Chapter 5
Somatic Symptom and Related Disorders and Dissociative Disorders

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Somatic Symptom Disorders, Part 1

- Types of *DSM-5* somatic symptom disorders
  - Illness anxiety disorder
  - Somatic symptom disorder
  - Conversion disorder (functional neurological symptom disorder)
  - Factitious disorder
  - Psychological factors affecting medical conditions

Somatic Symptom Disorders, Part 2

- Soma—meaning "body"
  - Preoccupation with health and/or body appearance and functioning
  - No identifiable medical condition causing the physical complaints

Somatic Symptom Disorders, Part 3

- Clinical description
  - Presence of one or more medically unexplained symptoms
  - Substantial impairment in social or occupational functioning
  - Concern about the symptoms
  - In severe cases, symptoms become the person's identity

Somatic Symptom Disorders, Part 4

- Statistics
  - Relatively rare condition
  - Onset usually in adolescence
  - More likely to affect unmarried, low SES women
  - Runs a chronic course
- Research to date is limited due to recent redefinition of the disorder in *DSM*

DSM-5 Criteria: Somatic Symptom Disorder (1 of 2)

Features of somatic symptom disorder include:

- One or more somatic symptoms that are distressing or result in significant disruption of daily life
- Excessive thoughts, feelings, and behaviors related to the somatic symptoms/health concerns as manifested by at least one of the following:
  - disproportionate and persistent thoughts about the seriousness of symptoms
  - high level of health-related anxiety
  - excessive time and energy denoted to symptoms/health concerns

DSM-5 Criteria: Somatic Symptom Disorder (2 of 2)

- Although any one symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)

Somatic Symptom Disorder with Predominant Pain

- Type of somatic symptom disorder, previously classified as "pain disorder"
- Clear physical pain that is medically unexplained
- Little is known about origin
- 5% to 8% of the population may have this disorder

Causal Factors in Somatic Symptom Disorders

- Little is known
- May include:
  - Familial history of illness
  - Stressful life events
  - Sensitivity to physical sensations
  - Experience suggesting that there are benefits to illness (e.g., attention)

Somatic Symptom Disorder: Causes and Treatment

- Treatment
  - CBT is the best treatment
  - Reduce the tendency to visit numerous medical specialists "doctor shopping"
  - Assign "gatekeeper" physician
  - Reduce supportive consequences of talk about physical symptoms

DSM-5 Criteria: Illness Anxiety Disorder (1 of 2)

Features of illness anxiety disorder include the following:

- Preoccupation with fears of having or acquiring a serious illness
- Somatic symptoms are not present or, if present, are only mild in intensity; if another medical condition is present or there is a high risk for developing one, the preoccupation is clearly excessive or disproportionate
- A high level of anxiety about health

DSM-5 Criteria: Illness Anxiety Disorder (2 of 2)

- The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctors' appointments)
- Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change.

Illness Anxiety Disorder, Part 1

- Clinical description
  - Physical complaints without a clear cause
  - Severe anxiety about the possibility of having a serious disease
  - Strong disease conviction
  - Medical reassurance does not seem to help
- Very similar to *DSM-IV* hypochondriasis

Illness Anxiety Disorder, Part 2

- Statistics
  - Prevalence estimated between 1% and 5%
  - Onset at any age
  - Sex ratio equal
  - Runs a chronic course
- Culturally specific disorders similar to illness anxiety disorder
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Illness Anxiety Disorder: Causes and Treatment

- Causes
  - Cognitive perceptual distortions
  - Familial history of illness
- Treatment
  - Challenge illness-related misinterpretations
  - Provide more substantial and sensitive reassurance and education
  - Stress management and coping strategies
  - CBT is generally effective
  - Antidepressants offer some help

Conversion Disorder (Functional Neurological Symptom Disorder)

- Clinical description
  - Physical malfunctioning of sensory or motor functioning
    - E.g., blindness or difficulty speaking (aphonia)
  - Lack physical or organic pathology
  - Persons may show "la belle indifference"
  - Retain most normal functions, but lack awareness

DSM-5 Criteria: Conversion Disorder

Features of conversion disorder (functional neurological symptom disorder) include the following:

- One or more symptoms of altered voluntary motor or sensory function
- Evidence of incompatibility between the symptom and recognized neurological or medical conditions
- The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation

Conversion Disorder

- Statistics
  - Rare condition, with a chronic intermittent course
  - Often comorbid with anxiety and mood disorders
  - Seen primarily in females
  - Onset usually in adolescence
  - Common in some cultural and/or religious groups

Conversion Disorder: Causes

- Not well understood
- Freudian psychodynamic view is still common, though unsubstantiated
  - Past trauma or unconscious conflict is "converted" to a more acceptable manifestation, i.e., physical symptoms
- Primary/secondary gains
  - Freud thought primary gain was the escape from dealing with a conflict
  - Secondary gains: attention, sympathy, etc.

Conversion Disorder: Treatment

- Similar to somatic symptom disorder
- If onset after a trauma, may need to process trauma or treat posttraumatic symptoms
- Remove sources of secondary gain
- Reduce supportive consequences of talk about physical symptoms

Factitious Disorders: An Overview

- Clinical description
  - Purposely faking physical symptoms
  - May actually induce physical symptoms or just pretend to have them
  - No obvious external gains
    - Distinguished from "malingering" in which physical symptoms are faked for the purpose of achieving a concrete objective (e.g., getting paid time off, avoiding military service)

DSM-5 Criteria: Factitious Disorder

Feature of factitious disorders include the following:

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease in oneself or someone else, associated with identified deception
- The individual presents himself or herself to others as ill, impaired, or injured, or presents another individual (victim) in this way
- The deceptive behavior is evident even in the absence of obvious external rewards

Factitious Disorder Imposed on Another

- Type of factitious disorder
- More commonly known as **Munchausen Syndrome by Proxy**
- Inducing symptoms in another person
  - Typically a caregiver induces symptoms in a dependent (e.g., child)
- Purpose = receive attention or sympath

Psychological Factors Affecting Medical Condition

- Diagnostic label useful for clinicians
- Indicates that psychological variables may be impacting a generam medical issue
- Examples:
  - Chronic anxiety attacks worsening asthma
  - Needle phobia making it impossible to get important bloodwork done

An Overview of Dissociative Disorders, Part 1

- Involve severe alterations or detachments from reality
- Affect identity, memory, or consciousness
- Depersonalization—distortion in perception of one's own body or experience (e.g., feeling like you own body isn't real)
- Derealization—losing a sense of the external world (e.g., sense of living in a dream)

An Overview of Dissociative Disorders, Part 2

- Types of *DSM-5* dissociative disorders
  - Depersonalization-derealization disorder
  - Dissociative amnesia
  - Dissociative trance disorder
  - Dissociative identity disorder

Depersonalization-Derealization Disorder: An Overview, Part 1

- Overview and defining features
  - Recurrent episodes in which a person has sensations of unreality of one's own body or surroundings
  - Feelings dominate and interfere with life functioning
  - Only diagnosed if primary problem involves depersonalization and derealization
    - Similar symptoms may occur in the context of other disorders, including panic disorder and PTSD

Depersonalization-Derealization Disorder: An Overview, Part 2

- Facts and statistics
  - High comorbidity with anxiety and mood disorders
  - 1% to 2% of the population
  - Onset is typically in adolescence
  - Usually runs a lifelong chronic course
  - Having a history of trauma makes this disorder more likely to manifest

DSM-5 Criteria: Depersonalization-Derealization Disorder

Features of depersonalization-derealization disorder include the following:

- Persistent or recurrent experiences of depersonalization, derealization, or both
- During the depersonalization or derealization experience, reality testing remains intact
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The disturbance is not attributable to the physiological effects of a substance or another medical or psychological condition

Depersonalization-Derealization Disorder: Causes and Treatment

- Risk factors
  - Cognitive deficits in attention, short-term memory, spatial reasoning
  - Deficits related to tunnel vision and mind emptiness
  - Such persons are easily distracted
- Treatment
  - Little is known due to limited research

Dissociative Amnesia: An Overview

- Dissociative amnesia
  - Includes several forms of psychogenic memory loss
  - Generalized vs. localized or selective type
  - May involve dissociative fugue
    - During the amnestic episode, person travels or wanders, sometimes assuming a new identity in a different place
    - Unable to remember how or why one has ended up in a new place

DSM-5 Disorder Criteria: Dissociative Amnesia

Features of dissociative amnesia include the following:

- An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The disturbance is not attributable to the physiological effect of a substance (e.g., alcohol or other drug of abuse), a neurological or other medical condition, or a different psychological disorder

Dissociative Amnesia and Fugue: Causes

- Statistics
  - Usually begin in adulthood
  - Show rapid onset and dissipation
- Causes
  - Little is known
  - Trauma and stress can serve as triggers

Dissociative Amnesia and Fugue: Treatment

- Most get better without treatment
- Most remember what they have forgotten

Dissociative Trance Disorder: An Overview

- Clinical description
  - Symptoms resemble other dissociative disorders
  - Dissociative symptoms and sudden changes in personality
  - Changes often attributed to possession by a spirit
  - Presentation varies across cultures
    - Nigeria—called vinvusa
    - Thailand—called phii pob
  - *Only* considered a disorder if leads to distress or impairment

Dissociative Trance Disorder: Causes and Treatment

- Causes
  - Often attributable to a life stressor or trauma
- Treatment
  - Little is known
  - May need to address stressor/trauma

DSM-5 Criteria: Dissociative Identity Disorder (1 of 2)

Features of dissociative identity disorder include the following:

- Disruption of identity characterized by two or more distinct personality states; the disruption or marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning
- Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting

DSM-5 Criteria: Dissociative Identity Disorder (2 of 2)

- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The disturbance is not a normal part of broadly accepted cultural or religious practice, and is not attributable to the physiological effects of a substance or another medical condition.

Dissociative Identity Disorder (DID): An Overview, Part 1

- Clinical description
  - Formerly known as multiple personality disorder
  - Defining feature is dissociation of personality
  - Adoption of several new identities (as many as 100; may be just a few; average is 15)
  - Identities display unique behaviors, voice, and postures

Dissociative Identity Disorder (DID): An Overview, Part 2

- Unique aspects of DID
  - Alters—different identities or personalities
  - Host—the identity that keeps other identities together
  - Switch—quick transition from one personality to another

Dissociative Identity Disorder (DID): An Overview, Part 3

- Statistics
  - Ratio of females to males is high (9:1)
  - Onset is almost always in childhood or adolescence
  - High comorbidity rates and lifelong, chronic course
  - More common than previously thought: 3% to 6%

Dissociative Identity Disorder (DID): Causes

- Causes
  - Typically linked to a history of severe, chronic trauma, often abuse in childhood
  - Closely related to PTSD, possibly an extreme subtype
  - Mechanism to escape from the impact of trauma
  - Biological vulnerability possible

Dissociative Identity Disorder (DID): Treatment

- Treatment
  - Focus is on reintegration of identities
  - Identify and neutralize cues/triggers that provoke memories of trauma/dissociation
  - Patient may have to relive and confront the early trauma
    - Some achieve through hypnosis
- Dr. Grieve's approach

Complete Memory Activity

False Memories

- Fairly easy to create false memories through suggestibility
- Interest in repressed memories has led to some patients thinking they have repressed memories of abuse, which are later shown to be false, but can be very damaging to patients and their families
- Therapists need to be well trained in memory function and be careful not to suggest an untrue history by mistake

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