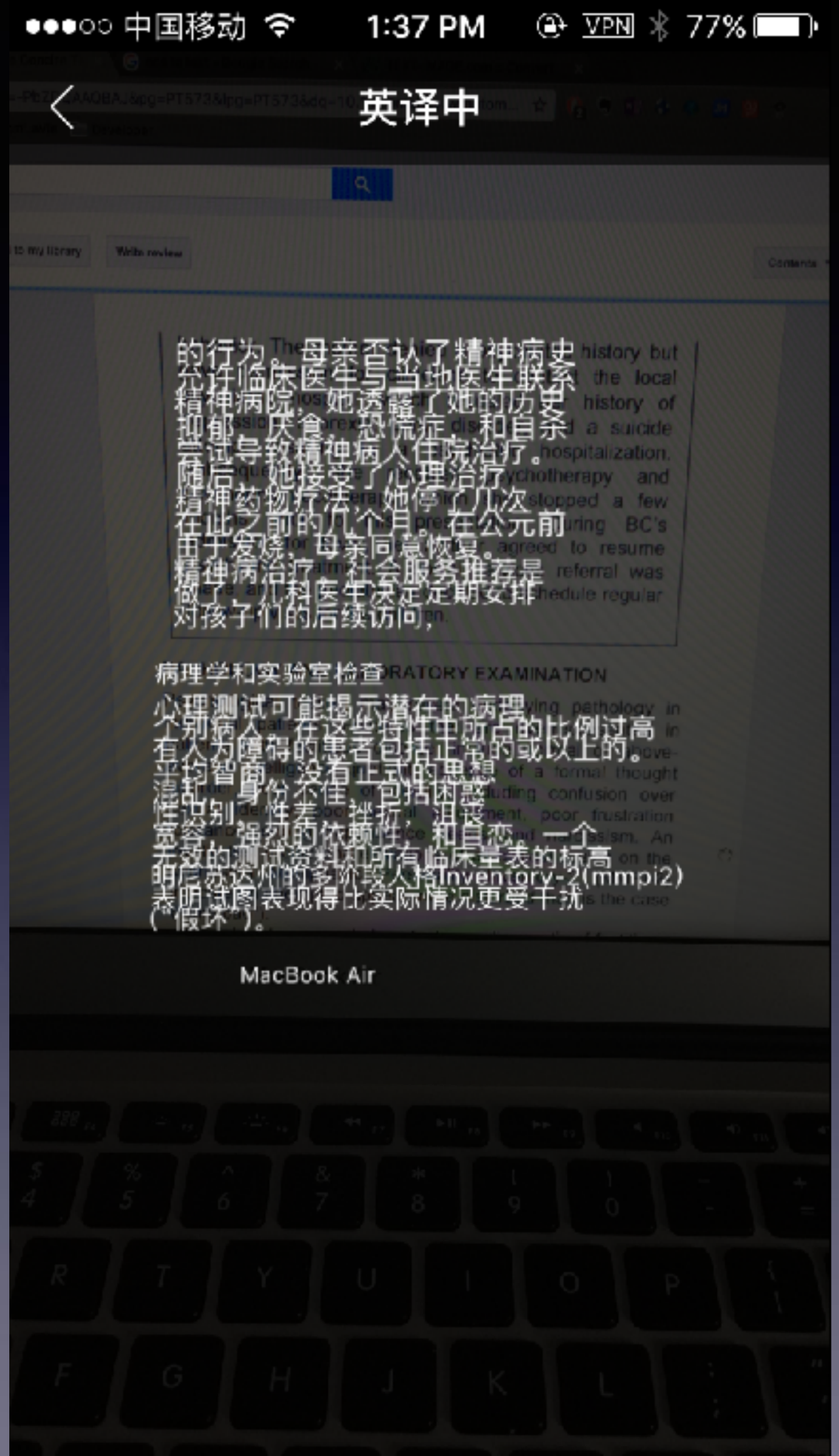
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的行为。母亲否认了精神病史
允许临床医生与当地医生联系
精神病院，她透露了她的历史
抑郁，厌食，恐慌症，和自杀
尝试导致精神病人住院治疗。
随后，她接受了心理治疗
精神药物疗法，她停了几次
在此之前的几个月。在公元前
由于发烧，母亲同意恢复。
精神病治疗，社会服务推荐是
做了，儿科医生决定定期安排
对孩子们的后续访问，
病理学和实验室检查
心理测试可能揭示潜在的病理
个别病人。在这些特性中所占的比例过高
有人为障碍的患者包括正常的或以上的。
平均智商，没有正式的思想
混乱，身份不佳，包括困惑
性别，性差，挫折，沮丧
宽容，强烈的依赖性需求，和自恋。一个
无效的测试资料和所有临床量表的标高
明尼苏达州的多阶段人格Inventory-2(mmpi2)
表明试图表现得比实际情况更受干扰
（"假坏"）。
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PATHOLOGY AND LABORATORY EXAMINATION

Psychological testing may reveal underlying pathology in individual patients. Features that are overrepresented in patients with factitious disorder include normal or above-average intelligence quotient, absence of a formal thought disorder, poor sense of identity, including confusion over sexual identify, poor sexual adjustment, poor frustration tolerance, strong dependence needs, and narcissism. An invalid test profile and elevations of all clinical scales on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) indicate an attempt to appear more disturbed than is the case ("fake bad").

No laboratory or pathology tests are diagnostic of factitious disorders, although they may help to confirm the diagnosis by demonstrating deception. Certain tests (e.g., drug screening), however, may help confirm or rule out specific mental or medical disorders.

DIFFERENTIAL DIAGNOSIS

Any disorder in which physical signs and symptoms are prominent should be considered in the differential diagnosis.

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病理学和实验室检查D LABORATORY EXAMINATION

心理测试可能提示出不充分的病理 underlying pathology in
个别病人。在这些特性中所占的比例过高 overrepresented in
有人为障碍的患者包括正常的或以上的 de normal or above-
平均智商，没有正式的思想 ent, absence of a formal thought
混乱，身份不佳，包括困惑 identity, including confusion over
性识别，性差，挫折，沮丧 sexual adjustment, poor frustration
容忍，强烈的依赖性，和自恋。一个 needs, and narcissism. An
无效的测试资料和所有临床量表的标高 all clinical scales on the
明尼苏达的多元人格特质(mpi-2) nality Inventory-2 (MMPI-2)
表明试图表现得比实际情况更受干扰 e disturbed than is the case
("假坏")。 bad").
没有实验室或病理学检查是人为的诊断 re diagnostic of factitious
障碍，尽管他们可能会帮助确诊 help to confirm the diagnosis by
展示欺骗。(如某些测试，药物筛选) tests (e.g., drug screening),
但是，可以帮助确认或排除特定的心理 out specific mental or
医疗疾病。 cal disorders.

鉴别诊断ERENTIAL DIAGNOSIS

任何身体体征和症状的障碍 physical signs and symptoms are
在鉴别诊断中应该考虑突出的。 dered in the differential diagnosis.

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and the possibility of authentic or concomitant physical illness must always be explored. Additionally, a history of many surgeries in patients with factitious disorder may predispose such patients to complications or actual diseases, necessitating even further surgery. Factitious disorder is on a continuum between somatoform disorders and malingering, the goal being to assume the sick role. On the one hand, it is unconscious and nonvolitional, and on the other hand, it is conscious and willful (malingering).

Conversion Disorders

A factitious disorder is differentiated from conversion disorder by the voluntary production of factitious symptoms, the extreme course of multiple hospitalizations, and the seeming willingness of patients with a factitious disorder to undergo an extraordinary number of mutilating procedures. Patients with conversion disorder are not usually conversant with medical terminology and hospital routines, and their symptoms have a direct temporal relation or symbolic reference to specific emotional conflicts.

Hypochondriasis or illness anxiety disorder differs from factitious disorder in that the hypochondriacal patient does not voluntarily initiate the production of symptoms and hypochondriasis typically has a later age of onset. As with conversion disorder, patients with hypochondriasis do not usually submit to potentially mutilating procedures.

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可能是真实的或伴随的身体疾病的可能性
必须探索。此外，许多人的历史
有人工障碍的病人的手术可能会预先处理
这些病人的并发症或实际的疾病，
需要进一步手术治疗。人为的障碍在a
躯体型障碍和畸形之间的连续体，
我们的目标是承担起病人的角色。一方面，它是
无意识和nonvolitional，另一方面，它是
意识和故意(伪)。

转换障碍

一种人为障碍与转化障碍有区别
通过自愿的人为症状的产生，
多住院治疗的极端过程，以及表面上的
患有一种人为障碍的患者的意愿
大量的切割程序。患者
转化障碍通常不熟悉医学
术语和医院例程，它们的症状有
直接时态关系或符号引用
情感冲突

低软骨症或疾病焦虑症不同于
疑病症患者的假性障碍
不主动提出症状的产生，并且
低骨病通常有较晚的发病年龄。与
转化障碍，疑病症患者没有
通常是提交潜在的切割程序。

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Personality Disorders

Because of their pathological lying, lack of close relationships with others, hostile and manipulative manner, and associated substance abuse and criminal history, patients with factitious disorder are often classified as having antisocial personality disorder. Antisocial persons, however, do not usually volunteer for invasive procedures or resort to a way of life marked by repeated or long-term hospitalization.

Factitious disorders must be distinguished from malingering. Malingerers have an obvious, recognizable environmental goal in producing signs and symptoms. They may seek hospitalization to secure financial compensation, evade the police, avoid work, or merely obtain free bed and board for the night, but they always have some apparent end for their behavior. Moreover, these patients can usually stop producing their signs and symptoms when they are no longer considered profitable or when the risk becomes too great.

Substance Abuse

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人格障碍

因为他们的病态撒谎，缺乏亲密的关系与他人，敌对和操控性的态度，以及相关的药物滥用和犯罪史，有假的病人混乱通常被归类为反社会人格障碍。然而，反社会的人通常不会自愿接受侵入性手术或采取一种生活方式以重复或长期住院为标志。

人为的障碍必须与恶意的障碍区分开来。Malingerers有一个明显的，可识别的环境在生产标志和症状方面的目标。他们可能会寻求hasp意大利语获得自由贸易补偿，逃避避免工作，或仅仅获得免费的床和板晚上，但是他们总是有一些明显的结束的行为，而且，这些病人通常可以停止当他们不再是他们的标志和症状时被认为是有利可图的，或者当风险太大的时候。

药物滥用

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Substance Abuse

Although patients with factitious disorders may have a complicating history of substance abuse, they should be considered not merely as substance abusers but as having coexisting diagnoses.

Ganser's Syndrome

Ganser's syndrome, a controversial condition most typically associated with prison inmates, is characterized by the use of approximate answers. Persons with the syndrome respond to simple questions with astonishingly incorrect answers. For example, when asked about the color of a blue car, the person answers "red" or answers "2 plus 2 equals 5." Ganser's syndrome may be a variant of malingering, in that the patients avoid punishment or responsibility for their actions. Ganser's syndrome can be classified in DSM-5 as a type of dissociative disorder and in *International Statistical Classification of Diseases and Related Health Problems*, 10th edition (ICD-10), it is classified under other dissociative or conversion disorders. In contrast, patients with factitious disorder with predominantly psychological signs and symptoms may *intentionally* give approximate answers.

COURSE AND PROGNOSIS

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药物滥用ce Abuse

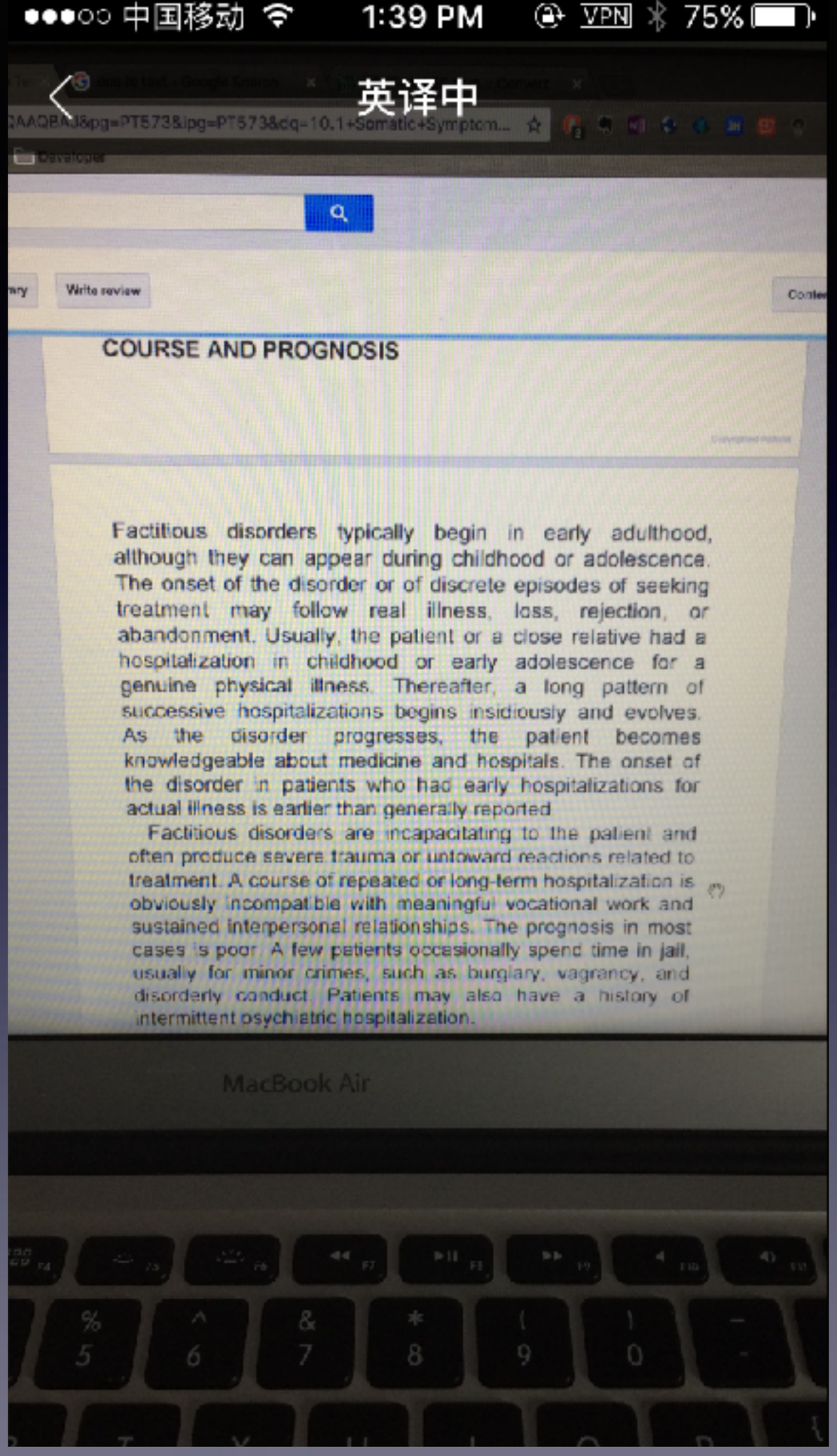
尽管有人为障碍的病人可能会有一段复杂的药物滥用史，但他们应该被认为不仅仅是药物滥用者，还应被认为是有共同的诊断。

甘塞尔综合征drome

Ganser的综合症，这是一种有争议的情况，通常与监狱囚犯有关，其特点是使用近似的答案。患有这种综合症的人会对简单的问题作出回答，答案是惊人的错误。例如,当被问及一个蓝色的汽车的颜色,这个人回答"红色"在回答12 + 2 = 50甘塞尔综合症可能是一个变种的伪病人避免惩罚或为自己的行为责任甘塞尔综合征可分为在dsm - 5作为解离症的类型和在国际疾病分类和相关的健康问题,第十版(CD-10),分类在其他离解或转换障碍。与此相反的是，患有心理障碍的患者主要是心理症状和g

症状可能会有一些近似的答案。

病程和预后 AND PROGNOSIS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COURSE AND PROGNOSIS
Factitious disorders typically begin in early adulthood, although they can appear during childhood or adolescence. The onset of the disorder or of discrete episodes of seeking treatment may follow real illness, loss, rejection, or abandonment. Usually, the patient or a close relative had a hospitalization in childhood or early adolescence for a genuine physical illness. Thereafter, a long pattern of successive hospitalizations begins insidiously and evolves. As the disorder progresses, the patient becomes knowledgeable about medicine and hospitals. The onset of the disorder in patients who had early hospitalizations for actual illness is earlier than generally reported.
Factitious disorders are incapacitating to the patient and often produce severe trauma or untoward reactions related to treatment. A course of repeated or long-term hospitalization is obviously incompatible with meaningful vocational work and sustained interpersonal relationships. The prognosis in most cases is poor. A few patients occasionally spend time in jail, usually for minor crimes, such as burglary, vagrancy, and disorderly conduct. Patients may also have a history of intermittent psychiatric hospitalization.
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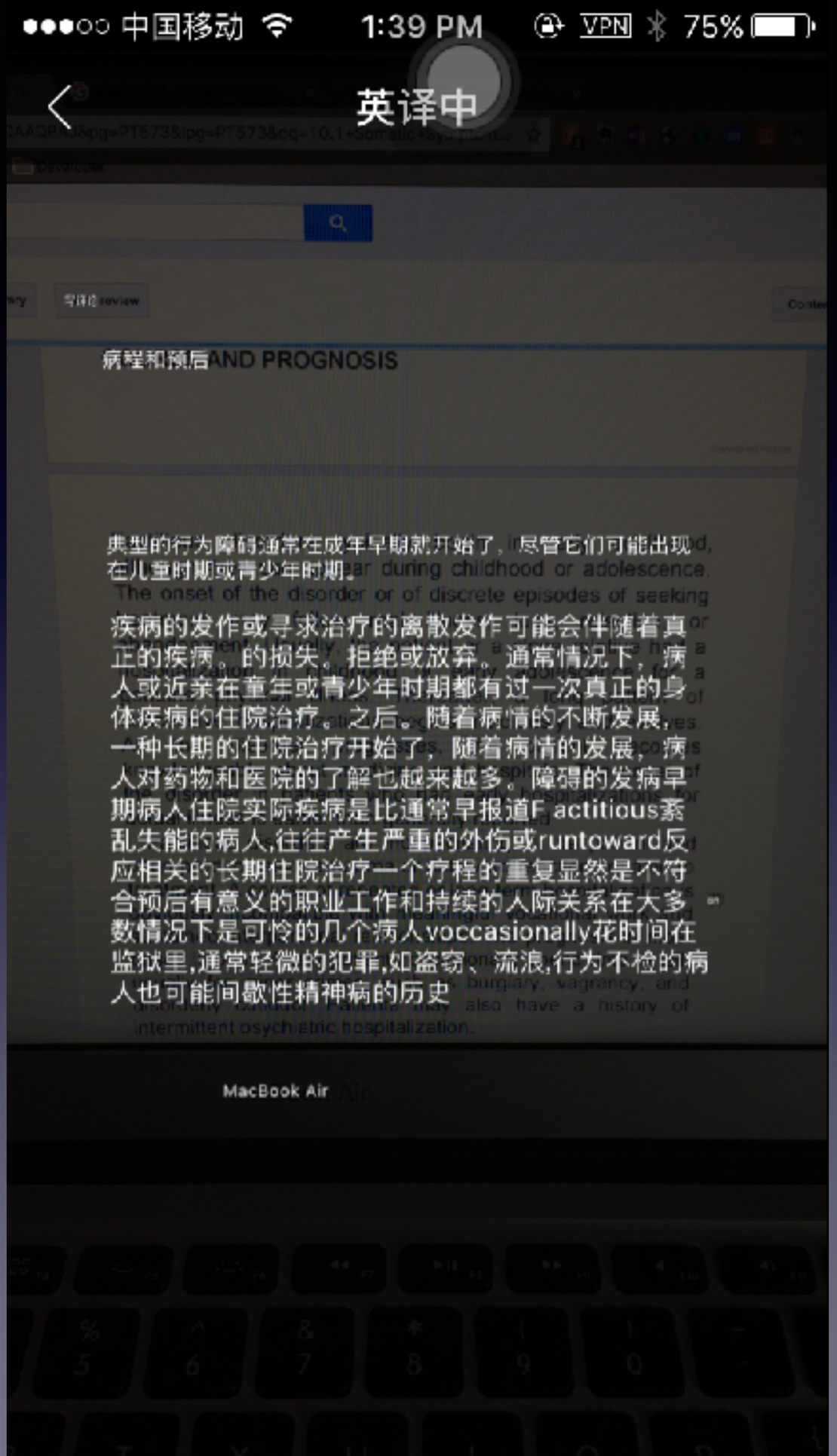
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病程和预后AND PROGNOSIS
典型的行为障碍通常在成年早期就开始了，尽管它们可能出现在儿童时期或青少年时期。
疾病的发作或寻求治疗的离散发作可能会伴随着真正的疾病，的损失，拒绝或放弃。通常情况下，病人或近亲在童年或青少年时期都有过一次真正的身体疾病的住院治疗。之后，随着病情的不断发展，一种长期的住院治疗开始了，随着病情的发展，病人对药物和医院的了解也越来越多。障碍的发病早期病人住院实际疾病是比通常早报道Factitious紊乱失能的病人,往往产生严重的外伤或runtoward反应相关的长期住院治疗一个疗程的重复显然是不符合预后有意义的职业工作和持续的人际关系在大多数情况下是可怜的几个病人voccasionally花时间在监狱里,通常轻微的犯罪,如盗窃、流浪,行为不检的病人也可能间歇性精神病的历史
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Although no adequate data are available about the ultimate outcome for the patients, a few of them probably die as a result of needless medication, instrumentation, or surgery. In view of the patients' often expert simulation and the risks that they take, some may die without the disorder being suspected. Possible features that indicate a favorable prognosis are (1) the presence of a depressive-masochistic personality; (2) functioning at a borderline, not a continuously psychotic, level; and (3) the attributes of an antisocial personality disorder with minimal symptoms.

TREATMENT

No specific psychiatric therapy has been effective in treating factitious disorders. It is a clinical paradox that patients with

the disorders simulate serious illness and seek and submit to unnecessary treatment while they deny to themselves and others their true illness and thus avoid possible treatment for it. Ultimately, the patients elude meaningful therapy by abruptly leaving the hospital or failing to keep follow-up appointments.

Treatment, thus, is best focused on management rather than on cure. Guidelines for the treatment and management of factitious disorder are given in Table 10.4–4. The three

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尽管对于患者的最终结果没有足够的数据，但其中一些人可能因不必要的药物、仪器或手术而死亡。考虑到患者通常的专家模拟和他们所承担的风险。有些人可能在没有这种疾病的情况下死亡。可能的特征表明良好的预后(1)存在一种epres-masocha人格(2)在边缘处运作，而不是持续的精神病，水平和(3)反社会的属性 an antisocial
人格障碍，症状最小。

治疗EATMENT

没有任何特定的精神疗法在治疗人为疾病方面是有效的。这是一个临床悖论

这些疾病模拟严重的疾病，寻求并接受不必要的治疗当他们否认自己和其他人的真实病情从而避免了可能的治疗最终，患者逃避有意义的治疗宾大的医生突然离开医院，无法继续进行后续的预约

治疗。因此，最关注的是管理而不是治疗和纳米技术的治疗指南

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Treatment, thus, is best focused on management rather than on cure. Guidelines for the treatment and management of factitious disorder are given in Table 10.4–4. The three major goals in the treatment and management of factitious disorders are to (1) reduce the risk of morbidity and mortality, (2) address the underlying emotional needs or psychiatric diagnosis underlying factitious illness behavior, and (3) be mindful of legal and ethical issues. Perhaps the single most important factor in successful management is a physician's early recognition of the disorder. In this way, physicians can forestall a multitude of painful and potentially dangerous diagnostic procedures for these patients. Good liaison between psychiatrists and the medical or surgical staff is strongly advised. Although a few cases of individual psychotherapy have been reported in the literature, no consensus exists about the best approach. In general, working in concert with the patient's primary care physician is more effective than working with the patient in isolation.

Table 10.4–4
Guidelines for Management and Treatment of Factitious Disorder

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英译中

Treatment, thus, is best focused on management rather

治疗。因此，最好把精力放在管理上而不是治疗上。在表10-4中给出了治疗和管理人为障碍的指导原则。治疗和管理人为障碍的三个主要目标是：(1)降低发病率和死亡率(2)解决潜在的情感需求或精神疾病行为背后的精神疾病的诊断。(3)注意法律和伦理问题也许在成功的管理中，最重要的因素是医生对这种疾病的认识，医生可以预先预防大量的痛苦和潜在危险的诊断程序。精神科医生与医疗或外科医生之间的良好联系是很好的建议。尽管个别心理疗法的案例已经被报道过

的文学。对于最好的方法，没有共识。一般来说，与病人的初级保健医师一起工作比单独与病人一起工作更有效。

人为障碍管理和治疗指南

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Active pursuit of a prompt diagnosis can minimize the risk of morbidity and mortality.

Minimize harm. Avoid unnecessary tests and procedures, especially if invasive. Treat according to clinical judgment, keeping in mind that subjective complaints may be deceptive.

Regular interdisciplinary meetings to reduce conflict and splitting among staff. Manage staff countertransference.

Consider facilitating healing by using the double-bind technique or face-saving behavioral strategies, such as self-hypnosis or bioteedback.

Steer the patient toward psychiatric treatment in an empathic, noncontrontational, face-saving manner. Avoid aggressive direct confrontation.

Treat underlying psychiatric disturbances, such as Axis I disorders and Axis II disorders. In psychotherapy, address coping strategies and emotional conflicts.

Appoint a primary care provider as a gatekeeper for all medical and psychiatric treatment.

Consider involving risk management professionals and bioethicists from an early point.

Consider appointing a guardian for medical and psychiatric decisions.

Consider prosecution for fraud, as a behavioral disincentive.

The personal reactions of physicians and staff members are of great significance in treating and establishing a working alliance with these patients, who invariably evoke feelings of futility, bewilderment, betrayal, hostility, and even contempt. In essence, staff members are forced to abandon a basic element of their relationship with patients—accepting the truthfulness of the patients' statements. One appropriate

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快速的失认症会使你的风险降到最低
morbicHty和死亡率。
减少伤害。没有必要的测试和程序
特别是红外入侵。根据临床医生的判断，
记住，主观的抱怨可能是
可接受的。
常规的inwdi5cip15次会议以减少冲突
之间的分裂。管理员工counterttansference。
通过双重约束来促进愈合
技术或laccmiiehtivi拉尔策略，例如
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引导病人去接受精神治疗。
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Appoint a primary care provider as a gatekeeper for all medical and psychiatric treatment.
一致的风险管理prctt的"ssiendlr"ni professionals and bioethicists from an early point.
Consider appointing a guardian for medical and psychiatric decisinn"ions.
Consider prosecution for fraud, as a behavioral disincentive.

医生和工作人员的个人反应
在治疗和建立工作上具有重要意义
与这些患者结盟，他们总是会唤起情感
徒劳，困惑，背叛，敌意，甚至是轻蔑。
本质上，员工被迫放弃基本的工作。
与病人的关系，与病人的关系

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英译中

The personal reactions of physicians and staff members are of great significance in treating and establishing a working alliance with these patients, who invariably evoke feelings of futility, bewilderment, betrayal, hostility, and even contempt. In essence, staff members are forced to abandon a basic element of their relationship with patients—accepting the truthfulness of the patients' statements. One appropriate psychiatric intervention is to suggest to the staff ways of remaining aware that even though the patient's illness is factitious, the patient is ill.

Physicians should try not to feel resentment when patients humiliate their diagnostic prowess, and they should avoid any unmasking ceremony that sets up the patients as adversaries and precipitates their flight from the hospital. The staff should not perform unnecessary procedures or discharge patients abruptly, both of which are manifestations of anger.

Clinicians who find themselves involved with patients with factitious disorders may become angry at the patients for lying and deceiving them. Hence, therapists must be mindful of countertransference whenever they suspect factitious disorder. Often, the diagnosis is unclear because a definitive physical cause cannot be entirely ruled out. Although the use of confrontation is controversial, at some point in the

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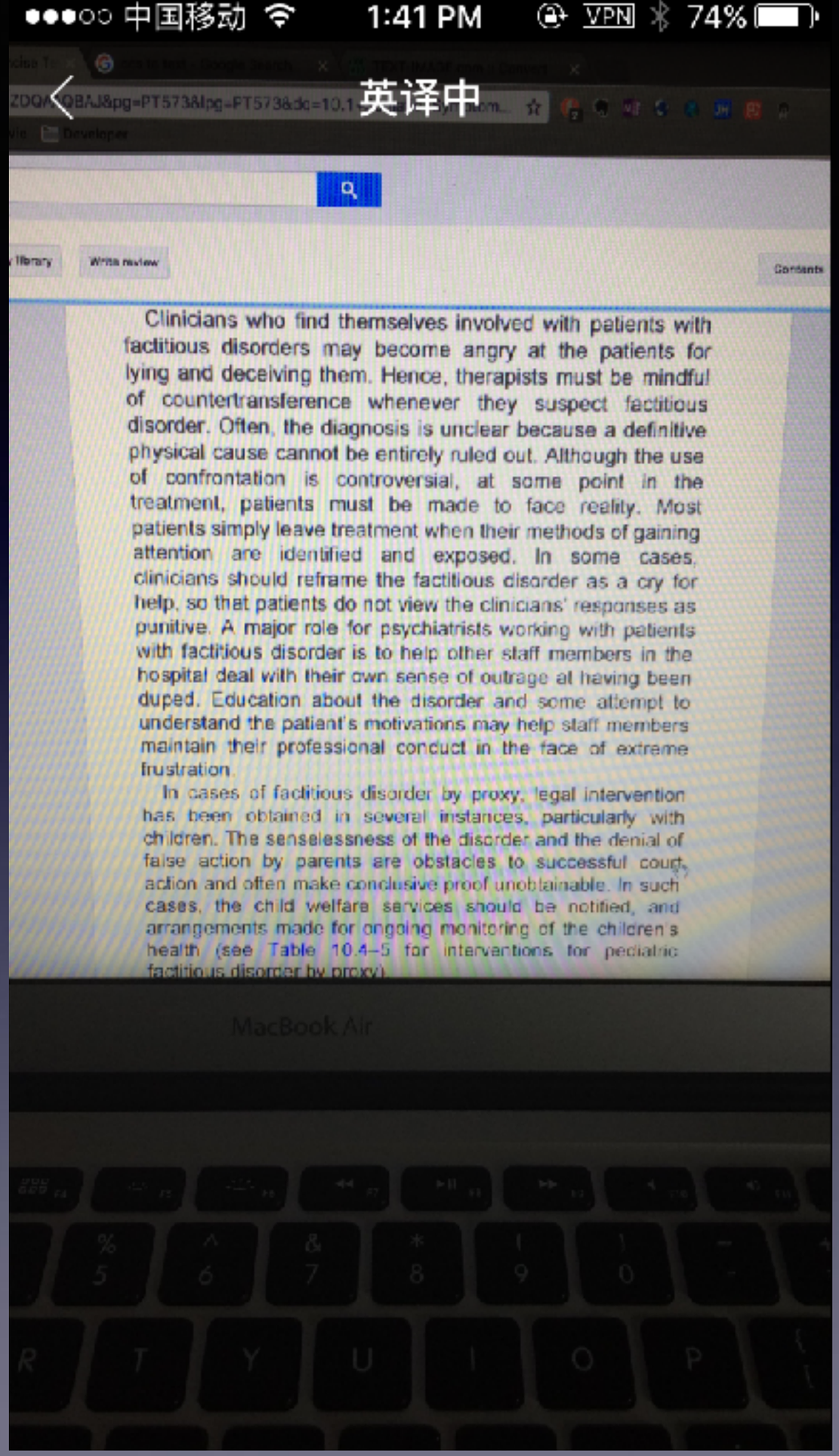
医生和工作人员的个人反应在治疗和建立与这些患者的工作联盟方面具有重要意义，他们总是唤起人们的徒劳和困惑。背叛，敌意，甚至是轻蔑的本质上，工作人员被迫放弃与他们关系的一个基本要素即接受病人陈述的真实性一个适当的精神干预是向工作人员表明，即使病人的病情是人为的，病人也会生病。

当病人在羞辱他们的诊断能力时，医生应该尽量不让他们感到愤慨，他们应该避免任何不掩饰的仪式，把病人作为对手，并从医院中沉淀。员工应该不做不必要的手术或突然出院，这两者都是愤怒的表现。

临床医师发现自己参与人为障碍患者可能会对病人说谎和ideceiving!他们因此,治疗师必须注意“untertransferenc每当他们怀疑人为障碍的诊断尚不清楚,因为明确的物理原因不能完全排除虽然使用对抗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Clinicians who find themselves involved with patients with factitious disorders may become angry at the patients for lying and deceiving them. Hence, therapists must be mindful of countertransference whenever they suspect factitious disorder. Often, the diagnosis is unclear because a definitive physical cause cannot be entirely ruled out. Although the use of confrontation is controversial, at some point in the treatment, patients must be made to face reality. Most patients simply leave treatment when their methods of gaining attention are identified and exposed. In some cases, clinicians should reframe the factitious disorder as a cry for help, so that patients do not view the clinicians' responses as punitive. A major role for psychiatrists working with patients with factitious disorder is to help other staff members in the hospital deal with their own sense of outrage at having been duped. Education about the disorder and some attempt to understand the patient's motivations may help staff members maintain their professional conduct in the face of extreme frustration.
In cases of factitious disorder by proxy, legal intervention has been obtained in several instances, particularly with children. The senselessness of the disorder and the denial of false action by parents are obstacles to successful court action and often make conclusive proof unobtainable. In such cases, the child welfare services should be notified, and arrangements made for ongoing monitoring of the children's health (see Table 10.4–5 for interventions for pediatric factitious disorder by proxy).
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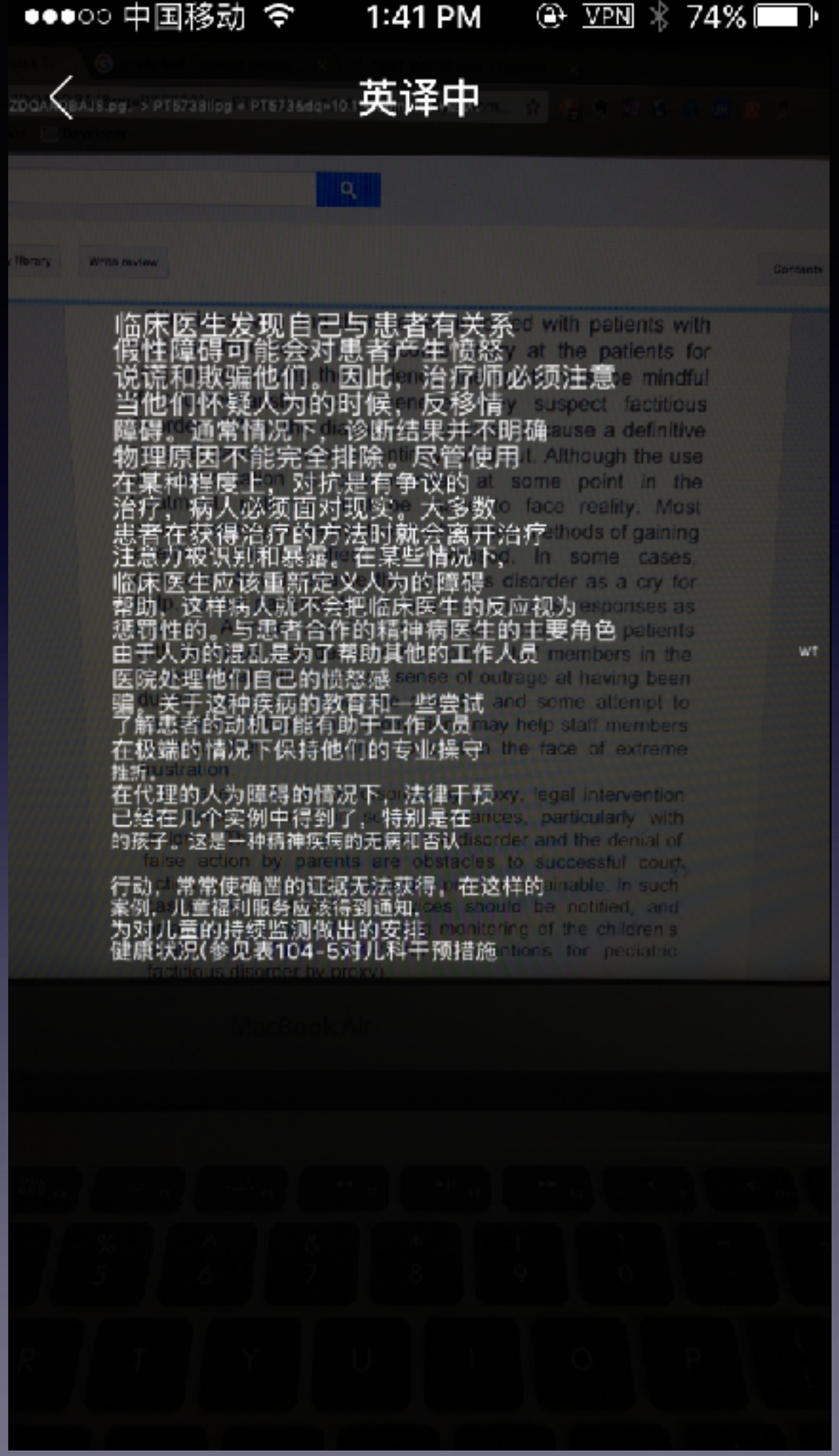
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临床医生发现自己与患者有关系
假性障碍可能会对患者产生愤怒
说谎和欺骗他们。因此，治疗师必须注意
当他们怀疑人为的时候，反移情
障碍。通常情况下，诊断结果并不明确
物理原因不能完全排除。尽管使用
在某种程度上，对抗是有争议的
治疗，病人必须面对现实。大多数
患者在获得治疗的方法时就会离开治疗
注意力被识别和暴露。在某些情况下，
临床医生应该重新定义人为的障碍
帮助，这样病人就不会把临床医生的反应视为
惩罚性的。与患者合作的精神病医生的主要角色
由于人为的混乱是为了帮助其他的工作人员
医院处理他们自己的愤怒感
骗。关于这种疾病的教育和一些尝试
了解患者的动机可能有助于工作人员
在极端的情况下保持他们的专业操守
挫折。
在代理的人为障碍的情况下，法律干预
已经在几个实例中得到了，特别是在
的孩子。这是一种精神疾病的无病和否认
行动，常常使确凿的证据无法获得，在这样的
案例，儿童福利服务应该得到通知，
为对儿童的持续监测做出的安排
健康状况(参见表104-5对儿科干预措施

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Write review Contents

arrangements made for ongoing monitoring of the children's health (see Table 10.4–5 for interventions for pediatric factitious disorder by proxy).

Pharmacotherapy of factitious disorders is of limited use. Major mental disorders such as schizophrenia will respond to antipsychotic medication; however, in all cases, medication should be administered carefully because of the potential for abuse. Selective serotonin reuptake inhibitors (SSRIs) may

Some pages are omitted from this book preview.

exist in how various ethnic and cultural groups respond to pain, but the usefulness of cultural factors for the clinician remains obscure to the treatment of individuals with pain disorder because of a lack of good data and because of high individual variability.

ETIOLOGY

Psychodynamic Factors

Patients who experience bodily aches and pains without identifiable and adequate physical causes may be

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为对儿童的持续监测做出的安排 monitoring of the children's
健康状况(参见表10-5对儿科干预措施 ventions for pediatric
人为的障碍通过代理)。 roxy).
人工疾病的药物治疗是有限的。 s disorders is of limited use.
精神障碍等主要精神障碍会对患者产生反应 nia will respond to
抗精神病药物;然而,在所有情况下,药物治疗 cases, medication
应该谨慎管理因为有潜力 carefully because of the potential for
滥用。选择性血清素再摄取抑制剂(SSRIs)可能 s (SSRIs) may

在这个book预览版中省略了一些页面。preview

存在于不同的种族和文化群体对 and cultural groups respond to
疼痛,但对于临床医生来说,文化因素的作用 for the clinician
对疼痛患者的治疗仍不清楚 e treatment of individuals with pain
因为缺乏良好的数据和高的数据 good data and because of high
个体差异性。 variability.

病因 IOLOGY

心理动力因素 amic Factors

没有经历过身体疼痛的病人 bodily aches and pains without
可识别和充分的物理原因可能是 physical causes may be

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Contents

ETIOLOGY

Psychodynamic Factors

Patients who experience bodily aches and pains without identifiable and adequate physical causes may be symbolically expressing an intrapsychic conflict through the body. Patients suffering from alexithymia, who are unable to articulate their internal feeling states in words, express their feelings with their bodies. Other patients may unconsciously regard emotional pain as weak and somehow lacking legitimacy. By displacing the problem to the body, they may feel they have a legitimate claim to the fulfillment of their dependency needs. The symbolic meaning of body disturbances may also relate to atonement for perceived sin, to expiation of guilt, or to suppressed aggression. Many patients have intractable and unresponsive pain because they are convinced they deserve to suffer.

Pain can function as a method of obtaining love, a punishment for wrongdoing, and a way of expiating guilt and atoning for an innate sense of badness. Among the defense mechanisms used by patients with pain disorder are displacement, substitution, and repression. Identification plays a part when a patient takes on the role of an ambivalent love object who also has pain, such as a parent.

Behavioral Factors

Pain behaviors are reinforced when rewarded and are

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病因OLOGY

心理动力因素mic Factors

Patients who experience bodily aches and pains without

身体疼痛的患者，如果没有明确的身体原因，可能会象征性地表达出一种精神上的冲突，通过身体的病人，他们无法用语言表达自己的内心感受，用身体表达自己的感受。其他病人可能会无意识地认为情感上的疼痛是软弱的，而且不知何故缺乏合法性。通过将问题转移到身体上，他们可能会觉得自己有合法的权利要求满足他们的依赖需求。身体干扰的象征意义也可能与赎罪的赎罪，或罪责的补偿有关，或

disturbances may also relate to atonement for perceived sin,

为了抑制攻击性，许多病人都有难以忍受的、无反应的疼痛，因为他们确信自己应该受到伤害。

疼痛可以作为一种获得爱的方法。对不道德行为的惩罚，以及一种补偿内疚的方式，以及为一种天生的不正当的防卫机制所做的辩护，这些机制使用的是“痛苦的病人，是流离失所、替换和压抑。”当一个病人扮演一个矛盾的“爱对象，也有痛苦，比如父母的角色”时，识别就起到了一定的作用。

who also has pain, such as a parent.

行为因素ioral Factors

当奖励和奖励时，疼痛行为得到强化

when rewarded and are

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Behavioral Factors

Pain behaviors are reinforced when rewarded and are inhibited when ignored or punished. For example, moderate pain symptoms may become intense when followed by the solicitous and attentive behavior of others, by monetary gain, or by the successful avoidance of distasteful activities.

Interpersonal Factors

Intractable pain has been conceptualized as a means for manipulation and gaining advantage in interpersonal relationships, for example, to ensure the devotion of a family member or to stabilize a fragile marriage. Such secondary gain is most important to patients with pain disorder.

Biological Factors

The cerebral cortex can inhibit the firing of afferent pain fibers. Serotonin is probably the main neurotransmitter in the descending inhibitory pathways, and endorphins also play a role in the central nervous system modulation of pain. Endorphin deficiency seems to correlate with augmentation of incoming sensory stimuli. Some patients may have pain disorder, rather than another mental disorder, because of

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行为因素ioral Factors

当受到奖励时，疼痛行为会得到强化，当被忽视或受到惩罚时，会受到抑制。例如，中度疼痛的症状可能在随后的时候变得强烈。

对他人的关心和细心的行为，通过金钱的收益，或成功地避免令人反感的行为。

人际关系因素nal Factors

难以处理的疼痛被认为是一种操纵和在人际关系中获得优势的手段例如，为了确保家庭成员的忠诚能够稳定脆弱的婚姻这种次要的收益对于患有疼痛的病人来说是最重要的。

生物因素ical Factors

大脑皮层可以抑制对传入的疼痛纤维血清素可能是主要的神经递质。下行抑制通路，内啡肽也扮演着中枢神经系统调节疼痛的作用。

内啡肽的缺乏似乎与增加的感官刺激有关，有些病人可能会有疼痛感。而不是另一种精神障碍。因为

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Biological Factors

The cerebral cortex can inhibit the firing of afferent pain fibers. Serotonin is probably the main neurotransmitter in the descending inhibitory pathways, and endorphins also play a role in the central nervous system modulation of pain. Endorphin deficiency seems to correlate with augmentation of incoming sensory stimuli. Some patients may have pain disorder, rather than another mental disorder, because of sensory and limbic structural or chemical abnormalities that predispose them to experience pain.

DIAGNOSIS AND CLINICAL FEATURES

Patients with pain disorder are not a uniform group, but a heterogeneous collection of persons with low back pain, headache, atypical facial pain, chronic pelvic pain, and other kinds of pain. A patient's pain may be posttraumatic, neuropathic, neurological, iatrogenic, or musculoskeletal; to meet a diagnosis of pain disorder, however, the disorder must have a psychological factor judged to be significantly involved in the pain symptoms and their ramifications.

Patients with pain disorder often have long histories of medical and surgical care. They visit many physicians, request many medications, and may be especially insistent in their desire for surgery. Indeed, they can be completely

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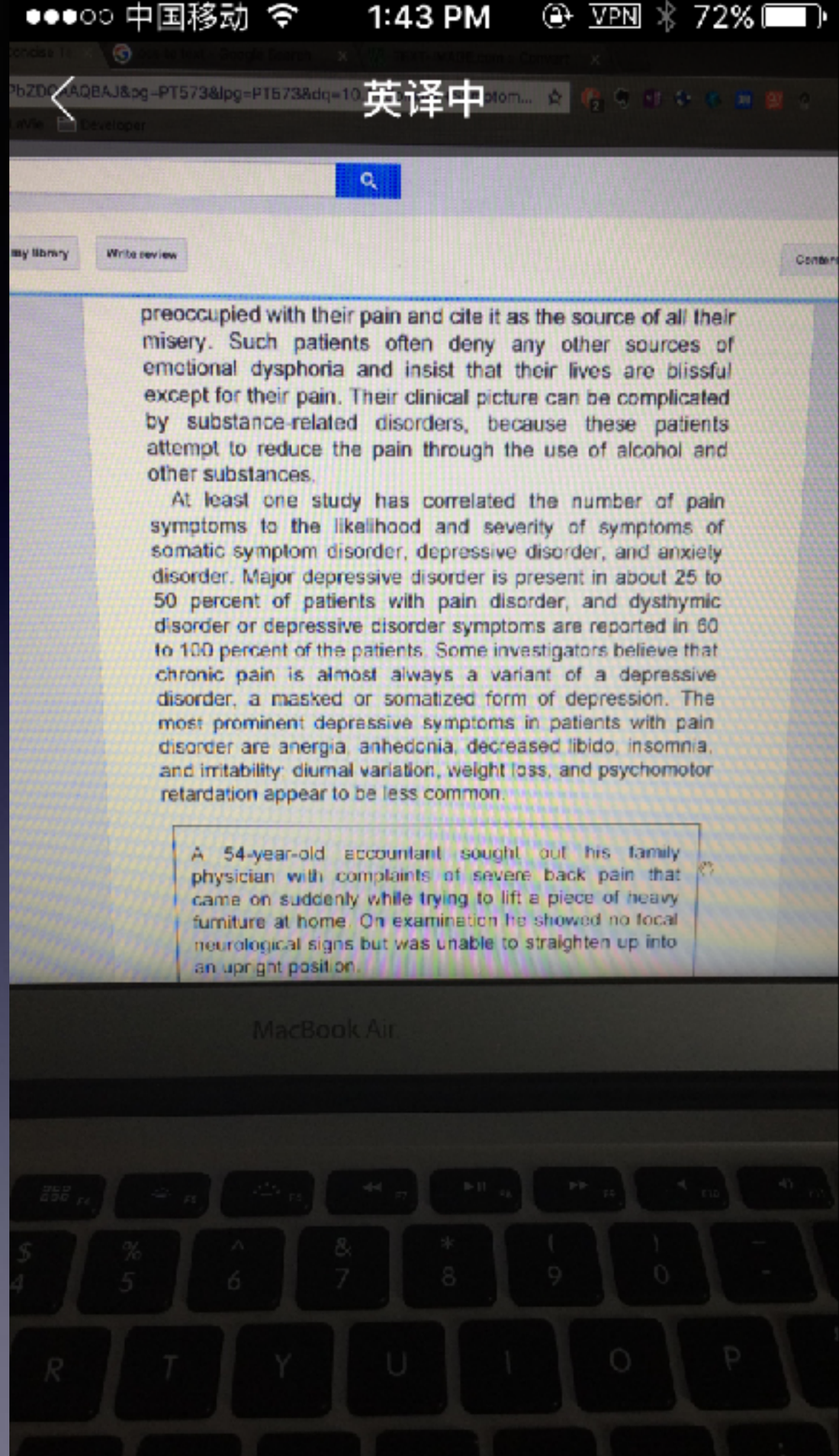
生物因素al Factors

大脑皮层可以抑制传入的疼痛纤维。血清素可能是下行抑制通路中的主要神经递质，而内啡肽在中枢神经系统调节疼痛中也起着重要作用。内啡肽的缺乏似乎与传入的感官刺激有关。有些病人可能会有疼痛障碍，而不是另一种精神障碍，因为感觉和边缘结构或化学异常会使他们感到疼痛。

诊断和临床特征是疼痛障碍的患者不是一个统一的群体，而是一群有着低腰痛和头痛的人群。非典型的面部疼痛，慢性骨盆疼痛和其他类型的疼痛。然而，病人的疼痛可能是一种疼痛的、神经的、神经的、医源性的、或者是努骨的，以适应疼痛的诊断。这种疾病必须有一个心理因素，认为Ibe在疼痛症状和他们的影响中有明显的影响。

患有疼痛的病人通常有很长时间的医疗和手术护理。他们拜访了许多医生，要求很多药物，而且可能特别坚持他们的外科手术。确实，他们可以完全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preoccupied with their pain and cite it as the source of all their misery. Such patients often deny any other sources of emotional dysphoria and insist that their lives are blissful except for their pain. Their clinical picture can be complicated by substance-related disorders, because these patients attempt to reduce the pain through the use of alcohol and other substances.
At least one study has correlated the number of pain symptoms to the likelihood and severity of symptoms of somatic symptom disorder, depressive disorder, and anxiety disorder. Major depressive disorder is present in about 25 to 50 percent of patients with pain disorder, and dysthymic disorder or depressive disorder symptoms are reported in 60 to 100 percent of the patients. Some investigators believe that chronic pain is almost always a variant of a depressive disorder, a masked or somatized form of depression. The most prominent depressive symptoms in patients with pain disorder are anergia, anhedonia, decreased libido, insomnia, and irritability; diurnal variation, weight loss, and psychomotor retardation appear to be less common.
A 54-year-old accountant sought out his family physician with complaints of severe back pain that came on suddenly while trying to lift a piece of heavy furniture at home. On examination he showed no focal neurological signs but was unable to straighten up into an upright position.
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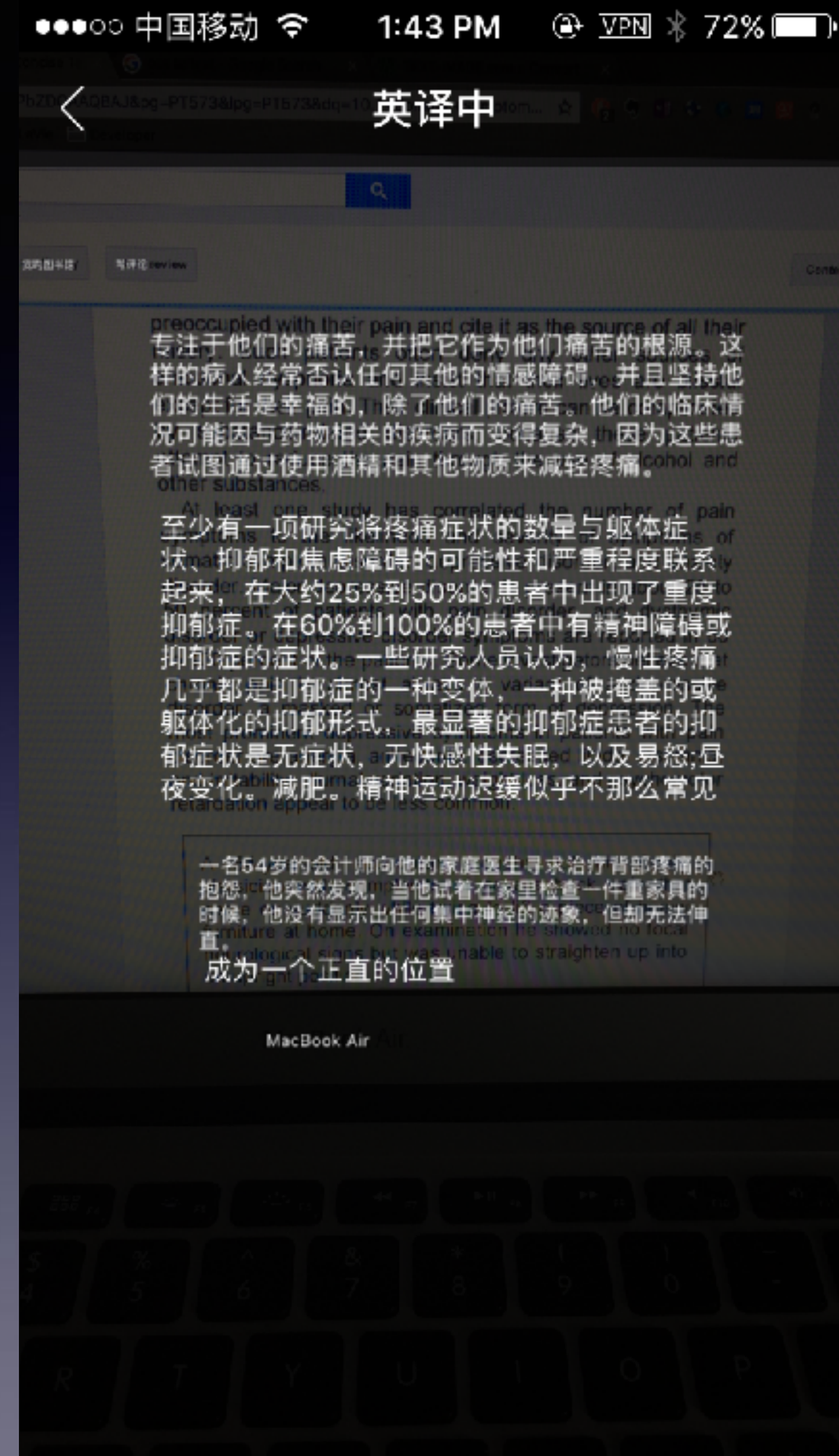
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专注于他们的痛苦，并把它作为他们痛苦的根源。这样的病人经常否认任何其他的情感障碍，并且坚持他们的生活是幸福的，除了他们的痛苦。他们的临床情况可能因与药物相关的疾病而变得复杂，因为这些患者试图通过使用酒精和其他物质来减轻疼痛。
至少有一项研究将疼痛症状的数量与躯体症状、抑郁和焦虑障碍的可能性和严重程度联系起来，在大约25%到50%的患者中出现了重度抑郁症。在60%到100%的患者中有精神障碍或抑郁症的症状。一些研究人员认为，慢性疼痛几乎都是抑郁症的一种变体，一种被掩盖的或躯体化的抑郁形式。最显著的抑郁症患者的抑郁症状是无症状，无快感性失眠，以及易怒;昼夜变化。减肥。精神运动迟缓似乎不那么常见
一名54岁的会计师向他的家庭医生寻求治疗背部疼痛的抱怨，他突然发现，当他试着在家里检查一件重家具的时候，他没有显示出任何集中神经的迹象，但却无法伸直。
成为一个正直的位置
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A 54-year-old accountant sought out his family physician with complaints of severe back pain that came on suddenly while trying to lift a piece of heavy furniture at home. On examination he showed no focal neurological signs but was unable to straighten up into an upright position.

The patient was referred for MRI, which revealed no structural abnormalities. He was advised to have several sessions with a physical therapist to treat what was diagnosed as "back strain," but as the therapy progressed, his pain became more severe, and he complained of muscle tension in his neck in addition to his back and spent most of his days sitting in a chair or lying on a bed board on his bed.

He was eventually referred to a psychiatrist and talked about the stress he was experiencing at work since an assistant that he relied on was fired because of his firm's need to downsize. His work load had increased tremendously as a result. The formulation by the psychiatrist was that the patient was "somatizing" his anger, transforming the strong affect into pain that enabled him to escape from the stressful situation. A course of psychoeducation was begun in which these

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英译中

一名54岁的会计找到了他的家人
医生有严重背痛的抱怨
在试图举起一件沉重的东西的时候突然出现了
家具在家里。在检查中他没有显示出任何焦点
神经信号，但无法伸直
一个正直的位置。
病人被提到了），他没有透露
结构异常。有人建议他
与理疗师进行几次疗程来治疗
被诊断为"后压力"，但作为治疗
进步了，他的痛苦变得更严重了，他
抱怨他脖子上的肌肉紧张
他的后背大部分时间都坐在椅子上
躺在床上的床上。

他最终被推荐给精神病医生
谈到他在工作中所经历的压力
因为他所依赖的助手被解雇了
他的公司需要缩减规模。他的工作负载
因此得到了极大的提高
精神病医生认为病人是在"躯体化"
他的愤怒，将强烈的情感转化为痛苦
使他能从紧张的处境中解脱出来。A
心理教育的课程是这样的。

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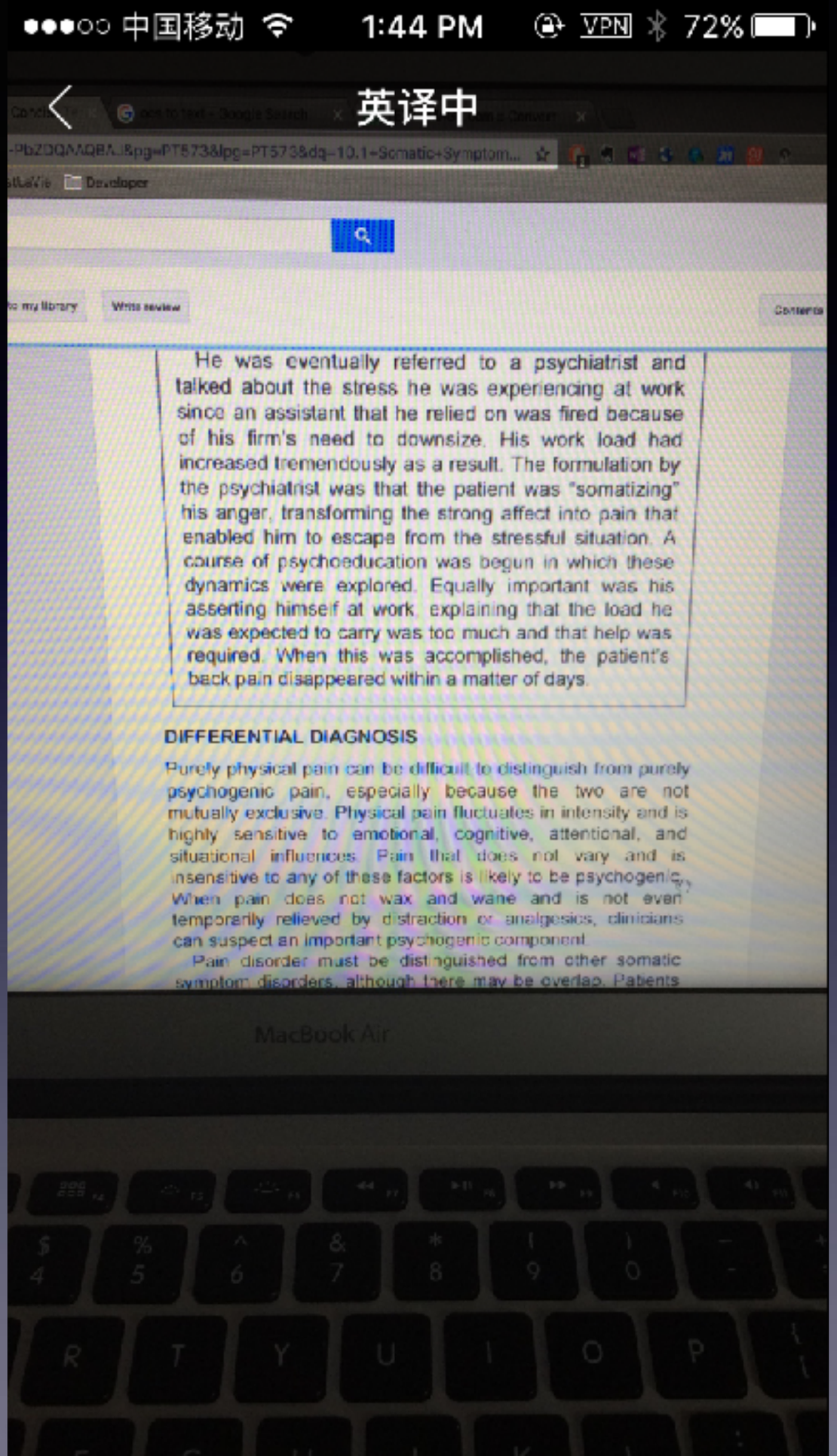
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DIFFERENTIAL DIAGNOSIS
Purely physical pain can be difficult to distinguish from purely psychogenic pain, especially because the two are not mutually exclusive. Physical pain fluctuates in intensity and is highly sensitive to emotional, cognitive, attentional, and situational influences. Pain that does not vary and is insensitive to any of these factors is likely to be psychogenic. When pain does not wax and wane and is not even temporarily relieved by distraction or analgesics, clinicians can suspect an important psychogenic component.
Pain disorder must be distinguished from other somatic symptom disorders, although there may be overlap. Patients
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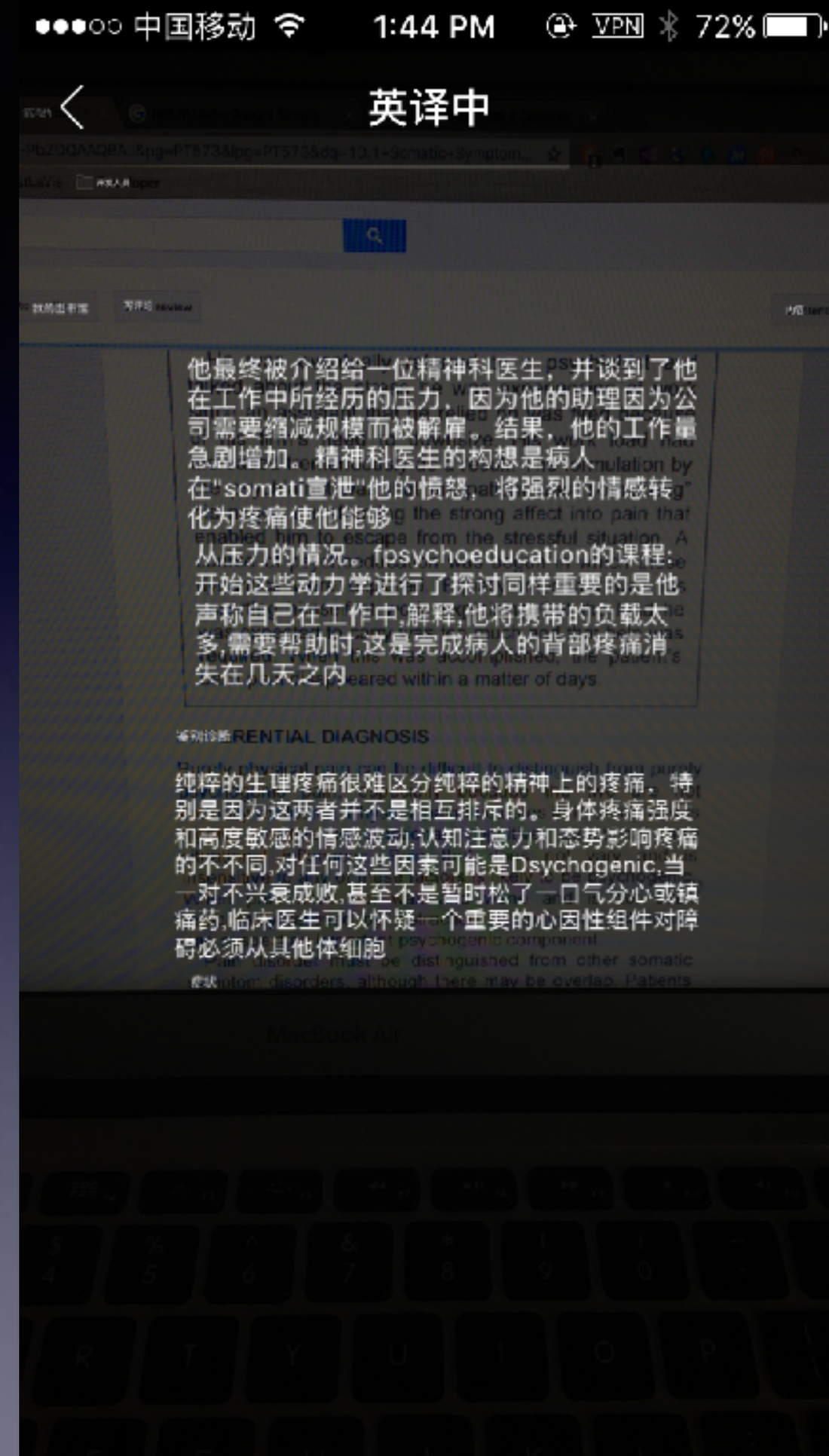
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他最终被介绍给一位精神科医生，并谈到了他在工作中所经历的压力，因为他的助理因为公司需要缩减规模而被解雇。结果，他的工作量急剧增加。精神科医生的构想是病人在"somati宣泄"他的愤怒，将强烈的情感转化为疼痛使他能够
从压力的情况。fpsychoeducation的课程:开始这些动力学进行了探讨同样重要的是他声称自己在工作中,解释,他将携带的负载太多,需要帮助时,这是完成病人的背部疼痛消失在几天之内
RENTIAL DIAGNOSIS
纯粹的生理疼痛很难区分纯粹的精神上的疼痛，特别是因为这两者并不是相互排斥的。身体疼痛强度和高度敏感的情感波动,认知注意力和态势影响疼痛的不不同,对任何这些因素可能是Dsychogenic,当一对不兴衰成败,甚至不是暂时松了一口气分心或镇痛药,临床医生可以怀疑一个重要的心因性组件对障碍必须从其他体细胞

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DIFFERENTIAL DIAGNOSIS

Purely physical pain can be difficult to distinguish from purely psychogenic pain, especially because the two are not mutually exclusive. Physical pain fluctuates in intensity and is highly sensitive to emotional, cognitive, attentional, and situational influences. Pain that does not vary and is insensitive to any of these factors is likely to be psychogenic. When pain does not wax and wane and is not even temporarily relieved by distraction or analgesics, clinicians can suspect an important psychogenic component.

Pain disorder must be distinguished from other somatic symptom disorders, although there may be overlap. Patients with hypochondriacal preoccupations may complain of pain, and aspects of the clinical presentation of hypochondriasis, such as bodily preoccupation and disease conviction, can also be present in patients with pain disorder. Patients with hypochondriasis tend to have many more symptoms than patients with pain disorder, and their symptoms tend to fluctuate more than those of patients with pain disorder.

Conversion disorder is generally short-lived, whereas pain disorder is chronic. In addition, pain is, by definition, not a symptom in conversion disorder. Malingering patients

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鉴别诊断RENTIAL DIAGNOSIS

纯粹的生理疼痛很难区分纯粹的精神上的疼痛，特别是因为这两者并不是相互排斥的。身体疼痛在强度上波动，对情绪高度敏感。认知、注意力和情境因素对疼痛的影响并不大，对这些因素的影响也不太敏感，这些因素很可能是心理因素造成的。

当疼痛不再有蜡和衰退的时候，甚至不能暂时缓解疼痛的止痛剂，临床医生可以怀疑一种重要的精神成分疼痛障碍必须与其他的躯体症状障碍区分开来，尽管可能有重叠。患有疑病症的患者可能会抱怨疼痛，以及疑病症的临床表现，比如身体上的专注和疾病的信念。也可以出现在有疼痛障碍的病人身上。患有疑病症的患者比有疼痛障碍的患者有更多的症状，而且他们的症状比那些有疼痛障碍的患者更容易出现波动。

转化障碍通常是短暂的，而疼痛则是慢性的。另外，根据定义，疼痛也是。不是病人的症状

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Conversion disorder is generally short-lived, whereas pain disorder is chronic. In addition, pain is, by definition, not a symptom in conversion disorder. Malingering patients consciously provide false reports, and their complaints are usually connected to clearly recognizable goals.

The differential diagnosis can be difficult because patients with pain disorder often receive disability compensation or a litigation award. Muscle contraction (tension) headaches, for example, have a pathophysiological mechanism to account for the pain and so are not diagnosed as pain disorder. Patients with pain disorder are not pretending to be in pain, however. As in all of these disorders, symptoms are not imaginary.

COURSE AND PROGNOSIS

The pain in pain disorder generally begins abruptly and increases in severity for a few weeks or months. The prognosis varies, although pain disorder can often be chronic, distressful, and completely disabling. Acute pain disorders have a more favorable prognosis than chronic pain disorders. A wide range of variability is seen in the onset and course of chronic pain disorder. In many cases, the pain has been present for many years by the time the individual comes to psychiatric care, owing to the reluctance of the patient and the physician's tendency to see pain as a psychiatric disorder. People with pain disorder who resume participation in regularly scheduled activities, despite the pain, have a more

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转化障碍通常是短暂的，而疼痛
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有意识地提供虚假的报告，他们的抱怨是
通常都与可辨认的目标联系在一起。
鉴别诊断可能很困难，因为病人
疼痛障碍通常会得到残疾补偿或一种uy
诉讼裁决。肌肉收缩(紧张)头痛，对Eji来说
举例来说，有一种病理生理学机制来解释我的
因为疼痛，所以没有被诊断为疼痛。
患有疼痛障碍的病人并不是在假装疼痛，
然而。在所有这些疾病中，症状并不是
虚构的。

病程和预后

疼痛的疼痛通常是由疼痛开始的
几个星期或几个月的严重程度增加。那
预后是不同的，尽管疼痛障碍通常是慢性的，
不幸的，完全禁用。急性疼痛疾病
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在开始和过程中可以看到多种多样的变化。
慢性疼痛障碍。在很多情况下，疼痛是。
精神病治疗，由于病人的不情愿
医生倾向于将疼痛视为一种精神疾病
有疼痛障碍的人重新参与进来

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TREATMENT

Because it may not be possible to reduce the pain, the treatment approach must address rehabilitation. Clinicians should discuss the issue of psychological factors early in treatment and should frankly tell patients that such factors are

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病程和预后AND PROGNOSIS

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慢性疼痛障碍。在很多情况下，疼痛是 the pain has been
在个体到来之前的很多年里 time the individual comes to
精神病治疗，由于病人的不情愿 uctance of the patient and
医生倾向于将疼痛视为一种精神疾病。 psychiatric disorder.
有疼痛障碍的人重新参与进来 who resume participation in
尽管有疼痛，但有规律的活动，有更多的活动 ve a more
比那些允许疼痛的人的预后良好 who allow the pain to
成为他们生活方式的决定性因素。 their lifestyle.

治疗REATMENT

因为不可能减轻疼痛，be possible to reduce the pain, the
治疗方法必须解决康复问题。临床医生 ilitation. Clinicians
应该讨论心理因素的问题 of psychological factors early in
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Write review

Some pages are omitted from this book preview.

This DSM-5 category is used to describe conditions characterized by one or more unexplained physical symptoms of at least 6 months' duration, which are below the threshold for a diagnosis of somatic symptom disorder. The symptoms are not caused, or fully explained, by another medical, psychiatric, or substance abuse disorder, and they cause clinical significant distress or impairment.

Two types of symptom patterns may be seen in patients with other specified or unspecified somatic symptom disorder: those involving the autonomic nervous system and those involving sensations of fatigue or weakness. In what is sometimes referred to as *autonomic arousal disorder*, some patients are affected with symptoms that are limited to bodily functions innervated by the autonomic nervous system. Such patients have complaints involving the cardiovascular, respiratory, gastrointestinal, urogenital, and dermatological systems. Other patients complain of mental and physical fatigue, physical weakness and exhaustion, and inability to perform many everyday activities because of their symptoms. Some clinicians believe this syndrome is neurasthenia, a diagnosis used primarily in Europe and Asia. The syndrome may overlap with chronic fatigue syndrome, which various research reports have hypothesized to involved psychiatric,

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这第五类用于描述条件表现为一个或多个原因不明的身体症状至少6个月的时间,这是低于阈值的躯体症状障碍的诊断症状并不引起,或完全解释说,由另一个医学、精神病学、或滥用药物,引起临床显著的痛苦或障碍。

模式两种类型的症状可能会在其他指定或未指明的躯体症状患者障碍:包括自主神经系统和感觉疲劳或虚弱,有时被称为自主唤醒障碍有些病人症状影响支配仅限于身体功能的自主神经系统。这样的

患者对心血管、呼吸系统、泌尿生殖系统和皮肤系统有抱怨。其他患者则抱怨精神和身体上的疲劳、身体的虚弱和疲惫，以及由于症状而无法进行日常活动的能力。

一些临床医生认为，这种综合征是一种主要在欧洲和亚洲使用的诊断疾病。这种综合症可能与慢性疲劳综合症有重叠，各种各样的研究报告都假设有精神病。

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以一个或多个无法解释的身体症状为特征
至少6个月的持续时间，低于阈值
诊断为躯体症状障碍。的症状
不是由另一种医学引起的，或完全解释的，
精神疾病或药物滥用障碍。他们会导致
临床意义重大的痛苦或损害。
在患者身上可以看到两种类型的症状模式
其他指定的或未指明的躯体症状障碍
包括自主神经系统和那些
包括疲劳或虚弱的感觉。在是什么
有时也被称为自主性觉醒障碍
患者受限于身体的症状
由自主神经系统支配的功能。这样的
患者对心血管疾病有抱怨
呼吸，胃肠，泌尿生殖和皮肤学
系统。其他病人抱怨精神和身体上的疾病
疲劳，身体虚弱和疲惫，以及无力
因为他们的症状，每天做很多的活动。
一些临床医生认为这种症状是神经衰弱，
诊断主要在欧洲和亚洲。这种综合症
可能与慢性疲劳综合症有重叠，这是多种多样的
研究报告假设涉及精神病学，virologicat,immunologicaf因素。其他条件
包括在这一未指明的躯体症状类别中
无序是假性的(在第23章讨论)
条件可能没有达到6个月的标准
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He was eventually referred to a psychiatrist and talked about the stress he was experiencing at work since an assistant that he relied on was fired because of his firm's need to downsize. His work load had increased tremendously as a result. The formulation by the psychiatrist was that the patient was "somatizing" his anger, transforming the strong affect into pain that enabled him to escape from the stressful situation. A course of psychoeducation was begun in which these dynamics were explored. Equally important was his asserting himself at work, explaining that the load he was expected to carry was too much and that help was required. When this was accomplished, the patient's back pain disappeared within a matter of days.

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他最终被介绍给一位精神科医生，并谈到了他在工作中所经历的压力，因为他的助理因为公司需要缩减规模而被解雇。结果，他的工作量急剧增加。精神科医生的构想是病人在"somati宣泄"他的愤怒，将强烈的情感转化为疼痛使他能够从压力的情况。fpsychoeducation的课程：开始这些动力学进行了探讨同样重要的是他声称自己在工作中,解释,他将携带的负载太多,需要帮助时,这是完成病人的背部疼痛消失在几天之内

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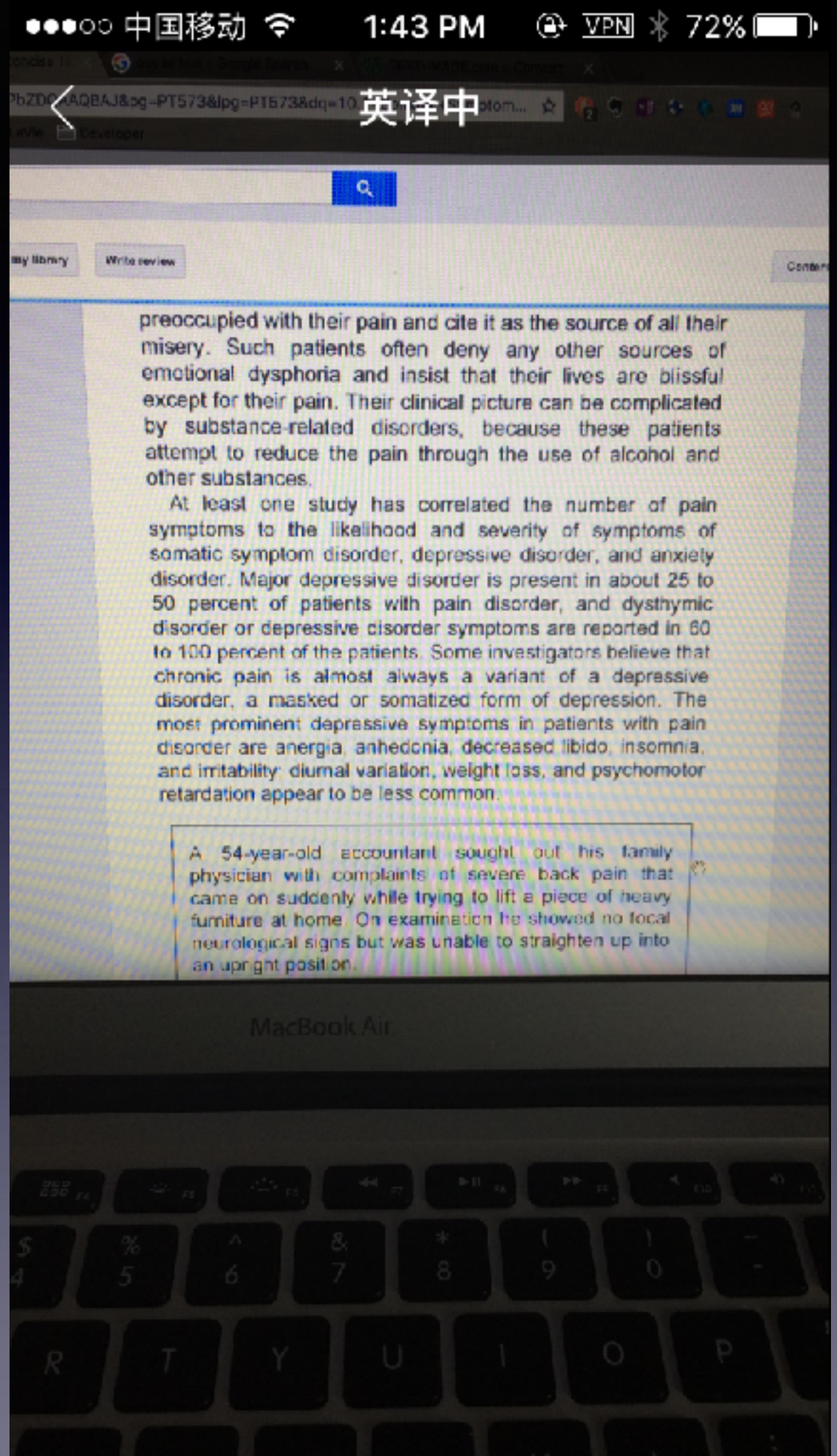
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preoccupied with their pain and cite it as the source of all their misery. Such patients often deny any other sources of emotional dysphoria and insist that their lives are blissful except for their pain. Their clinical picture can be complicated by substance-related disorders, because these patients attempt to reduce the pain through the use of alcohol and other substances.
At least one study has correlated the number of pain symptoms to the likelihood and severity of symptoms of somatic symptom disorder, depressive disorder, and anxiety disorder. Major depressive disorder is present in about 25 to 50 percent of patients with pain disorder, and dysthymic disorder or depressive disorder symptoms are reported in 60 to 100 percent of the patients. Some investigators believe that chronic pain is almost always a variant of a depressive disorder, a masked or somatized form of depression. The most prominent depressive symptoms in patients with pain disorder are anergia, anhedonia, decreased libido, insomnia, and irritability; diurnal variation, weight loss, and psychomotor retardation appear to be less common.
A 54-year-old accountant sought out his family physician with complaints of severe back pain that came on suddenly while trying to lift a piece of heavy furniture at home. On examination he showed no focal neurological signs but was unable to straighten up into an upright position.
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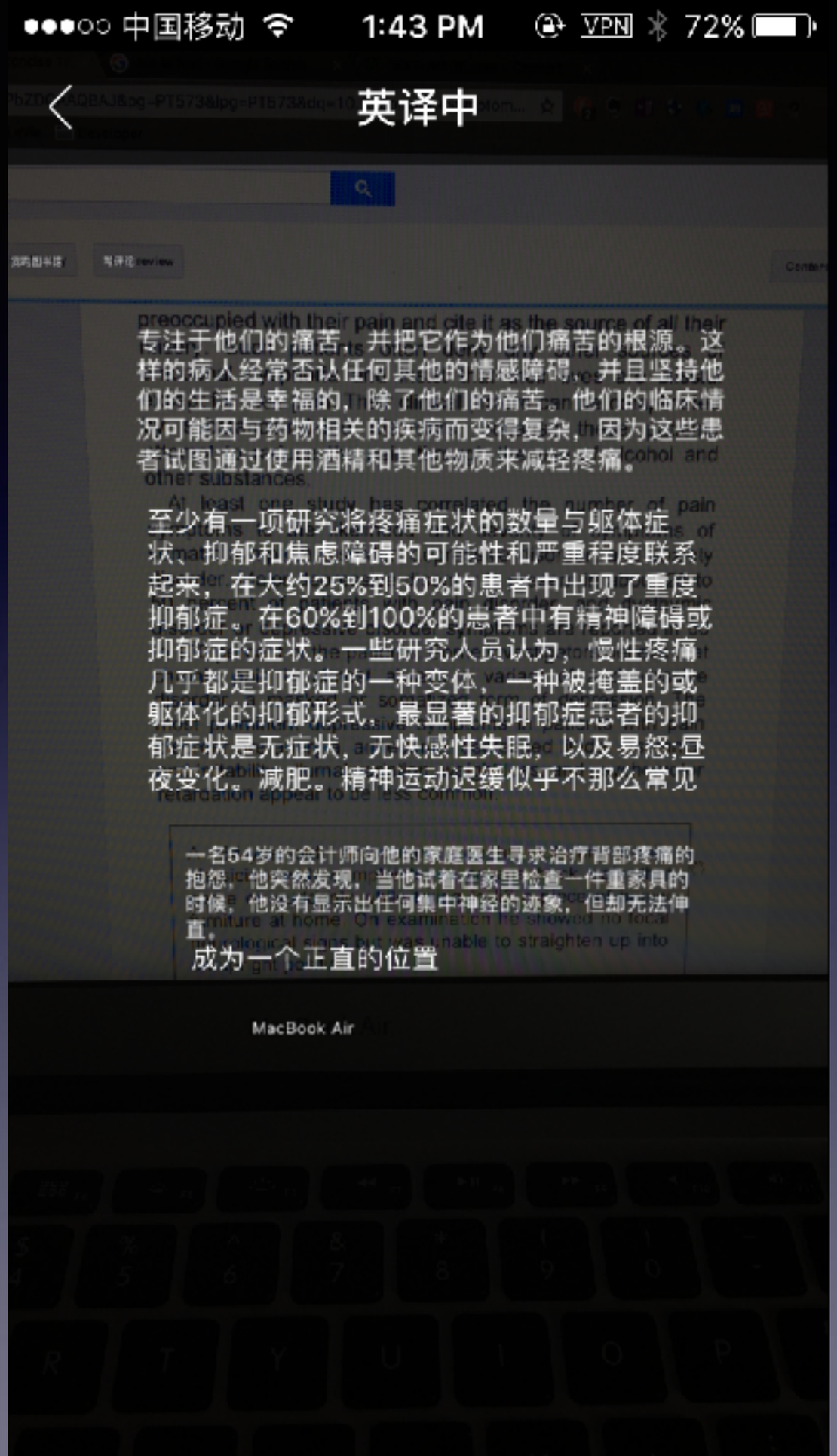
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专注于他们的痛苦，并把它作为他们痛苦的根源。这样的病人经常否认任何其他的情感障碍，并且坚持他们的生活是幸福的，除了他们的痛苦。他们的临床情况可能因与药物相关的疾病而变得复杂，因为这些患者试图通过使用酒精和其他物质来减轻疼痛。
至少有一项研究将疼痛症状的数量与躯体症状、抑郁和焦虑障碍的可能性和严重程度联系起来，在大约25%到50%的患者中出现了重度抑郁症。在60%到100%的患者中有精神障碍或抑郁症的症状。一些研究人员认为，慢性疼痛几乎都是抑郁症的一种变体，一种被掩盖的或躯体化的抑郁形式。最显著的抑郁症患者的抑郁症状是无症状，无快感性失眠，以及易怒;昼夜变化。减肥。精神运动迟缓似乎不那么常见
一名54岁的会计师向他的家庭医生寻求治疗背部疼痛的抱怨，他突然发现，当他试着在家里检查一件重家具的时候，他没有显示出任何集中神经的迹象，但却无法伸直。
成为一个正直的位置
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