CHAPTER 8: Somatic Symptom and Dissociative Disorders

Chapter Overview/Summary

The *DSM-5* now includes somatic symptom disorder (formerly known as somatoform disorders), which is comprised of disorders previously known as hypochondriasis, somatization disorder, and pain disorder. Related disorders now include illness anxiety disorder, conversion disorder, and factitious disorder. In somatic symptom and related disorders, psychological problems are manifested in physical disorders (or complaints of physical disorders) that often mimic medical physical conditions, but for which there can be found no evidence of corresponding organic pathology. In hypochondriasis, one of the former somatoform disorders most commonly seen, there is an anxious preoccupation with having a disease based on a misinterpretation of bodily signs or symptoms. Medical reassurance does not help. The former somatization disorder was characterized by many different complaints of physical ailments in four symptom categories spreading over several years. The symptoms did not need to have actually existed as long as they were complained about. The former pain disorder was characterized by pain severe enough to cause life disruption. Although a medical condition could contribute to the pain, psychological factors were judged to play an important role in the onset, severity, exacerbation, or maintenance of the pain. Illness anxiety disorder is new to the *DSM-5* and involves high anxiety about having or developing a serious illness. Conversion disorder involves patterns of symptoms or deficits affecting sensory or voluntary motor functions, leading one to think there is a medical or neurological condition, even though a medical examination reveals no physical basis for the symptoms. Body dysmorphic disorder involves obsessive preoccupation with some perceived flaw or flaws in one’s appearance. Compulsive checking behaviors (such as mirror checking) and avoidance of social activities, because of fear of being rejected, are also common.

Dissociative disorders occur when the normal processes regulating awareness and the multichannel capacities of the mind apparently become disorganized, leading to various anomalies of consciousness and personal identity. Depersonalization/derealization disorder occurs in people who experience persistent and recurrent episodes of derealization (losing one’s sense of reality) and depersonalization (losing one’s own sense of self and one’s own reality). Dissociative amnesia involves an inability to recall previously stored information that cannot be accounted for by ordinary forgetting and seems to be a common initial reaction to stressful circumstances. The memory loss is primarily for episodic or autobiographical memory. In dissociative fugue, a person not only goes into an amnesiac state but also leaves his or her environment and becomes confused about his or her identity, sometimes assuming a new one. In dissociative identity disorder (DID), the person manifests at least two or more distinct identities or personality states that alternate in some way in taking control of behavior. Alter identities may differ in many ways from the host identity. There are many controversies about DID, including whether it is real or faked, how it develops, whether memories of childhood abuse are real, and, if the memories are real, whether the abuse played a causal role.

Detailed Outline

I. Somatic Symptom and Related Disorders
   A. Somatic Symptom Disorders
      1. Soma—means body.
      2. Malingering—a person intentionally produces physical symptoms and is motivated by external incentives.
      3. Factitious disorder—a person intentionally produces symptoms and has no external incentives.
      4. Somatic symptom disorder. Changes in the *DSM-5* include dropping the old disorders of (1) hypochondriasis, (2) somatization disorder, and (3) pain disorder. Most people who would have previously been diagnosed with one of these disorders will now be diagnosed with somatic symptom disorder. The history and research are based on the old disorders and are important to discuss.

   B. Hypochondriasis
      1. Major characteristics
a. Estimated that 75 percent of the people previously diagnosed with hypochondriasis will be diagnosed with somatic symptom disorder in the DSM-5.

b. Vague and ambiguous physical symptoms are common.

c. Sincere in their conviction that the symptoms represent illness.

d. Around 2 percent to 7 percent of general medical practice patients are hypochondriacs.

e. Case study: An “abdominal mass.”

2. Major characteristics
   a. Highly preoccupied with bodily functions, minor physical abnormalities, and ambiguous physical sensations.
   b. Have intrusive thoughts where they attribute physical symptoms to a suspected disease.
   c. They are not malingering or consciously faking symptoms to achieve specific goals.

3. Causal factors in hypochondriasis
   a. Minimal information available.
   b. May be closely related to the anxiety disorders.
   c. Called health anxiety.
   d. Misinterpretations of bodily sensations are seen as a causal factor in cognitive conceptualizations.
   e. Past experiences lead to a set of dysfunctional assumptions.
   f. Attentional bias for illness-related information.
   g. Role of secondary reinforcements.
   h. Hypochondriacal occurrences reduced by onset of serious medical conditions.

4. Treatment of hypochondriasis
   a. Cognitive-behavioral treatments have been found to be quite effective.
   b. SSRIs may also be effective.
   c. Behavioral techniques.
   d. Group therapy.

C. Somatization Disorder

1. Somatization disorder.
   a. Seen most often in primary medical care.
   b. DSM-IV-TR symptoms no longer required due to arbitrary nature:
      (1) Four pain symptoms.
      (2) Two gastrointestinal symptoms.
      (3) One sexual symptom.
      (4) One pseudoneurological symptom.
   c. Case study: Not-Yet-Discovered Illness.

2. Demographics, comorbidity, and course of illness
   a. Begins in adolescence.
   b. Seen in patients in primary medical care settings.
   c. Complaints not faked.
   d. 3–10 times more common among women.
   e. Occurs more often in lower socioeconomic classes.
   f. Co-occurs with major depression, panic disorder, phobic disorders, and generalized anxiety disorders (GAD).
   g. Complaints of physical ailments over several years before age 30.
   h. Considered a chronic condition.

3. Causal factors in somatization disorder
   a. Uncertain about developmental course and specific etiology.
   b. Familial linkage between antisocial personality disorder in men and somatization disorder in women.
   c. Interaction of personality, cognitive, and learning variables.
   d. Selectively attend to bodily sensations as somatic symptoms.
   e. People high on neuroticism.
4. Treatment of somatization disorder
   a. Identification of one physician who integrates patient care and reduces medications and unnecessary testing.
   b. Primary care physicians experience a great deal of uncertainty and frustration when working with these individuals.
   c. See patients on a regular basis.
   d. Medical management is more effective if combined with cognitive-behavioral therapy focused on promoting appropriate behavior such as better coping and personal adjustment, and discouraging inappropriate behavior and preoccupation with physical symptoms.

D. Pain Disorder
1. Pain disorder
   a. The subjectivity of pain
   b. Persistent and severe pain in one or more areas.
   c. Diagnosed more frequently in women.
   d. Comorbid with anxiety and mood disorders.
   e. An invalid lifestyle can result.
   f. Social isolation.
   g. Often unable to work, fatigue, and loss of strength.
   h. Pain could be viewed as acute (less than six months) or chronic (more than six months).
2. Treatment of pain disorder
   a. Cognitive–behavioral treatment is successful.
   b. Treatment programs include: relaxation training, support and validation that the pain is real, scheduling of daily activities, cognitive restructuring, and reinforcement of “no-pain” behaviors.
   c. Tricyclic antidepressants also reduce pain intensity.
   d. SSRIs.

3 Illness Anxiety Disorder
   a. High anxiety about developing a serious illness
   b. Distressing and/or disruptive but few somatic symptoms
   c. Estimated that 25 percent of people will be diagnosed with hypochondriasis

E. Conversion Disorder (Functional Neurological Symptom Disorder)
1. Conversion disorder
   a. Physical malfunction or loss of control is the central feature.
   b. Hysteria was an early term for the disorder.
   c. Freud used the term conversion hysteria to represent his belief that the symptoms were an expression of repressed sexual energy.
   d. La belle indifférence—French for the beautiful indifference—occurs in only about 20 percent of cases.
2. Precipitating circumstances, escape, and secondary gains
   a. Physical symptoms as a socially acceptable means of escaping form negative responsibilities.
   b. Primary and secondary gain.
3. Decreasing prevalence and demographic characteristics
   b. 1%–3% of all disorders referred for treatment.
   c. Prevalence in general population may be only about 0.005 percent.
   d. Decreasing prevalence may be closely related to increasing sophistication about medical and psychological disorders.
   e. More common among rural populations from lower socioeconomic circles.
   f. “Outbreak” of cases among five Amish girls.
   g. 2–10 times more common among women.
   h. Generally rapid onset after a significant stressor; often resolves within 2 weeks if stressor is removed.
4. Range of conversion disorder symptoms
   a. Sensory symptoms or deficits
      (1) Today symptoms are most often in the visual system, in the auditory
          system, or in the sensitivity to feeling (anesthesia).
      (2) Glove anesthesia is one of the most common.
      (3) Sensory input appears to be received but screened from conscious
          recognition—implicit perception.
   b. Motor symptoms or deficits
      (1) Usually confined to a single limb; loss of function is usually selective.
      (2) Aphonia (talking only in a whisper) is the most common speech-related
          conversion disturbance.
   c. Seizures
      (1) Typically do not show any EEG abnormalities.
      (2) Do not show confusion and loss of memory following the seizure.
      (3) Often show excessive thrashing about and writhing; rarely injure
          themselves in falls or lose control over their bowels or bladder.

5. Important issues in diagnosing conversion disorder
   a. Symptoms do not conform clearly to the particular disease or disorder simulated.
   b. Selective nature of the dysfunction.
   c. Accurate diagnosis can be extremely difficult.
   d. Medical tests.
   e. Hypnosis or narcosis (sleplike state induced by drugs) can remove dysfunction.

6. Treatment of conversion disorder
   a. No well-controlled studies have been conducted.
   b. Motor conversion symptoms have been successfully treated with behavioral
      therapy and reinforcements.

F. Distinguishing Somatization, Pain, and Conversion Disorders from Malingering and Factitious Disorder
   a. Malingering diagnosed when symptom production is intentional to gain an
      external goal.
   b. Factitious disorder diagnosed when symptom production is intentional to
      maintain a sick role (see 8.2 The World Around Us).
   c. Severe and chronic forms of factitious disorder have been called Munchausen’s
      syndrome.
   d. Difficult diagnostic challenges.

I. Dissociative Disorders

II. Dissociation Refers to the Human Mind’s Capacity To Engage in Complex Mental Activity

III. Group of Conditions Involving Disruptions in a Person’s Consciousness, Memory, Identity, or Perception

II. Dissociative Disorders
   A. Depersonalization/Derealization Disorder
      1. Depersonalization/Derealization Disorder
         a. Depersonalization (loss of self or one’s own reality) and derealization (one’s
            sense of the reality of the outside world).
         b. Reality testing remains intact.
         c. Implicit memory.
         d. Implicit perception.
         e. Out-of-body experiences can occur.
         f. Acute stress triggers the reactions.
         g. Personal reactions to the symptoms.
         h. The experience is usually frightening.
i. Comorbid anxiety and mood disorders.

j. Average age of onset is 23.

k. Chronic course in 80 percent of cases.

l. Differential diagnosis is important.

m. Depersonalization symptoms can signal decompensation.

n. Psychotic states often show early depersonalization symptoms.

o. Case Study: A Foggy Student.

B. Dissociative Amnesia and Dissociative Fugue

a. Retrograde amnesia involves the partial or total inability to recall or identify previously acquired information or past experiences; anterograde amnesia is the partial or total inability to retain new information.

b. Dissociative amnesia is also known as psychogenic amnesia.

c. Types of retrograde amnesia found in dissociative amnesia
   (1) Localized—specific period.
   (2) Selective—forgets some but not all of what occurred during a specific period.
   (3) Generalized—loss of all life history, including identity.
   (4) Continuous—remembers nothing beyond a certain point until the present.

1. Typical symptoms associated with amnestic episodes
   a. Amnestic episodes typically last between a few days and a few years.
   b. Basic habit patterns—such as reading, talking, performing skilled work—are maintained.
   c. Most commonly impacts episodic (experienced events) or autobiographical memory, leaving intact semantic (language and concepts), procedural (how to do things), and short-term storage.

2. Dissociative fugue
   a. New identities may be assumed.
   b. Fugue may last for days, weeks, or years.
   c. French for flight.

3. Patterns of defense for amnesia and fugue are similar to conversion disorder
   a. Threatening information becomes inaccessible.
   b. Suppression is involved in memory loss.

4. Memory and intellectual deficits in dissociative amnesia and fugue
   a. Little systematic research.
   b. Semantic knowledge appears to be intact.
   c. Primary deficit is compromised episodic or autobiographical memory.
   d. When presented with autobiographical information, show reduced activation in their right frontal and temporal brain areas.
   e. Implicit memory generally intact (e.g., when asked to dial numbers randomly, one man dialed his mother’s number).
   f. Compared with related deficits in explicit perception that occurs in conversion disorder.

C. Dissociative Identity Disorder (DID)

1. Dissociative identity disorder
   a. Two or more personality systems are created from stressful precipitating events.
   b. Personalities are dramatically different.
   c. Formerly known as multiple personality disorder (MPD).
   e. Needs inhibited in one personality are displayed in another.
   f. Personality most frequently encountered and who carries the person’s real name is known as the host identity.
   g. Alter identities represent fragments of a single person; some alters may have more knowledge than others.
h. Switches between alters and host may occur very quickly or may be more gradual.

i. People with DID may also show depression, self-mutilation, and frequent suicidal ideation and attempts.

j. Usually starts in childhood; diagnosis is typically not until teens, 20s, or 30s.

k. 3 to 9 times more common in women.

l. Females tend to have more alters than males.

m. Believed this gender difference is due to the greater proportion of childhood sexual abuse among females.

n. Case Study: Mary and Marian.

o. Number of alters has increased over time; 50 percent now show more than 10 identities; increasing multiplicity suggests the importance of social factors.

p. Another recent trend is bizarre and unusual identities.

q. Host unaware of alters but alters know one another.

r. See 8.4 DID, Schizophrenia, and Split Personality: Clearing Up the Confusion.

2. Prevalence—Why has DID been increasing?
   a. Prior to 1979 only about 200 cases reported.
   b. Prevalence increasing dramatically in recent years; by 1999, more than 30,000 cases reported in North America alone
      (1) Increased public awareness through books and movies.
      (2) Increased professional acceptance of disorder.
      (3) Decreased misdiagnosis of cases as schizophrenia.
      (4) Increases are artifactual—occurred because therapist suggested the existence of alter identities to patients or therapists have reinforced patients for producing alter identities.

3. Experimental studies of DID
   a. Only a small number of experimental studies have been conducted.
   b. Traditionally, assumed that what one alter learns is not necessarily transmitted to other alters—interpersonality amnesia; at least one study has challenged this finding; documenting at least partial transfer of explicit and implicit memory across alters.
   c. Emotional reactions learned by one identity are also transferred across identities.
   d. Putnam found differences in brain waves between identities, and that these differences were larger than found between actors simulating different identities.
   e. Tsai and colleagues, using fMRI brain-imaging techniques, found changes in hippocampal and medial temporal lobe activity during the switch from one identity to another.

4. Causal factors and controversies about DID
   a. Is DID real or is it faked?
      (1) Use of DID as a criminal defense; deliberate faking in Bianchi trial.
      (2) Factitious and malingering cases of DID are rare.
   b. If DID is not faked, how does it develop: posttraumatic theory or sociocognitive theory?
      (1) Posttraumatic theory
         (a) More than 95 percent of DID patients report memories of severe abuse.
         (b) DID is an attempt to cope with an overwhelming sense of hopelessness and powerlessness.
         (c) Escape—dissociation—occurs through a process like self-hypnosis.
         (d) Since only some abused children develop DID it leads to a diathesis-stress model
            i) Children prone to fantasy.
            ii) Easily hypnotizable.
         (e) DID as a variant of PTSD.
      (2) Sociocognitive theory
D. Sociocultural Factors in Dissociative Disorders

1. Prevalence is influenced by the degree to which they are accepted or tolerated by the surrounding cultural context.
2. Identified in all racial groups, socioeconomic classes, and cultures where it has been studied.
3. Dissociative trance disorder.
4. Possession trance.
5. Cross-cultural variations such as Amok.

E. Treatment and Outcomes in Dissociative Disorders

1. Little is known about dissociative amnesia, fugues, and depersonalization.
2. No systematic controlled research has been conducted.
3. Dissociative identity disorder treatment is focused on integration; treatment is typically psychodynamic and insight-based.
4. Outcome studies are few.
5. Studies biased for good outcomes.
6. 8.5 The World Around Us: DID, Schizophrenia, and Split Personality: Clearing Up the Confusion

III. Unresolved Issues: DID and the Reality of “Recovered Memories”

A. “Believers” Are Usually Practitioners
1. View sexual abuse as the cause of DID.
2. Recovered memories are accurate; before treatment, such memories were repressed.

B. “Disbelievers” Come from Academics and Science-oriented Professionals
1. Challenge that sexual abuse is the cause of DID.
2. DID is due to the social enactment of roles encouraged or induced by misguided therapy.
3. Recovered memories are inaccurate; human memory is malleable, constructive, and subject to modification.

C. False Memory Syndrome Foundation

Key Terms

alter identities conversion disorder hypochondriasis
depersonalization hysteria
depersonalization/derealization disorder implicit memory
derealization implicit perception
dissociation malingering
dissociative amnesia pain disorder
dissociative disorders posttraumatic theory (of DID)
dissociative fugue primary gain
dissociative identity disorder (DID) secondary gain
factitious disorder sociocognitive theory (of DID)
factitious disorder imposed on another host identity soma
 SOMATIC SYMPTOM DISORDERS
somatoform disorder