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Chapter 6

Somatic Symptom and Related Disorders and Dissociative Disorders

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Outline

- Somatic Symptom and Related Disorders
  - Somatic symptom disorder
  - Illness anxiety disorder
  - Psychological factors affecting medical condition
  - Conversion disorder
- Dissociative Disorders
  - Depersonalization/Derealization Disorder
  - Dissociative amnesia
  - Dissociative identity disorder

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Focus Questions

- *What are the features of somatic symptom disorders?*
- *How are somatic symptom disorders treated?*
- *What are the features of dissociative disorders?*
- *How do dissociative disorders develop?*

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Definition of Somatic Symptom Disorders

- Somatic symptom disorders = excessive or maladaptive response to physical symptoms or health concerns

- *Soma* = Body
  - Preoccupation with health or symptoms
  - Physical complaints
  - Usually no identifiable medical condition

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Types of Somatic Symptom Disorders

- Types of disorders
  - Somatic symptom disorder
  - Illness anxiety disorder
  - Psychological factors affecting medical condition
  - Conversion disorder

Somatic Symptom Disorder

- First identified by French doctor who noticed patients coming to him with numerous complaints with no medical basis
- Formerly called *Briquet's syndrome*

Somatic Symptom Disorder, Continued

- Presence of one or more somatic symptoms
  - Symptom is often medically unexplained
- Excessive thoughts, feelings, and behaviors related to the symptoms (e.g., excessive thoughts about seriousness of the symptom, frequent complaints and requests for help, health-related anxiety, excessive research)
- Substantial impairment in social or occupational functioning

DSM-5 Criteria: Somatic Symptom Disorder

A. One or more somatic symptoms that are distressing and/or result in significant disruption of daily life.

B. Excessive thoughts, feelings, and behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.

2. High level of health-related anxiety.

3. Excessive time and energy devoted to these symptoms or health concerns.

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

Specify if: With predominant pain (previously pain disorder): This specifier is for individuals whose somatic complaints predominantly involve pain.

Specify current severity: Mild: Only one of the symptoms in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Somatic Symptom Disorder, Part 3

- 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-5

Definition of Illness Anxiety Disorder

- Very similar to DSM-IV hypochondriasis
- Clinical description:
  - Severe anxiety about the possibility of having or acquiring a serious disease
  - Actual symptoms are either very mild or absent
  - Strong disease conviction
  - Medical reassurance does not seem to help

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DSM-5 Criteria: Illness Anxiety Disorder

A. Preoccupation with fears of having or acquiring a serious illness.

B. 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 a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.

C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.

D. 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 and hospitals).

E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.

F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, generalized anxiety disorder, or obsessive-compulsive disorder.

Specify whether: Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used. Care-avoidant type: Medical care is rarely used.
From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

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Statistics for Illness Anxiety Disorder

- Only 20% of patients who used to meet the diagnostic criteria for DSM-IV hypochondriasis now meet criteria for illness anxiety disorder
- Severe illness anxiety has a late age of onset, possibly because more physical health problems occur with aging
- Often comorbid with anxiety and mood disorders

Culturally Specific Disorders

- Koro = Fear in some Asian cultures of genitals retracting into the abdomen
- Dhat = Symptoms (e.g., dizziness, fatigue) attributed to semen loss in some Indian cultures
- Kyol goeu = “Wind overload” among Khmer people of Cambodia
  - Fear that wind cannot circulate effectively through the body
  - Dizziness, weakness, fatigue, and trembling are seen as signs of this illness

Causes of Somatic Symptom Disorders

- Consistent overreaction to physical signs and sensations
- Cause is unlikely to be found in isolated biological or psychological factors
- May have learned from family to focus anxiety on physical sensations

Causes of Somatic Symptom Disorders, Continued

- Three additional factors that may contribute to etiology
  - Stressful life events
  - Illness in family during childhood
  - Benefits of illness (e.g., sympathy, attention)

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Example: Causes of Illness Anxiety Disorder

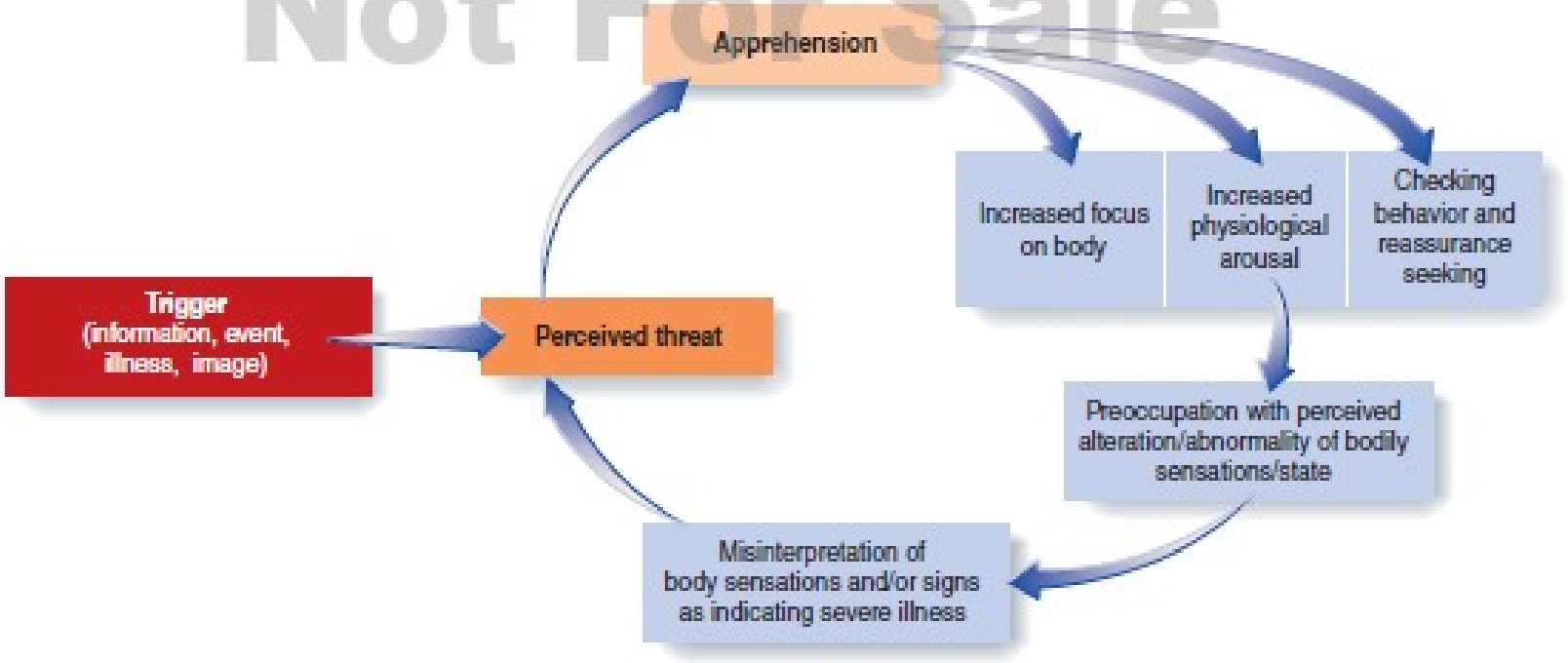

FIGURE 6.1

Integrative model of causes of hypochondriasis. (Based on Warwick, H. M., & Salkovskis, P. M. [1990]. Hypochondriasis. *Behavior Research Therapy*, 28, 105–117.)

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Treatment for Somatic Symptom Disorders

- Limited research on treatment effectiveness to date
- Mild cases of illness anxiety disorder may benefit from cognitive behavioral treatments, detailed education, and some reassurance from medical professionals
- Exposure treatment can effectively treat illness anxiety disorder

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Treatment for Somatic Symptom Disorders, Continued

- Antidepressants may be helpful
- “Gatekeeper” physician assigned to limit excessive use of medical services
- Reduce supportive consequences of illness
  - E.g., family members stop providing attention

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Psychological Factors Affecting Medical Condition

- Diagnostic label useful for clinicians
- Indicates that psychological variables may be impacting a general medical issue
- Examples:
  - Patient's concentration difficulties make it hard to take medication on time
  - Patient fails to comply with medical advice due to being in denial about diagnosis

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Definition of Conversion Disorder

- Full name: Conversion Disorder (Functional Neurological Symptom Disorder)
- Key feature: Altered motor or sensory function that is inconsistent with neural/medical conditions and not better explained by another disorder
  - Often suggestive of neurological problem, but no such problem is detected
- Must cause significant distress/impairment

Conversion Disorder

- May display indifferent attitude toward symptoms ("la belle indifference")
- Functioning may be mostly normal
- *Not* deliberately faking symptoms for the purpose of concrete gains (malingering)

DSM-5 Criteria Summary: Conversion Disorder

- One or more symptoms of altered motor or sensory function
- Incompatibility between symptom and medically-recognized conditions
- Not better explained otherwise
- Causes significant distress

Conversion Disorder, Continued

- 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

Conversion Disorder: Causes, Continued

- Primary/secondary gains
  - Freud thought primary gain was the escape from dealing with a conflict
  - Secondary gains: Attention, sympathy, etc.
- Sociocultural factors
  - More common in lower education, lower SES
  - Patients likely to adopt symptoms with which they are already familiar

Conversion Disorder: Treatment

- 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

- Purposely faking physical symptoms
- May actually induce physical symptoms or just pretend to have them
- No obvious external gains
  - Only external gain may be benefit of “sick role” (e.g., sympathy)
  - 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 Summary: Factitious Disorder

- Falsification of physical or psychological signs or symptoms
- Individual presents self as ill or injured
- Deceptive behavior is evident in absence of external rewards
- Not otherwise explained

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Factitious Disorder Imposed on Another

- 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 sympathy

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An Overview of Dissociative Disorders

- Severe alterations or detachments from reality
- Affect identity, memory, or consciousness
- Depersonalization – distortion in perception of one's body or experience (e.g., feeling like your 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 Disorder, Continued

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

Depersonalization/Derealization Disorder

- 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

DSM-5 Criteria Summary: Depersonalization/Derealization Disorder

- Persistent or recurrent experiences of depersonalization, derealization, or both
- Reality testing is intact
- Symptoms cause significant distress
- Not result of substance us
- Not better explained otherwise

Other Features of Depersonalization/Derealization Disorder

- Other features
  - Cognitive deficits in attention, short-term memory, spatial reasoning
  - Easily distractable
  - Difficulty absorbing new information
  - Reduced emotional responding
  - May have dysregulation of HPA axis in brain

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Dissociative Experiences Scale

TABLE 6.3 Dissociative Experiences Scale Item Scores in 117 Participants with Depersonalization- Derealization Disorder (Arranged in Descending Frequency)

Abbreviated Description	Mean	SD
Surroundings seem unreal	67.4	29.6
Looking at the world through a fog	60.0	37.3
Body does not belong to one	50.6	34.7
Did not hear part of conversation	43.6	29.3
Finding familiar place strange and unfamiliar	35.3	33.0
Staring off into space; unaware of time	32.7	31.8
Can't remember if just did something or thought it	31.6	28.8
Do usually difficult things with ease/spontaneity	31.2	31.2
Act so differently/feel like two different people	28.7	32.5
Talk out loud to oneself when alone	28.4	32.2

SD – 5 standard deviation.

Adapted from Simeon, D., Knutelska, M., Nelson, D., & Guralnik, O. (2003). Feeling unreal: A depersonalization disorder update of 119 cases. *Journal of Clinical Psychiatry*, 185, 31–36. © Physicians Post Graduate Press, Inc.

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Depersonalization/Derealization Disorder: Facts and Statistics

- Facts and statistics
  - High comorbidity with anxiety and mood disorders
  - 1 to 3% 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

Treatment for Depersonalization/Derealization Disorder

- Treatment
  - Research is very scarce
  - No systematic research on psychological treatments
  - Trial of antidepressant (Prozac) showed no effect above placebo

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
  - Ex: Three faces of Eve

DSM-5 Criteria: Dissociative Amnesia

A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting. Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, or other neurological condition).

D. The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Specify if: With dissociative fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Dissociative Amnesia and Fugue: Statistics

- Statistics
  - Prevalence: 2 to 7%
  - Usually begin in adulthood
  - Rarely appear in childhood or late adulthood
  - Show rapid onset and dissipation
- Causes
  - Little is known
  - Trauma and stress can serve as triggers
- Most recover/remember without treatment

Dissociative Trance

- Presentation varies across cultures
  - Nigeria – called vinvusa
  - Thailand – called phii pob
- Dissociative symptoms and sudden changes in personality
- Change may be attributed to possession by a spirit
- Only considered a disorder if leads to distress or impairment

Dissociative Identity Disorder (DID)

- 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

DSM-5 Criteria: Dissociative Identity Disorder

A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of 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. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. *Note:* In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

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Aspects of Dissociative Identity Disorder (DID)

- 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

Controversy: Can DID be Faked?

- Some patients presenting with DID symptoms are faking (possibly subconsciously)
  - Example: Patients more likely to "produce" a fake alter when therapist suggests this possibility
- Some DID patients are *not* faking
  - Case studies reveal changes in physiological and brain function when switching between alters

Dissociative Identity Disorder: Statistics

- Statistics
  - Prevalence: not well known, perhaps 1 to 2%
  - More common in females
  - Onset is almost always in childhood or adolescence
  - High comorbidity rates with other psychological disorders
  - Typically follows lifelong, chronic course

Causes of Dissociative Identity Disorder

- Typically linked to a history of severe, chronic trauma, often abuse in childhood
  - Risk increases if there is no social support after the trauma
- Mechanism: Dissociation offers an opportunity to escape from the impact of trauma
- Closely related to PTSD, possibly an extreme subtype
- Biological vulnerability possible but not well understood; almost all risk is environmental

Treating Dissociative Identity Disorder

- 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

False Memories

- Problem: Possible to create false memories of abuse by the power of suggestion
- Consequence: Some patients think they have repressed memories of abuse which are later shown to be false, but can be very damaging to patients and their families
- Conclusion: Therapists need to be well trained in memory function and be careful not to suggest an untrue history by mistake

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Summary of Somatic Symptom Disorders and Dissociative Disorders

- Features of somatic symptom disorders
  - Physical concerns without a clear medical cause
- Features of dissociative disorders
  - Extreme distortions in perception and memory
- For both classes of disorders, well-established treatments are generally lacking