NARAYANA
COLLEGE OF NURSING

Unit – VII
Nursing management of patient with Neurotic stress related and somatization disorders

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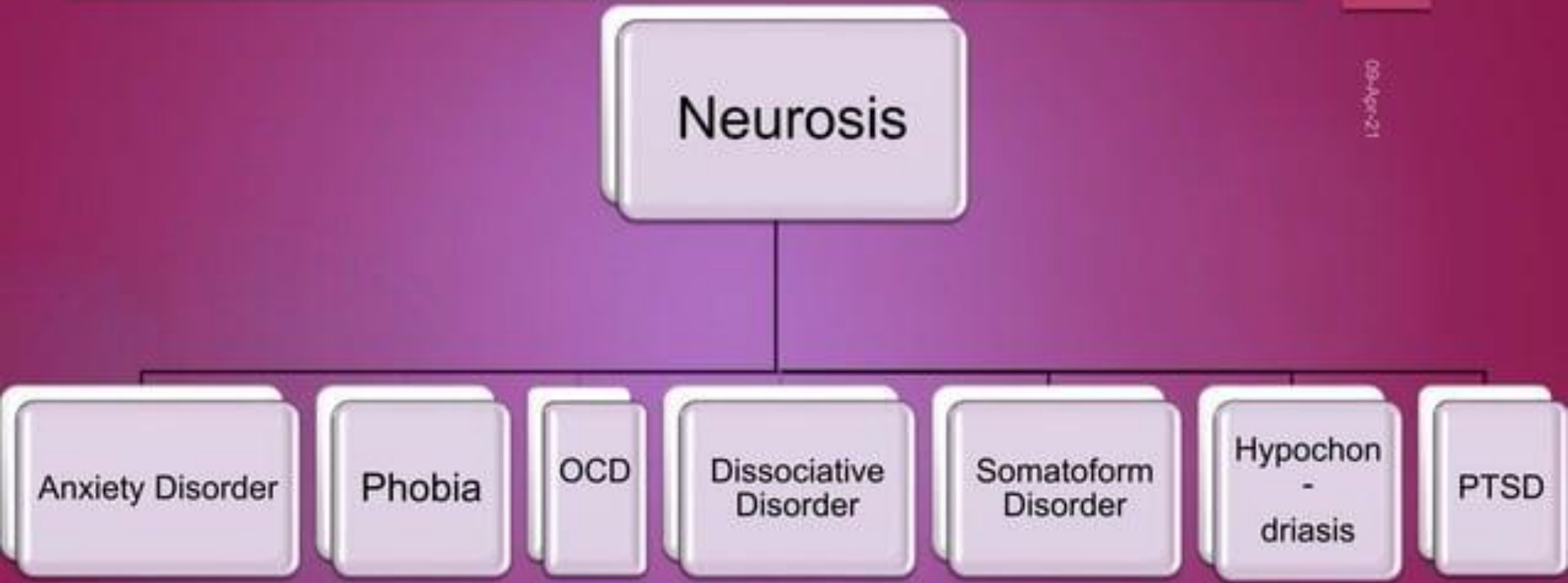
NURSING MANAGEMENT OF PATIENT WITH NEUROTIC,STRESS RELATED AND SOMATO FORM DISORDERS

NEUROSIS

The term "Neurosis" is derived from two greek words, 'Neuron' means 'nerve' with the suffix 'osis' means 'diseased' or 'abnormal condition'.

Majority of people are affected by neurosis in some mild form or other, which may include physical symptoms e.g anxiety, hysteria, phobia, depression, obsessive compulsive tendencies.

CLASSIFICATION:



ICD-10 CLASSIFICATION:

F40-F48 NEUROTIC, STRESS-RELATED & SOMATOFORM DISORDERS

F40 - Phobic anxiety disorders

F41 - Other anxiety disorders

F42 - Obsessive compulsive disorders

F43 - Reaction to severe stress & adjustment disorders

F44 - Dissociative (Conversion) disorders

F45 - Somatoform disorders

F48 - Other neurotic disorders

1.ANXIETY DISORDER:

Anxiety is a ‘normal’ phenomenon which is characterized by a state of apprehension or unease arising out of anticipation of danger.

Types of anxiety:

1): Trait theory: this is habitual tendency to be anxious in general (a trait). “I often feel anxious”

2): State anxiety: this is the anxiety felt at the present. “I feel anxious now”

CLINICAL SYMPTOMS:

I. PHYSICAL SYMPTOMS

a): Tremors

b): Restlessness

c): Muscle twitches

d): Fearful Facial Expression

e): Palpitation

f): Tachycardia

g): Sweating

h): Dyspnea

i): Diarrhoea

CLINICAL SYMPTOMS:

II. PSYCHOLOGICAL SYMPTOMS

a): Poor Concentration

b): Distractibility

c): Hyper arousal

d): Negative automatic thoughts

e): Derealization

f): Depersonalization

g): Fearfulness

h): Inability to relax

i): Insomnia

GENERALIZED ANXIETY DISORDER

It is characterized by an Insidious onset in third decade, usually chronic course which may or may not be with panic attacks (episodes of acute anxiety).

Symptoms should last for at least 6 months to diagnose G.A.D.

PANIC DISORDER

It is characterized by discrete episodes of acute anxiety onset is in early third decade, with chronic course.

Panic attack occur recurrently every few days last for few minutes & characterized by very severe anxiety.

ETIOLOGY:

1. Psychodynamic Theory:

Anxiety is a signal that disturb internal psychological equilibrium. This is called signal anxiety.

It arouses ego to take defensive action (Repression) primary. When it fails (Conversion, Isolation) secondary.

ETIOLOGY:

2. Behavioral Theory:

According to this theory, Anxiety is an unconditioned inherent response of organism to painful or dangerous stimuli.

3. Cognitive Behavioral Theory:

There is evidence of selective information processing (more attention paid to threat- related information), cognitive distortions, Negative automatic thoughts.

ETIOLOGY:

4. Biological Theory:

a). Genetic evidence: 15-20% Ist degree relative

Monozygotic- 80%

Dizygotic- 20%

b). Chemically Induced:

GABA it is the most prevalent inhibitory neurotransmitter in the CNS. Alteration in GABA levels lead to production of Anxiety.

TREATMENT:

Treatment of anxiety disorder is usually multimodal

1. Psychotherapy (Supportive & CBT etc)
2. Relaxation techniques (Exercise, Yoga, Pranayama, Meditation)
3. Other behavior therapies (Biofeedback & Hyperventilation control)
4. Drug treatment:
   - Benzodiazepines (GAD)
   - Antidepressant (Panic Disorder)
   - Beta Blockers (Propranolol & atenolol)
   - Buspirone (Anti-anxiety Drug)

2. PHOBIC DISORDER:

Phobia is defined as irrational fear of a specific object, situation or activity, often leading to persistent avoidance of the feared object, situation or activity.

CHARACTERISTIC FEATURES:

a): Presence of fear of an object, situation or activity.

b): Patient recognizes the fear as irrational & unjustified

c): Patient is unable to control fear

d): It leads to persistent avoidance of a particular object, situation or activity.

DEFINITION:

- **According to MARKS, 2OO7**
- “Persistent avoidance behavior secondary to irrational fear of specific objects, activity or situation”. The criteria is

1. The fear is out of proportion to the demands of the situation.
2. It can’t explain or reasonable way.
3. It beyond fear of the voluntary control.

INCIDENCE:

- Phobia is more in women then in man
- 8-18% of Americans are suffering from phobia.
- Severe fears & Specific phobias are present in 10-15% of children.
- Specific phobias are found in 15% of adults

ICD 10 Classification

- F 40.0 Agoraphobia
- F 40.1 Social phobia
- F4 0.2 Specific phobia
- F 40.8 Other phobic anxiety disorder
- F 40.9 Phobic anxiety disorder, unspecified

TYPES OF PHOBIA

- Phobia mainly divided into 3 types they are

- Simple Phobia
- Social Phobia
- Agora Phobia

SIMPLE PHOBIA

- It is an irrational fear of specific object or stimuli. It is common in child hood. In teenage most of these fears are lost, but few may persist till adult life. sometimes they may reappear after a symptom free period Exploring to the object often results in panic attacks.
- EX; acro phobia –fear of heights
- Heamato phobia-fear of the sight of blood
- Zoophobia –fear of animals
- Gamo phobia –fear of marriage
- Claustrophobia-fear of closed spaces
- Micro phobia- fear of germs
- Algo phobia – fear of pain

AGORAPHOBIA:

It is characterized by an irrational fear of situations or being in places away from the familiar setting of home. It includes fear of open spaces, public spaces, crowded places, where there is no escape.

SOCIAL PHOBIA:

Irrational fear of activities or social interaction, characterized by irrational fear of performing activities in the presence of other people or interacting with others.

SPECIFIC PHOBIA:

It is characterized by an irrational fear of a specified object or situation. Some of the example of simple phobia include-

***Acrophobia**
***Zoophobia**
***Xenophobia**
***Algophobia**
***Claustrophobia**

ETIOLOGY:

1. Psychodynamic Theory:

Anxiety is usually dealt with defense mechanism of (Repression) when it fails, secondary defense mechanism (Displacement) come into action.

2. Behavioral Theory:

It explains phobia as a conditioned reflex.

3. Biological Theory:

All phobias especially agoraphobia are closely linked to panic disorders..

CLINICAL MANIFESTATIONS OF SIMPLE PHOBIA

- Irrational and persistent fear of object or situation.
- Immediate anxiety with on contact with object
- Loss of control
- Fainting
- Avoidance of feared objects
- Anxiety when thinking about stimuli
- Impaired social functioning

CLINICAL MANIFESTATIONS OF SOCIAL PHOBIA

- ❖ Hyper ventilation
- ❖ Sweating
- ❖ Cold and clammy skin
- ❖ Blushing
- ❖ Palpitations
- ❖ Confusion
- ❖ Trembling voice and hands
- ❖ Urinary urgency
- ❖ Muscle tension

- Failure in the situation

CLINICAL MANIFESTATIONS OF AGORA PHOBIA:

- Fear of open or public places
- Avoiding the public places
- Deep concern that help might not be available
- Fear that having panic attack in public places lead to embarrassment
- Gradual restriction in day to day activities
- The activity may become so severely restricted that the person becomes self-imprisoned at home.

TREATMENT:

Treatment approach is usually multimodal:

1. Psychotherapy (Supportive, Behavior therapy, CBT etc).
2. Drug treatment:
   - Benzodiazepines (Alprazolam)
   - Antidepressant (SSRI, TCA, MAOI for panic attacks)
   - Clonazepam, Diazepam

NURSING DIAGNOSIS:

- Self-care deficit related to disease condition as evidenced by dependent on other.
- GOAL: Client will be performing his self-care activities and improve his independency.
- INTERVENTIONS:
- 1. Assess patient in accepting necessary amount of dependence.
- 2. Set short range goals with patient.
- 3.Provide the reinforcement for all activities

- 4. Encourage patient to feed as soon as possible. Encourage independence but interfere when patient cannot interfere
- EXPECTED OUTCOME: Client may perform self-care activities without dependence.
- 2. Fear related to specific stimulus as evidenced by avoidance of objects.
- GOAL: Decrease the fear of the patient.
- INTERVENTIONS:

1. Maintain the therapeutic relationship with patient.
2. Ventilate the patient feelings

3. OBSESSIVE COMPULSIVE DISORDER:

An obsession is defined as:

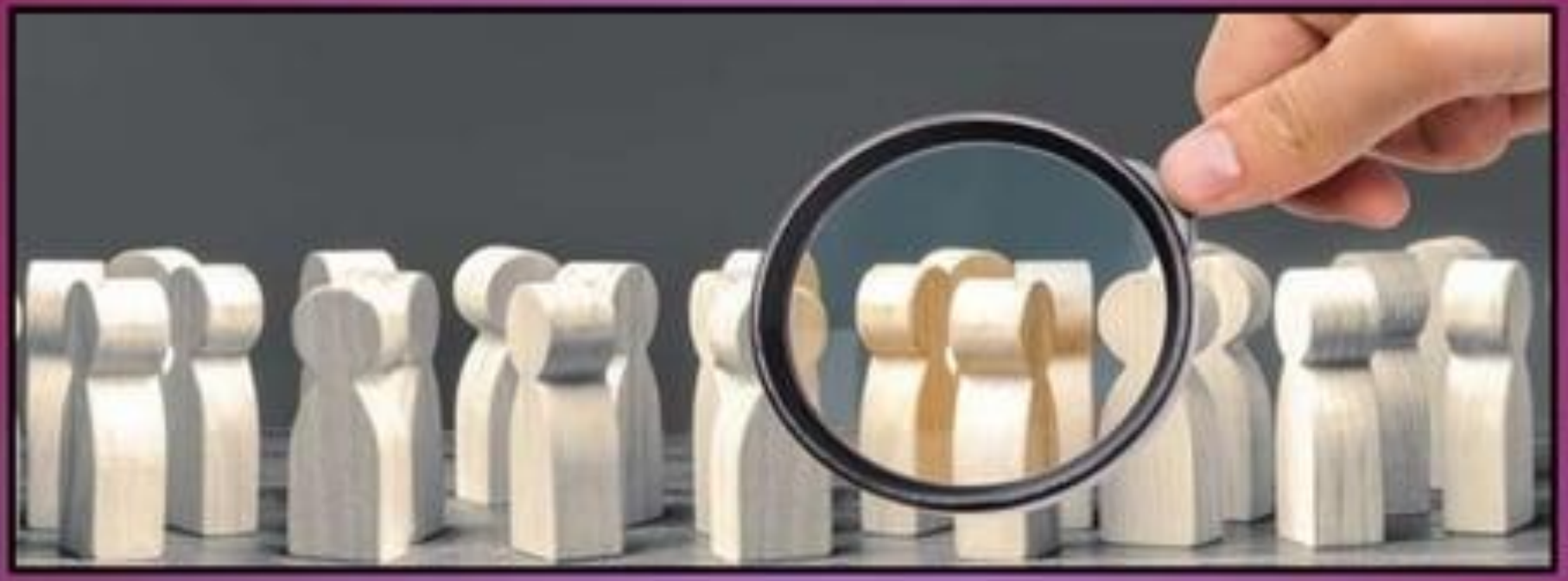
1): An Idea, impulse or image which intrudes into the conscious awareness repeatedly.
2): It is recognized as irrational & absurd. (Insight is present)
3): Patient tries to resist against it but is unable to.

Compulsion is defined as :

1): A form of behavior which usually follows obsessions.

2): The behavior is not realistic and is either irrational or excessive.

EPIDEMIOLOGY:



In India, OCD is more common in married males, while In other countries, no gender differences are reported. Average onset is late third decade in India.

CLINICAL SYMPTOMS:

*ICD-10 Classifies OCD into three clinical subtypes:

1): Predominately Obsessive thoughts or ruminations.
2): Predominately Compulsive acts (Compulsive rituals).
3): Mixed Obsessional thoughts & acts.

* Depression is very common associated with OCD

Four clinical syndrome have been described :

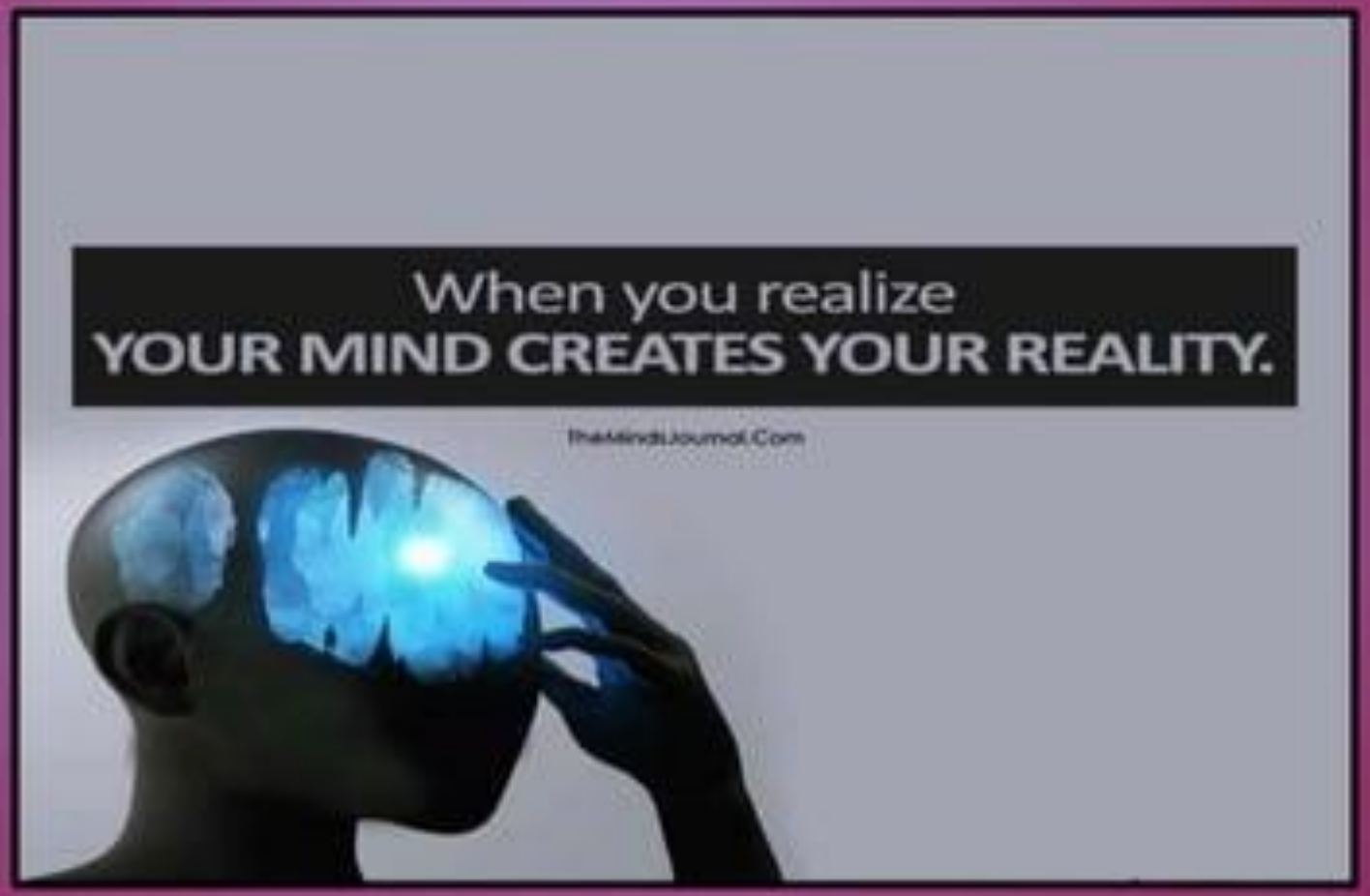
1|. Washers:

Four clinical syndrome have been described :

2|. Checkers:

Four clinical syndrome have been described :

3|. Pure Obsessions:



Four clinical syndrome have been described :

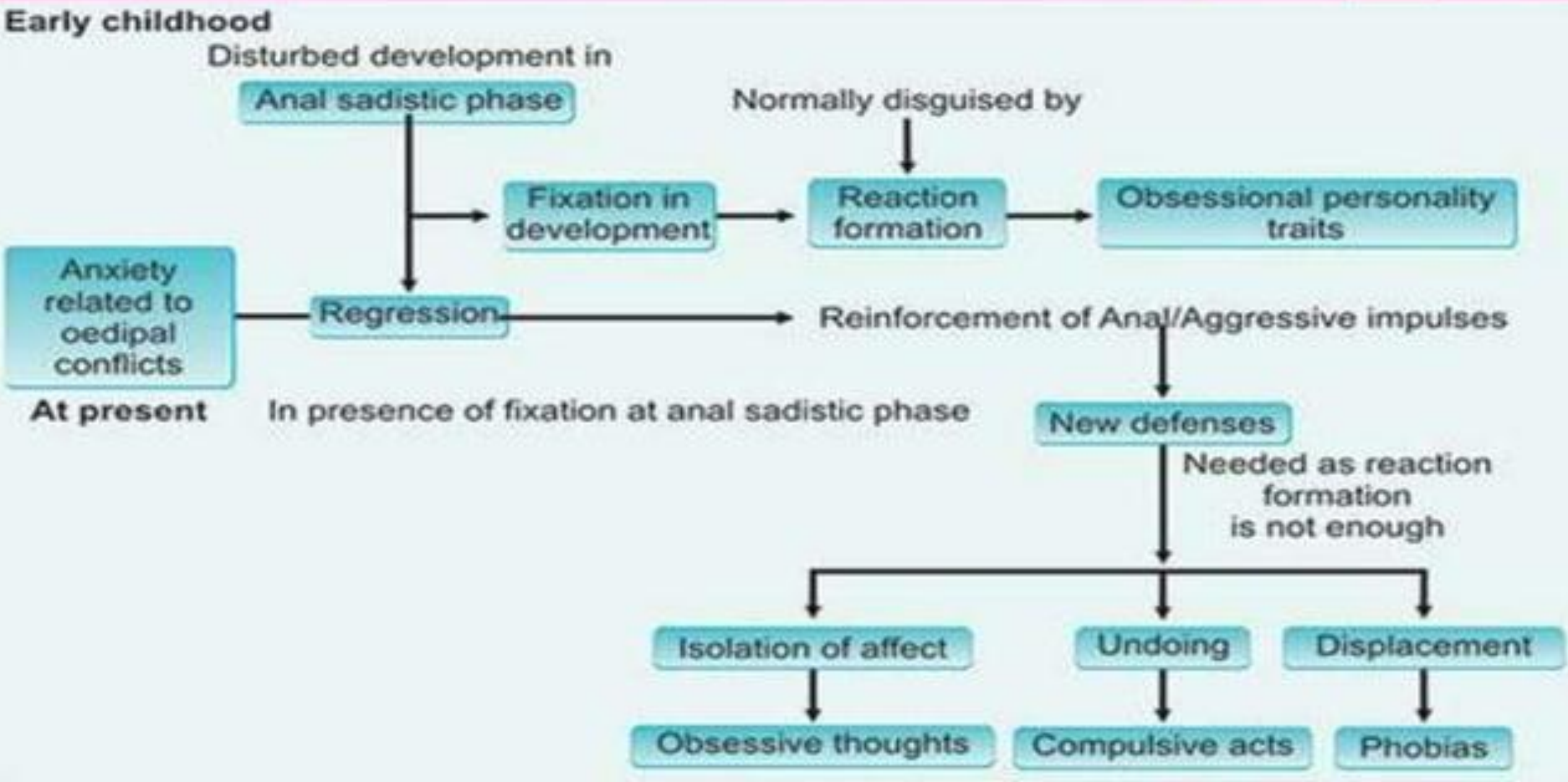
4|. Primary Obsessive Slowness:

Relatively rare syndrome, characterized by severe obsessive ideas & extensive compulsive rituals.

ETIOLOGY:

1].PSYCHODYNAMIC THEORY

ETIOLOGY:


Early childhood
Disturbed development in
Anal sadistic phase
Normally disguised by
Fixation in development
Reaction formation
Obsessional personality traits
Anxiety related to oedipal conflicts
Regression
Reinforcement of Anal/Aggressive impulses
At present
In presence of fixation at anal sadistic phase
New defenses
Needed as reaction formation is not enough
Isolation of affect
Undoing
Displacement
Obsessive thoughts
Compulsive acts
Phobias

ETIOLOGY:

2]. BIOLOGICAL THEORIES

ETIOLOGY:

1. Neurotransmitters:

Serotonin and Noradrenalin were found to have higher level in brain.

2. Genetics:

It is transmitted genetically.

3. Electrophysiological Studies:

-Electroencephalography: Temporal lobes spikes and increased theta waves

ETIOLOGY:

4. Brain Imaging:

Cranial CT and MRI Scans:

Increased ventricular- brain ratio, caudate nuclei.

3]. BEHAVIORAL THEORIES

From the learning theory perspective, obsessions and compulsion are understood as the result of interplay of classical and operant conditioning paradigms.

TREATMENT MODALITIES:

1]. PHARMACOLOGICAL MANAGEMENT

PHARMACOLOGICAL MANAGEMENT

1): Clomipramine (25 to 75 mg in divided doses)
2): Fluoxetine (Antidepressant)
3): Fluvoxamine (Significant in Obsessive-Compulsive Symptoms)

2]. BEHAVIOR THERAPY:

❖**Classical Behavioral Therapy techniques have been used in treatment of OCD. These include:**

1) **Systematic desensitization**
2) **Flooding**
3) **Modeling**
4) **Response prevention**
5) **Negative practice**
6) **Implosion**
7) **Thought stopping**

2]. BEHAVIOR THERAPY:

8) **Aversion relief**
9) **Shaping**
10) **Exposure and Response Prevention**

3): Cognitive Behavior Therapy (Modeling & Polarized thinking)

4): Psychotherapy (Supportive Insight-oriented psychotherapies)

5): Electroconvulsive therapy (8-10 ECT)

6): Psychosurgery (Prefrontal leucotomy, Transorbital Leucotomy, Rostral Leucotomy, Tractomy)

4. SOMATOFORM DISORDERS:

Somatoform disorders is defined as the use of physical symptoms to express emotional problems and psychosocial stress. it is also known as Hysteria or Briquet Syndrome.

Its main feature is pattern of multiple, recurring and significant physical complaints

Classification of Somatoform Disorders:

1) Somatization Disorder
2) Undifferentiated Somatoform
3) Hypochondriacal Disorders
4) Somatoform Autonomic Dysfunction
5) Persistent Somatoform Pain Disorder
6) Other Somatoform Disorder
7) Somatoform Disorder Unspecified

1.SOMATIZATION DISORDER:

It is characterized by presence of recurrent and multiple frequently changing somatic complaints of several years duration for which medical attention has been sought, but these apparently are not due to any physical disorder.

ETIOLOGY:

Exact Etiology is not known but probably due to:

1. Familial Factors:

It has been found that risk to develop disorder is 10-20% in female first- degree relatives.

2. Socio- Cultural Factors:

It has been documented that the tendency to perceive and report distress in psychological or somatic term is influenced by various social & cultural factors including stigma.

CLINICAL SYMPTOMS:

Symptoms may refer to any part of the body:

- **Gastrointestinal symptoms**

(Abdominal pain, Bowel problems, Nausea, Vomiting, Regurgitation etc)

- **Pain in various body part**

(extremities, back, joint etc)

- **Conversion symptoms**

(Pseudoseizures, Fainting, Incoordination, loss of voice, difficulty in swalloing)

TREATMENT MODALITIES:

MANAGEMENT

Morrison has summarized the management of somatization disorder in ABC as follows:

A. Accommodate initially
B. Behavior modification
C. Confrontation later about effects of behavior
D. Decrease drugs gradually
E. Educate about course and meaning of illness
F. Family involvement to give information
G. Guilt should be assuaged in physicians
H. Hospitalize
I. Intercurrent depression should be treated conservatively.

2. Undifferentiated Somatoform Disorder:

When physical complaint are multiple, varying and persistent but the complete and typical clinical picture of somatisation disorder is not fulfilled, this category is to be considered.

3. Hypochondriacal Disorder:

Essential features is a persistent preoccupation with the possibility of having one or more serious & progressive physical disorders.

4. Somatoform Autonomic Dysfunction:

Patient present the symptoms as if they were due to a physical disorder of a system or organ that is largely or completely under Autonomic innervation & control like. (Cardio-vascular, GI, Respiratory systems, Genito Urinary etc)

5. Persistent Somatoform Pain Disorder:

Predominant complaint is of persistent, severe, distressing pain which cannot be explained fully by a physiological process or a physical disorder.

6. Other Somatoform Disorder:

In these disorders the presenting complaints are not mediated through the autonomic nervous system and are limited to specific systems or parts of the body.

5. HYPOCHONDRAISIS:

It is characterized by a preoccupation with fear of having or developing a serious physical illness. The fear is often a result of unrealistic interpretation of physical signs or sensations as evidence of disease.

ETIOLOGY:

There are three theories of origin of hypochondriasis:

1. Psychodynamic theory:

Aggressive and Hostile wishes towards others are transformed into physical complaints through repression or displacement .

2. Socio- Cultural theory:

Sick role serves to convey about their distress and disability to others, serving nonverbal communication.

ETIOLOGY:

3. Neuropsychological theory:

hypochondriasis is the result of an underlying perceptual or cognitive abnormality.

CLINICAL SYMPTOMS:

- Patient believes that he has serious disease

- Pain

- Patient comes with a detailed pathophysiological model explaining his symptoms

MANAGEMENT:

Hypochondraisis are one of the most difficult patient to treat. It can be managed by general physicians. But patient "Doctor Shopping" Behavior also elicits negative reaction from the treating physician.

Basic principles of treatment are as follows:

- Treatment by a single physician
- Supportive approach & regularly scheduled visit
- Avoidance of hospitalization, diagnostic procedures & medications with abuse potential
- Focusing on symptoms & brief examination in initial visit.

TERMINOLOGIES RELATED TO PTSD:

1. Flashbacks

2. Hyper vigilance

3. Avoidance

4. Numbness

5. POST- TRAUMATIC STRESS DISORDER

PTSD is a set of reactions to an extreme stressor such as intense fear, helplessness or horror that leads individual to relieve the trauma.

CLINICAL SYMPTOMS:

-Episodes of repeated relieving of the trauma ("Flashbacks") or dreams.

- Flashbacks occurring (against persisting background of a sense of "numbness" and emotional blunting)
- Detachment from other people
- Unresponsiveness to surroundings
- Anhedonia

INCIDENCE & ONSET OF SYMPTOMS:

- 1-14% develop PTSD from a few week to months

- Rarely exceeds 6 months

DIAGNOSTIC CRITERIA:

- Evidence of trauma
- Onset within 6 months of a traumatic event
- Repetitive intrusive recollection
- Day time imagery or dreams
- Conspicuous emotional detachment
- Numbing of feeling

ETIOLOGY:

1. Stressor:

- Presence of childhood trauma.
- Borderline, Paranoid
- Antisocial personality disorder
- Inadequate support system
- Recent stressful life changes

2. Psychodynamic factors:

* Cognitive model composites that affected person are unable to process, rationalize the trauma that precipitated the disorder
* Behavioral model has two phases:

First the trauma, Second instrumental learning

ETIOLOGY:

3. Biological factors:

- Many neurotransmitter system have been responsible for PTSD (Nor epinephrine, Dopamine, Benzodiazepine receptor and Hypothalamic- pituitary- adrenal axis)

MANAGEMENT:

PHARMACOLOGICAL TREATMENT:

- Antidepressants
- Fluoxetine
- Mood stabilizers (Reducing Dissociative & Numbing Behavior)
- Antihypertensive (Propranolol or Clonidine)
- Anxiolytics (Clonazepam & Alprazolam)

DISSOCIATIVE (CONVERSION)DISORDER

- Conversion disorder is characterized by the presence of one or more symptoms suggesting the presence of a neurological disorder that cannot be explained by any known neurological or medical disorder.

DEFINITION

- Dissociation disorder may take the form of amnesia, pseudo – dementia, fugue, stupor, trance, possession states, multiple personality disorders & pseudo – seizures.

- Dissociation reactions are the psychological manifestations which will occur when there is a partial or complete loss of the normal integration between past memories & awareness of identity, perception or consciousness due to underlying psychological conflicts. (**Lowenstein, 1994)**

- Dissociation is one type of defence mechanism where the person will be protected from traumatic events by allowing the mind to forget or remove itself from painful situation or memory.

- Dissociative disorders are defined by a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment **-APA**

ICD-10 CLASSIFICATION OF DISSOCIATION DISORDER:-

F44 Dissociative [conversion] disorders

- F44.0 Dissociative amnesia
- F44.1 Dissociative fugue
- F44.2 Dissociative stupor
- F44.3 Trance and possession disorders
- F44.4 Dissociative motor disorders
- F44.5 Dissociative convulsions
- F44.6 Dissociative anaesthesia and sensory loss
- F44.7 Mixed dissociative [conversion] disorders
- F44.8 Other dissociative [conversion] disorders

- .80 Ganser's syndrome
- .81 Multiple personality disorder
- 82 Transient dissociative [conversion] disorders occurring in childhood and adolescence
- .88 Other specified dissociative [conversion] disorders

DISSOCIATIVE AMNESIA:

Dissociative amnesia is an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness and is not due to the direct effects of substance use or a neurological or other general medical condition (APA, 2000).

- **a) Localized Amnesia:** The inability to recall all incidents associated with the traumatic event for a specific time period following the event (usually a few hours to a few days). **EX**: The individual cannot recall events of the automobile accident and events occurring during a period after the accident (a few hours to a few days).

- **b) Selective Amnesia:** This type is the inability to recall only certain incidents associated with a traumatic event for a specific period after the event.

- **EX:** The individual may not remember events leading to the impact of the accident but may remember being taken away in the

CONT……

- **Continuous Amnesia:** This is the inability to recall events occurring after a specific time up to and including the present.
- **EX:** The individual cannot remember events associated with the automobile accident and anything that has occurred since. That is, the individual cannot form new memories although he or she is apparently alert and aware.
- **d) Generalized Amnesia:** The rare phenomenon of not being able to recall anything that has happened during the individual's entire lifetime, including his or her personal identity.
- **e) Systematized Amnesia:** With this type of amnesia, the individual cannot remember events that relate to a specific category of information (e.g., one's family) or to one particular person or event

DISSOCIATIVE FUGUE

- The characteristic feature of dissociative fugue is a sudden, unexpected travel away from home or customary place of daily activities, with inability to recall some or all of one's past (APA, 2000). An individual in a fugue state cannot recall personal identity and often assumes a new identity.

.DISSOCIATIVE IDENTITY DISORDER

- Dissociative identity disorder (DID) was formerly called multiple personality disorder. This disorder is characterized by the existence of two or more personalities in a single individual.

DEPERSONALIZATION DISORDERS:-

- Depersonalization disorder is characterized by a temporary change in the quality of self-awareness, which often takes the form of feelings of unreality, changes in body image, feelings of detachment from the environment, or a sense of observing oneself from outside the body.

DISSOCIATIVE STUPOR:-

- The individual’s behavior fulfills the criteria for stupor, but examination & investigation reveal no evidence of a physical cause. There is a positive evidence of psychogenic causation in the form of either recent stressful events or prominent interpersonal or social problem.

TRANCE & POSSESSION DISORDERS:-

There is a temporary loss of both the sense of personal identity & full awareness of the surroundings, in some instances the individual acts as taken over by another personality, spirit, deity or force.

- **DISSOCIATIVE MOTOR DISORDERS:-**Loss of ability to move the whole or a part of a limb or limbs. Paralysis may be partial with movements, being weak or complete.

DISSOCIATIVE CONVULSIONS:-

Pseudo seizures may mimic epileptic seizures very closely in terms of movements, but tongue biting serious bruising due to falling, and incontinence of urine are rare in dissociative convulsions & loss of consciousness is absent or replaced by a state of stupor or trance.

- **DISSOCIATIVE ANESTHESIA & SENSORY LOSS:-**

- Anesthetic areas of skin often have boundaries, which make it clear that they are associated more with the patient’s ideas about bodily functions than with the medical knowledge.

CLINICAL FEATURES:-

- Disturbance in the normal integrated functions of consciousness, identity & memory.
- The disturbances may be sudden or gradual, & the disturbance is usually temporary, recovery is often abrupt.
- These disorders tend to occur in response to severe trauma or abuse. A frequent stressful situation is an ongoing war.
- Significant impairment in general & social functioning.

CONT------

- Lacks of attachment have effect on neurotransmitters like serotonin.
- Depersonalization cause block in neurotransmitter link.
- Onset is usually sudden & the disturbance is usually temporary. Recovery often is abrupt.
- The symptoms are not intentionally produced.
- Absence of medical & neurological abnormalities or organic deformities.

CONT

- Symptoms of depersonalization.
  - Feeling of unreality
  - Body image distortion
- Dysfunction in usual pattern of behavior.
  - Absence from work
  - Withdrawal behavior
  - Alteration in functional aspects

CONT.....

- Feeling of absence of control over memory, behavior, awareness.
- Unable to explain the action or behavior in altered state.
- Interrupted family processes related to amnesia or other changing behavior.
- **La Belle difference** is client's reaction like indifference to the symptoms & displaying no anxiety or lack of concern about the symptoms.
- The disturbance is not under voluntary control but symptoms occur in organ under voluntary control.

DIAGNOSIS:-

- Rule out physical disorders & substance abuse. Standard tests including the Dissociative Experience Scale & the Dissociative disorders Interview Schedule to demonstrate presence of dissociation.
- The Dissociative Experiences Scale (DES) Perceptual Alterations Scale (PAS)
- According to ICD 10 criteria. History of childhood abuse/trauma
- Female Age 20-40 Previous diagnosis or suspicion of borderline personality disorder
- Previous unsuccessful treatment Self-destructive behavior

NURSING DIAGNOSIS:-

- ✓ Disturbed thought process related to severe psychological stress and repression of anxiety as evidenced by loss of memory
- ✓ Ineffective coping related to severe psychosocial stressor or substance abuse and repressed severe anxiety as evidenced by sudden travel away from home with inability to recall previous identity
- ✓ Disturbed personal identity related to childhood trauma/abuse as evidenced by the presence of more than one personality within the individual
- ✓ Disturbed sensory perception (visual/kinesthetic) related to severe psychological stress and repression of anxiety as evidenced by alteration in the perception or experience of the self or the environment

- Chronic low self esteem related to weak underdeveloped ego as evidenced by negative self talking

- ✓ Impaired verbal communication related to lack of quality of social exchange as evidenced by impaired memory
- ✓ Altered role performance related to inability to make decisions as evidenced by lack of problem solving skills
- ✓ Altered family process related to long standing illness as evidenced by changes in the family function
- ✓ Ineffective health maintenance related to lack of insight as evidenced by unable to identify physical symptoms.