

Pseudo-COVID-19. A new mental disorder?

Pseudo-COVID-19 ¿hacia un nuevo trastorno mental?

Because of the COVID-19 pandemic, a disease first described in China in late 2019, and all that it has caused worldwide,¹⁻³ some people have experienced symptoms similar to those of COVID infection. In these cases, patients visit the emergency services due to headaches, cough, fatigue, sore throat, and shortness of breath, along with a feeling of anxiety and the certainty of being infected. Although, on some occasions, individuals have had close contact with an acquaintance or family member who tested positive for COVID-19, they do not present with fever, chills, recent loss of smell or taste, or oxygen desaturation, and their confirmatory laboratory tests are negative. The authors of this editorial have named this clinical presentation as pseudo-COVID-19.

This paper is an introduction to pseudo-COVID-19 and aims to encourage studies to establish the implications of this new mental disorder, taking into account that the current pandemic is just beginning and that COVID-19 may be endemic for a long time and, consequently, cause various alterations in the mental health of the world population.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5),⁴ pseudo-COVID-19 can be defined as a mental disorder that presents with somatic symptoms (F45.1) that are predominantly associated with COVID-19 and cause significant problems in daily life. Moreover, people who suffer from this disorder have excessive behaviors concerning biosecurity measures related to the disease and experience great concern about their health status and the possibility of imminent death. Although the test results to confirm the presence of the virus are negative in these subjects, the disorder can last several months.

A differential diagnosis should be made to distinguish pseudo-COVID-19 from illness anxiety disorder (F45.21). In this sense, the difference between both conditions is that the symptoms of the former are mainly somatic. Furthermore, it is also necessary to differentiate this condition from a factitious disorder (F68.10) because the patient feels affected by the virus in pseudo-COVID-19, develops symptoms similar to those of COVID-19 and is convinced of having the disease even though the confirmation test is negative. There are even people who demand to be hospitalized and act like patients with a confirmed diagnosis.

Pseudo-COVID-19 can also be the result of a conscious simulation (Z76.5), meaning that the subject makes a conscious and voluntary representation of false or exaggerated symptoms of COVID-19. Said representation, which is sometimes motivated by external incentives to obtain a secondary gain, such as avoiding work obligations or obtain a leave of absence, is mainly observed in health workers who have close contact with positive cases and state that they feel similar symptoms while they await the confirmation of the diagnosis, and leave the medical service, although the results are negative.

The symptoms observed in subjects with pseudo-COVID-19 may also be secondary to exacerbated anxiety disorders, such as the case of patients with generalized anxiety disorder (F41.15) who have a great fear of contracting COVID-19 and, consequently, develop exaggerated or inappropriate avoidance behaviors that do not improve with the intervention of family members and require psychiatry care. They can also occur as part of a somatic type of delusional disorder (F22), in which patients have the idea of having been infected and that their death is imminent.

Although it can occur in anyone, subjects with risk factors associated with higher mortality from pseudo-COVID-19, such as high blood pressure, obesity, diabetes

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mellitus, lung or heart disease, and age over 60, tend to develop more easily symptoms of pseudo-COVID-19.

Patients with pseudo-COVID-19 have anxious signs and symptoms that are caused by the fear of suffering the disease. They report obsessive, phobic, and avoidant ideas due to the fear of contagion or of already being infected and asymptomatic. They also have fear going out and, when they do, they use personal protective equipment recommended only for health care personnel or people at greater risk of contagion (N95 face masks, goggles, face masks, gloves, and anti-fluid clothing). Moreover, they begin to feel that there is a biological war or an international plot to end humanity; they are always worried about the relatives with whom they live; they adopt compulsive behaviors such as washing their hands more frequently than recommended by health authorities or remaining in strict lockdown (many of these subjects have not left their homes since the beginning of the pandemic); and present sleep disturbances popularly known as "coronasomnia" (waking up anxious, difficulty to fall asleep, nightmares, and ruminations about the risk and the consequences of contracting the virus.)⁶

Due to excessive care, people with pseudo-COVID-19 may develop contact dermatitis from compulsive handwashing and indiscriminate use of substances recommended in biosafety protocols. In addition, their functionality and performance in daily activities can be significantly affected by the fear of going out and having contact with others, even to the point of restricting visits of close relatives as much as possible and not admitting strangers into their homes for any reason.

A possible scenario for pseudo-COVID-19 is when a worker in a company tests positive for COVID-19 and other employees working around him develop subjective symptoms of the disease. The problem arises when doctors, based on the symptoms and/or a probability of contact, decide to send all the employees to their homes because they take to the extreme the sanitary norms and protocols to avoid the ethical implications referred to by Echeverry-Raad & Navarro-Vargas⁷ and that occur when health systems are overwhelmed, even though there really was no close contact and the tests were negative.

It is worth mentioning that the current situation of pseudo-COVID-19 recalls the clinical descriptions of the pseudo-AIDS cases reported in the literature,⁸ which were secondary to the beginning of the epidemic produced by human immunodeficiency virus infection and the acquired immunodeficiency syndrome (HIV/AIDS) at the beginning of the 1980s.⁹

In this context, the psychiatric approach proposed here to manage pseudo-COVID-19 is focused on treating the underlying mental disorder, as well as the possible comorbidities, through crisis intervention psychotherapy, cognitive-behavioral therapy, and, in some cases, hypnotics, anxiolytics, and/or antidepressants. However, as mentioned above, further research on this disorder is necessary to make a more effective diagnosis and offer better treatments.

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Referencias

1. Asselah T, Durantel D, Pasmant E, Lau G, Schinazi RF. COVID-19: discovery, diagnostics and drug development. *J Hepatol.* 2020;S0168-8278(20)33675-8. <https://doi.org/fgf6>.
2. Rabaan AA, Al-Ahmed SH, Sah R, Al-Tawfiq JA, Haque S, Harapan H, *et al.* Genomic Epidemiology and Recent Update on Nucleic Acid-Based Diagnostics for COVID-19. *Curr Trop Med Rep.* 2020;1-7. <https://doi.org/fgf7>.
3. Platto S, Xue T, Carafoli E. COVID19: an announced pandemic. *Cell Death Dis.* 2020;11(9):799. <https://doi.org/fgf8>.
4. American Psychiatric Publishing (APA). *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. Arlington, VA: APA; 2013.
5. Ramírez-Ortiz J, Castro-Quintero D, Lerma-Córdoba C, Yela-Ceballos F, Escobar-Córdoba F. Mental health consequences of the COVID-19 pandemic associated with social isolation. *Colombian Journal of Anesthesiology.* 2020;48(4). <https://doi.org/fb2k>.
6. Ramírez-Ortiz J, Fontecha-Hernandez J, Escobar-Córdoba F. Efectos del aislamiento social en el sueño durante la pandemia COVID-19. In press. 2020. <https://doi.org/fgf9>.
7. Echeverry-Raad J, Navarro-Vargas JR. Ethical and clinical issues in the provision of medical care during the COVID-19 pandemic in Colombia: a global perspective for a contribution in the local context. *Rev. Fac. Med.* (1):e89474. <http://dx.doi.org/10.15446/revfacmed.v69n1.89474>.
8. Riccio M, Thompson C. Pseudo-AIDS, AIDS Panic or AIDS Phobia? *Br J Psychiatry.* 1987;151(6):863. <https://doi.org/cb6whg>.
9. Sepkowitz KA. AIDS--the first 20 years. *N Engl J Med.* 2001;344(23):1764-72. <https://doi.org/cbqwk7>.