NCLEX MENTAL HEALTH · PSYCHIATRIC NURSING · 2026 TEST PLAN

Somatic Symptom *& Related Disorders*

A high-yield review of psychiatric disorders in which real physical symptoms arise from psychological distress — not fabrication. Master the differentials, priorities, and test traps that trip up nursing students.

PSYCH / MENTAL HEALTH | CLINICAL JUDGMENT | HIGH-YIELD | CANVA READY

DEFINITION · OVERVIEW

What It Is & Why It Matters

01

- **A group of psychiatric disorders** where physical (somatic) symptoms exist without a clear medical cause — OR where emotional distress over health is disproportionate to findings.
- **Symptoms are REAL to the patient** — not faked, not imagined. This is the single most-tested concept on NCLEX.
- **Impact:** repeated ER visits, "doctor shopping," unnecessary tests, impaired daily function, and high risk for comorbid depression & anxiety.

PATHOPHYSIOLOGY · SIMPLIFIED

Mind → Body Conversion Pathway

02

1. Unresolved psychological conflict, stress, or trauma builds up →
2. Emotions are **unconsciously** suppressed (no awareness by patient) →
3. Brain redirects distress through somatic (body) pathways →
4. Neural amplification: bodily sensations are perceived as intense/alarming →
5. **Real physical symptoms emerge** — with no medical explanation.

THE 5 SUBTYPES (KNOW THE DIFFERENCES!)

Somatic Symptom	Illness Anxiety	Conversion	Factitious	Malingering
Multiple real symptoms + excessive worry	Fear of disease; few/no symptoms (old: hypochondriasis)	Sudden neuro deficit (paralysis, blindness, seizures)	Intentionally fakes — wants **sick role** (internal gain)	Fakes for **external gain** (NOT a mental illness)

SIGNS & SYMPTOMS

Recognize the Pattern

03

Mild / Early

- Multiple vague complaints (pain, GI, fatigue)
- Frequent provider visits, normal labs
- Excessive worry, checking body
- Anxiety about "missed" diagnosis
- Symptom migration (location shifts)

Severe / Late

- Disability, withdrawal from work & social roles
- Doctor shopping; unnecessary procedures/surgeries
- Dependence on pain meds / benzos (risk!)
- Depression, hopelessness, suicidal ideation
- Conversion: sudden paralysis, aphonia, blindness

RED FLAG FINDINGS — ACT NOW

- **Suicidal ideation / self-harm** — always the #1 priority assessment
- **"La belle indifférence"** — calm indifference to a serious symptom (classic conversion disorder sign)
- **Signs of abuse** in factitious disorder imposed on another (caregiver causing illness in child/dependent)
- **Opioid/benzo dependency** from chronic unexplained pain

PRIORITY NURSING INTERVENTIONS

ABCs, Safety, Therapeutic Relationship

04

ASSESS **Suicide risk first** — every shift. Rule out medical causes before labeling "psych."

VALIDATE **Acknowledge symptoms are real** to the patient. Never argue or confront.

LIMIT **Reduce secondary gain** — avoid excessive attention during symptom focus; don't reinforce sick role.

REDIRECT **Shift focus** from physical complaints → feelings, coping, and daily activities.

STRUCTURE **Consistent caregiver + scheduled brief visits** (not PRN). Set firm, kind limits on symptom discussion.

TEACH **Relaxation, journaling, deep breathing, mindfulness** — non-pharm first.

MONITOR **Medication overuse** — especially opioids, benzos, OTCs.

REFER **CBT is gold standard.** Include family; support groups when appropriate.

🎯 **NCLEX Priority Order:** Safety (suicide) → Medical rule-out → Therapeutic relationship → Limit-setting → Teaching

PHARMACOLOGY

Meds That Help (& What to Avoid)

05

SSRIs

★ FIRST LINE

sertraline · fluoxetine · paroxetine · citalopram

MOA	Block serotonin reuptake → more serotonin in synapse → mood ↑
S/E	GI upset, HA, insomnia, sexual dysfunction, SEROTONIN SYNDROME
TEACH	4–6 wks for full effect · take daily · don't stop abruptly · ↑ suicide risk in young adults first weeks

SNRIs

duloxetine · venlafaxine

MOA	Block serotonin + norepinephrine reuptake
S/E	↑ BP, nausea, dry mouth, dizziness, sweating
BONUS	Helps with chronic pain — useful in somatic pain complaints

TCAs (low-dose)

amitriptyline · nortriptyline

USE	Chronic pain, headache, functional GI symptoms
S/E	Anticholinergic: dry mouth, constipation, urinary retention, sedation, CARDIAC TOXICITY IN OD
CAUTION	Lethal in overdose — screen suicide risk before prescribing

Buspirone

for coexisting anxiety

MOA	Partial serotonin agonist — non-addictive anxiolytic
S/E	Dizziness, nausea, HA — well tolerated
TEACH	Takes 2–4 wks; not PRN; preferred over benzos

⛔ **AVOID BENZODIAZEPINES** (alprazolam, lorazepam, diazepam) — high addiction & dependence risk in this population. Same caution with opioids for unexplained pain.

NCLEX TEST TRAPS

⚠️ What Students Mix Up

06

🎭 Factitious Disorder

INTERNAL gain — wants the sick role, attention, caregiving. Symptoms are intentionally produced. *Munchausen syndrome.*

💰 Malingering

EXTERNAL gain — money, avoiding work/jail, drugs. NOT a mental illness — it's a behavior.

🧠 Conversion Disorder

Unconscious — neurological symptoms (paralysis, blindness, pseudoseizure). Patient shows "la belle indifférence."

😰 Illness Anxiety

Fear of having a disease with few or no actual symptoms. Formerly "hypochondriasis."

🎯 Priority Traps to Memorize

Never say "your symptoms are not real" **VS** Do say "I know these symptoms are real to you."
Don't confront or demand proof **VS** Do acknowledge & redirect.
Don't give extra attention *during* symptom talk **VS** Do reinforce healthy behaviors & feelings.
Always rule out medical cause **BEFORE** assigning psychiatric diagnosis.

PATIENT EDUCATION

Empower the Patient & Family

07

🧘 **Stress Management**
Deep breathing, progressive relaxation, mindfulness, yoga

📔 **Journal Feelings**
Track moods + symptoms to spot emotional triggers

📅 **Scheduled Visits**
One primary provider; regular appts — not PRN crisis visits

🏃 **Regular Exercise**
30 min/day: ↑ endorphins, ↓ anxiety, improves sleep

💊 **Med Adherence**
Take daily; effects 4–6 wks; report SI or worsening mood

🗣️ **CBT Therapy**
Gold standard — learn to reframe bodily sensations

👨‍👩‍👧‍👦 **Family Support**
Family avoids reinforcing sick role; encourage function

🚫 **Limit Doctor Shopping**
Avoid seeking multiple opinions / unnecessary tests

☎️ **Crisis Plan**
Call provider or 988 (Suicide & Crisis Lifeline) if SI

MEMORY BOOSTERS

Mnemonics, Hooks & Pattern Recognition

08

🧠 "SOMATIC" — Core Features of Somatic Symptom Disorder

S Symptoms real (to patient)	**O** Over-worry about health	**M** Multiple physical complaints	**A** Anxiety & doctor-shopping	**T** Tests all come back normal
I Impairs daily function	**C** CBT + SSRIs = Tx			

🎯 "FIM" — Differentiate the 3 Big Confusers

Factitious = Feels good to be sick (internal/emotional gain — the sick role).
Illness Anxiety = Imagines illness (fear-based, few/no symptoms).
Malingering = Money/freedom motive (external gain — not a mental illness).

✨ "La Belle Indifférence" Cue

If the NCLEX describes a patient who suddenly can't see or walk but seems *strangely unbothered* → think **CONVERSION DISORDER**. Beautiful = belle. Indifference = indifférence. The calm doesn't match the crisis.

⚡ Pattern Recognition Hooks

- "Multiple normal workups" + anxious patient → **Somatic Symptom Disorder**
- "Sudden paralysis after trauma, not bothered by it" → **Conversion**
- "Parent brings child in repeatedly with unexplained symptoms" → **Factitious imposed on another** (child abuse — REPORT)
- "Claims severe pain, wants disability/drugs" → **Malingering**
- Answer choice with "*I understand these symptoms feel very real to you*" → almost always correct.