

Somatoform & Dissociative Disorders

Somatoform and Dissociative Disorders

- In addition to disorders covered earlier, two other kinds of disorders are commonly associated with stress and anxiety:
 - Somatoform disorders
 - Dissociative disorders

Somatoform and Dissociative Disorders

- Somatoform disorders are problems that appear to be physical or medical but are due to psychosocial factors
 - How are these different than the disorders we talked about last week?
- Dissociative disorders are syndromes that feature major losses or changes in memory, consciousness, and identity, but do not have physical causes

Somatoform Disorders

- When a physical ailment has no apparent medical cause, physicians may suspect a somatoform disorder
- People with somatoform disorder do not consciously want or purposely produce their symptoms
 - They believe their problems are genuinely medical
 - They may actually experience changes in their physical functioning
 - Often hard to distinguish from genuine medical problems
 - It is always possible that a diagnosis of hysterical disorder is a mistake and the patient's problem actually has an undetected organic cause

What Are Somatoform Disorders?

- DSM-IV lists three “hysterical” somatoform disorders:
 - Conversion disorder
 - Somatization disorder
 - Pain disorder associated with psychological factors
- And two “preoccupation” somatoform disorders
 - Hypochondriasis
 - Body Dysmorphic Disorder

What Are Hysterical Somatoform Disorders?

- Conversion disorder
 - psychosocial conflict or need is converted into dramatic physical symptoms that affect voluntary or sensory functioning
 - Symptoms often seem neurological, such as paralysis, blindness, or loss of feeling
 - Most conversion disorders begin between late childhood and young adulthood
 - They are diagnosed in women twice as often as in men
 - They usually appear suddenly and are thought to be rare

What Are Hysterical Somatoform Disorders?

- Somatization disorder
 - People with somatization disorder have numerous long-lasting physical ailments that have little or no organic basis
 - To receive a diagnosis, a patient must have multiple ailments that include
 - several pain symptoms
 - gastrointestinal symptoms
 - a sexual symptom
 - a neurological symptom

What Are Hysterical Somatoform Disorders?

- Somatization disorder
 - Patients usually go from doctor to doctor seeking relief
 - This disorder usually lasts much longer than a conversion disorder, typically for many years
 - Symptoms may fluctuate over time but rarely disappear completely without psychotherapy

What Are Hysterical Somatoform Disorders?

- Pain disorder associated with psychological factors
 - Patients may receive this diagnosis when psychosocial factors play a central role in the onset, severity, or continuation of pain
 - The precise prevalence has not been determined, but it appears to be fairly common
 - The disorder often develops after an accident or illness that has caused genuine pain
 - The disorder may begin at any age, and more women than men seem to experience it

Table 7-1. DSM-IV Checklist

CONVERSION DISORDER

1. One or more physical symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
2. Psychological factors judged to be associated with the symptom or deficit.
3. Symptom or deficit not intentionally produced or feigned.
4. Symptom or deficit not fully explained by a general medical condition or a substance.
5. Significant distress or impairment.

SOMATIZATION DISORDER

1. A history of many physical complaints, beginning before the age of 30, that occur over a period of several years and result in treatment being sought or a significant impairment.
2. Physical complaints over the period include all of the following:
 - (A) Four different kinds of pain symptoms.
 - (B) Two gastrointestinal symptoms.
 - (C) One sexual symptom.
 - (D) One neurological/eye symptom.
3. Physical complaints not fully explained by a known general medical condition or a drug, or extending beyond the usual impact of such a condition.
4. Symptoms not intentionally produced or feigned.

PAIN DISORDER ASSOCIATED WITH PSYCHOLOGICAL FACTORS

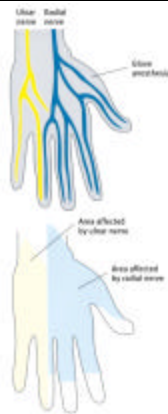
1. Significant pain is the primary problem.
2. Psychological factors judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain.
3. Symptom or deficit not intentionally produced or feigned.
4. Significant distress or impairment.

Revised in APA, 2000, 1191.

Somatoform Disorders

Hysterical vs. medical symptoms

- It is often difficult for physicians to differentiate between hysterical disorders and "true" medical conditions
 - They often rely on oddities in the medical presentation to help distinguish the two
 - For example, hysterical symptoms may be at odds with the known functioning of the nervous system, as in cases of glove anesthesia



Slide 12

Somatoform Disorders

- Hysterical vs. factitious symptoms
 - somatoform disorders must also be distinguished from patterns in which individuals are faking medical symptoms
 - Patients may be malingering – intentionally faking illness to achieve external gain (e.g., financial compensation, military deferment)
 - Patients may be manifesting a factitious disorder – intentionally producing or feigning symptoms simply from a wish to be a patient

Factitious Disorder

- People with a factitious disorder often go to extreme lengths to create the appearance of illness
 - May give themselves medications to produce symptoms
 - Patients often research their supposed ailments and become very knowledgeable about medicine
 - May undergo painful testing or treatment, even surgery

Factitious Disorder

- Munchausen syndrome is the extreme and chronic form of factitious disorder
 - In a related disorder, Munchausen syndrome by proxy, parents make up or produce physical illnesses in their children
 - When children are removed from their parents, symptoms disappear

Preoccupation Somatoform Disorders

- People with these problems are healthy but mistakenly worry that there is something physically wrong
 - They misinterpret and overreact to bodily symptoms or features

Preoccupation Somatoform Disorders

- Hypochondriasis
 - People with hypochondriasis unrealistically interpret bodily symptoms as signs of serious illness
 - Often their symptoms are merely normal bodily changes, such as occasional coughing, sores, or sweating
 - Although some patients recognize that their concerns are excessive, many do not

Preoccupation Somatoform Disorders

- Body dysmorphic disorder (BDD)
 - This disorder, also known as dysmorphophobia, is characterized by deep and extreme concern over an imagined or minor defect in one's appearance
 - Foci are most often wrinkles, spots, facial hair, or misshapen facial features (nose, jaw, or eyebrows)
 - Most cases of the disorder begin in adolescence but are often not revealed until adulthood
 - Up to 2% of people in the U.S. experience BDD, and it appears to be equally common among women and men

What Causes Somatoform Disorders?

- The psychodynamic view
 - Freud believed that hysterical disorders represented a conversion of underlying emotional conflicts into physical symptoms
 - Because most of his patients were women, Freud looked at the psychosexual development of girls and focused on the phallic stage (ages 3 to 5)...

What Causes Somatoform Disorders?

- The psychodynamic view
 - During this stage, girls experience a pattern of sexual desires for their father (the Electra complex) and recognize that they must compete with their mother for his attention
 - Because of the mother's more powerful position, however, girls repress these sexual feelings
 - Freud believed that if parents overreact to such feelings, the Electra complex would remain unresolved and the child might reexperience sexual anxiety throughout her life
 - Freud concluded that some women hide their sexual feelings in adulthood by converting them into physical symptoms

What Causes Somatoform Disorders?

- The psychodynamic view
 - Modern theorists propose that two mechanisms are at work in the hysterical disorders:
 - Primary gain: hysterical symptoms keep internal conflicts out of conscious awareness
 - Secondary gain: hysterical symptoms further enable people to avoid unpleasant activities or to receive kindness or sympathy from others

What Causes Somatoform Disorders?

- The behavioral view
 - Behavioral theorists propose that the physical symptoms of hysterical disorders bring rewards to sufferers
 - May remove individual from an unpleasant situation
 - May bring attention to the individual
 - In response to such rewards, people learn to display symptoms more and more
 - This focus on rewards is similar to the psychodynamic idea of secondary gain, but behaviorists view the gains as the primary cause of the development of the disorder

What Causes Somatoform Disorders?

- The cognitive view
 - Cognitive theorists propose that hysterical disorders are a form of communication, providing a means for people to express difficult emotions
 - Like psychodynamic theorists, cognitive theorists hold that emotions are being converted into physical symptoms
 - This conversion is not to defend against anxiety but to communicate extreme feelings

How Are Somatoform Disorders Treated?

- People with somatoform disorders usually seek psychotherapy as a last resort
- Individuals with preoccupation disorders typically receive the kinds of treatments applied to anxiety disorders:
 - Antidepressant medication
 - Especially selective serotonin reuptake inhibitors (SSRIs)
 - Exposure and response prevention (ERP)

Gail

- Anytime she experiences a headache, she states that she thinks she has a tumor.
- When she feels breathless, she tells you that she may be having a heart attack
- She avoids, drinking, exercise, and even laughing because the sensations she experiences make her think she's dying.
- She always watches the "on your health" part of the news to see the "disease of the month"

Linda

- Has difficulty coming to the party because she has trouble breathing and swelling in the joints of her arms and legs
- May have to rush out in the middle of conversation because she has a chronic urinary tract infection that is acting up.
- In addition, she tells you she has chronic headaches, GI problems, difficulties with her menstrual cycle, and has some difficulty with her balance.

Celia

- You see a woman at the party with a cane, and figure she probably is a bit less work, so you go talk to her.
- She tells you she lost her sight suddenly, after a car accident.
- As you are talking, you begin walking together, and you notice that she expertly negotiates a tricky floor transition without help or her cane.

Bob

- Bob is a 1st year medical student who recently separated from his wife
- He reports abdominal pain, which he says they just haven't found a cause of yet
- He states that he has done some relaxation, and that he thinks the pain is improving

Jim

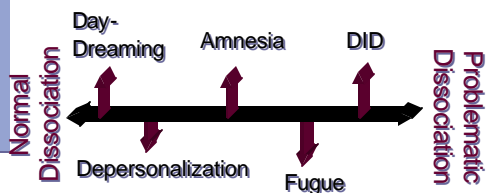
- You notice a man staring into the window, and you go over to see what he's looking at.
- You realize that he can't see out the window, but can only see his reflection.
- When you ask what he's looking at, he smiles and thanks you for being so kind. When you ask what he's talking about, he says thank you for pretending that you do not notice the shape of his head.

Dissociative Disorders

DISSOCIATIVE DISORDERS

- Group of disorders based on the phenomenon of dissociation - separation of part of the person's consciousness or identity from the central identity
- Conceptualized as being on a continuum from day dreaming to highway hypnosis to pathological dissociation
- Common with extreme anxiety

Continuum of Dissociative States



Types of Dissociative Disorders

1. Depersonalization Disorder
2. Dissociative (psychogenic) fugue
3. Dissociative (psychogenic) amnesia
4. Dissociative Identity Disorder (formerly MPD)

Features of Dissociative disorders

- individual experiences an alteration of identity
- disturbance in memory of events occurring during dissociation period
- typically traumatically induced

Adaptive features

- Escape from reality that is too overwhelming to deal with,
 - "go off into their own world"
 - these occur on a continuum from no pathology to severe

Depersonalization Disorder

- Sense that you are detached from your body and mind
- don't feel like yourself
- like observing self, being outside of self
 - Not the same as the near death experience
 - But the experience may be similar
- sense of lack of reality

Depersonalization Disorder

- Accompanied by derealization
 - whole world seems unreal
 - loss of sense of reality
 - not "just spacing out" - this is very distressing to the person involved
- relatively common among the Dissociative disorders and Anxiety disorders

Dissociative Fugue

- Sudden unexplained and unexpected travel which involves confusion about or assuming a new identity
- usually follows some serious pathological stress and may be associated with very heavy alcohol use
- usually lasts a short period of time

Dissociative Fugue

- recovery is usually rapid – spontaneous remission
- person does not remember what they did while in the fugue state
- distinction between fugue and amnesia - fugue involves travel, amnesia doesn't

Dissociative Amnesia

- not induced organically - not from brain injury
- trauma which results in some form of memory loss (important information)
- loss might be for some specific time or loss might be more generalized
- memory for these periods is often accessible under hypnosis
- recovery is usually very sudden - spontaneous remission

Dissociative Identity Disorder

- Formerly *Multiple Personality Disorder* or *MPD*
- classified as complex and chronic dissociative disorder characterized by a disturbances of identity and memory
- there are two or more distinct personalities within one person

DID

- Symptoms/Behaviors
 - anxiety
 - depressed mood
 - severe headaches
 - memory disturbance
 - loss of time, blackout
 - change in voice, body language, posture, gestures, handedness

Core features of DID

- Existence of alter personalities who exchange control over the individual
- alter personality is defined as an entity with firm, persistent, and well rounded self
 - alter has a characteristic and consistent pattern of relating to the world
- the number of personalities is related to the severity and number of childhood traumatic events (average = 13 personalities)

DID

- Switching - changing from one alter to another
 - may or may not be consciously done by the individual
 - may be triggered by an event in the environment (stressor)
 - see physical changes - facial (grimacing), postural, speech
 - can also see psychophysiological sensitivity changes
 - alter may have different threshold for pain, different response to alcohol or medications

DID

- Need to differentiate the following
 - Schizophrenia
 - this is an important distinction to make
 - these are totally different phenomena
 - Bipolar disorder -- scattered thoughts of mania
 - Depression (with psychotic features)
 - Borderline personality disorder

Etiology of DID

- Childhood trauma
 - 98% of DID sufferers have been abused
 - MOST people who are abused do NOT develop DID
 - 83% are survivors of child sexual abuse
 - 67% experienced extreme neglect or abandonment as a child

Etiology of DID

- Often see ritualistic abuse in client's history
 - brutal form of abuse which involves rituals over an extended period of time
 - this is painful, humiliating, and severe

Psychodynamic theory of DID

- Psychoanalytic and psychodynamic theories rely on repression and defense mechanisms
- Kluff's 4 factor theory
 - 1) possess the capacity to dissociate
 - 2) experience overwhelming trauma that draws on the dissociative capacity as a defense mechanism
 - e.g., profound sexual or physical abuse by a parent)

Kluft's 4 factor theory of DID

- 3) develop an alternate personality around naturally occurring phenomena
 - e.g., the hidden observer, ego states, or an imaginary companion
 - This prevents the personality from achieving a cohesive sense of self
- 4) experience the failure of significant others to protect the child from further trauma and reestablish normal development

Braun & Sach's 3-P factor theory

- 3-P factor theory
- (1) Predisposition: The genetic capacity to dissociate, and the repeated, long-term experience of severe childhood trauma.
- (2) Precipitation: dissociation is triggered as a defensive mechanism
 - Through state dependent learning and other mechanisms, dissociative episodes become linked into alter personalities or fragments.

Braun & Sach's 3-P factor theory

- (3) Perpetuation: Ongoing abuse, and other situational factors that involve the patient's repeated use of dissociation
 - affects the shaping of the fragments
 - ensures the continuation of the personalities

Behavioral Theories of DID

- Behavioral position - coping mechanism that is an avoidance move
 - Putnam (1985) - disruption in the development task of learning to generalize across different states of consciousness
 - Essentially problems in learning when and where to engage in specific behaviors

Behavioral Theories of DID

- behavioral repertoire approach
 - Everyone has different repertoires under specific contextual control
 - These contexts can evoke repertoires even when haven't been around for a period of time
 - e.g., grown child visiting parents

Behavioral Theories of DID

- behavioral repertoire (continued)
 - DID may have extremely tightly controlled repertoires that evolved this way
 - DID may be reverting to behavior repertoires that had reinforcing properties for the individual (resurgence, not repression)
 - Treatment goals may be different with this theory

DID Treatment

- Primary goal is understanding and “integration” into one consistent self
- goal in psychodynamic therapy is to uncover the traumatic experience in the person's childhood
 - make it so the client can tolerate having these experiences

DID Treatment

- Therapist must always see the person as a whole and at the same time must be respectful of the individual personalities
 - see the whole person and the parts at the same time
 - Attempts to destroy specific personalities in a DID client have, historically, failed miserably

Controversy of DID

- This disorder is of questionable rarity
 - controversy as to whether it is more or less rare than originally thought
- may be valid diagnosis (not as rare) because:
 - better criteria are available for diagnosing the disorder
 - there is a growing belief in the authenticity of the diagnosis
 - the incidence of DID may have been under reported before now

Controversy of DID

- May **not** be as common as those people think
 - may be "diagnosis of the year(s)"
 - zeitgeist issue -- find what you are looking for
- Changing rates
 - Before the book Sybil in 1973, there were only about 75 cases of this disorder in recorded history
 - mostly between 1876 and 1920, with only 8 reported between 1960 and 1970

Controversy of DID

- Now estimates are 40,000 diagnosed cases
- vast majority of psychologists and psychiatrists have never seen a single case
 - a very small minority of clinicians report the great majority of cases

Controversy of DID

- Special hospital units collect huge amounts of insurance money to treat multiple personality.
 - not unusual for the treatment of one multiple personality patient to cost \$1 million
 - One case cost \$2.75 million
 - When one woman reached her \$1 million insurance limit, the hospital put her into a state facility, which then determined she had no significant mental illness and discharged her
