# Abnormal Psychology

PSYCH 40111

## Somatoform and Dissociative Disorders

**EXPLORING SOMATOFORM AND DISSOCIATIVE DISORDERS**

**These two sets of disorders share some common features and are strongly linked historically as "hysterical neuroses." Both are relatively rare and not yet well understood.**

## Somatoform Disorders

- Soma – Meaning Body
  - Overly preoccupied with their health or body appearance
  - No identifiable medical condition causing the physical complaints
- Types of DSM-IV Somatoform Disorders
  - Conversion disorder involves a change in sensory/motor function
  - Somatization disorder involves recurrent, multiple somatic complaints
  - Pain disorder, chronic pain results in distress
  - Body dysmorphic disorder involves a preoccupation with an imagined physical defect
  - Hypochondriasis is a preoccupation with disease

**Table 10-2 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 in 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-type 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.

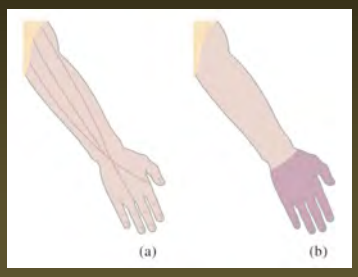
**PAIN DISORDER ASSOCIATED WITH PSYCHOLOGICAL FACTORS**

1. Significant pain as 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.

Based on APA, 2000, 1994.

## Conversion Disorder

- Conversion Disorder involves sensory or motor symptoms
  - Not related to known physiology of the body
    - E.g. glove anesthesia
  - Conversion symptoms appear suddenly
  - Conversion symptoms are related to stress
  - Malfunctioning often involves sensory-motor areas
  - Persons show la belle indifference
  - Retain most normal functions, but without awareness of this ability



## Conversion Disorder

- Facts and Statistics
  - Rare condition, with a chronic intermittent course
  - Seen primarily in females, with onset usually in adolescence
  - More prevalence in less educated, low SES groups
  - Not uncommon in some cultural and/or religious groups

## Conversion Disorder: Causes and Treatment

- Causes
  - Freudian psychodynamic view is still popular
  - Emphasis on the role of trauma, conversion, and primary/secondary gain
  - Detachment from the trauma and negative reinforcement seem critical
  - Behavioral view focuses on similarity to malingering
  - The incidence of conversion disorder has declined, suggesting a role for social factors
- Treatment
  - Core strategy is attending to the trauma
  - Removal of sources of secondary gain
  - Reduce supportive consequences of talk about physical symptoms

## Somatization Disorder

- Somatization Disorder involves recurrent, multiple somatic complaints with no known physical basis
  - Extended history of physical complaints before age 30
  - Substantial impairment in social or occupational functioning
  - Concerned over the symptoms themselves, not what they might mean
  - Symptoms become the person's identity
- Facts and Statistics
  - Rare condition (Lifetime prevalence is < 0.5%)
  - Onset usually in adolescence
  - Mostly affects unmarried, low SES women
  - Runs a chronic course

## Somatization Disorder: Causes and Treatment

- Causes
  - Familial history of illness
  - Relation with antisocial personality disorder
  - Weak behavioral inhibition system
- Treatment
  - No treatment exists with demonstrated effectiveness
  - Reduce the tendency to visit numerous medical specialists
  - Assign "gatekeeper" physician
  - Reduce supportive consequences of talk about physical symptoms

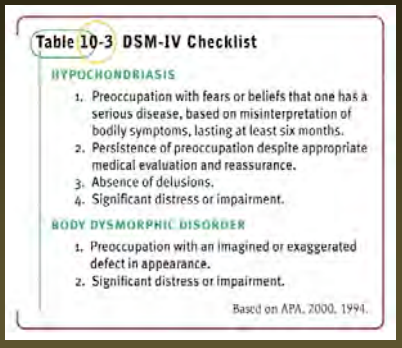


**Table 10-3 DSM-IV Checklist**

HYPOCHONDRIASIS

1. Preoccupation with fears or beliefs that one has a serious disease, based on misinterpretation of bodily symptoms, lasting at least six months.
2. Persistence of preoccupation despite appropriate medical evaluation and reassurance.
3. Absence of delusions.
4. Significant distress or impairment.

BODY DYSMORPHIC DISORDER

1. Preoccupation with an imagined or exaggerated defect in appearance.
2. Significant distress or impairment.

Based on APA, 2000, 1994.

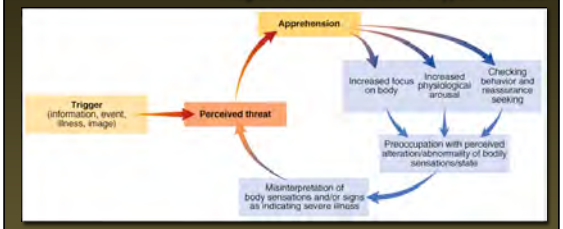
## Hypochondriasis

- Overview and Defining Features
  - Physical complaints without a clear cause
  - Severe anxiety focused on the possibility of having a serious disease
  - Strong disease conviction
  - Medical reassurance does not seem to help
- Facts and Statistics
  - Good prevalence data are lacking
  - Onset at any age, and runs a chronic course

## Hypochondriasis: Causes and Treatment

- Causes
  - Cognitive perceptual distortions
  - Familial history of illness
- Treatment
  - Challenge illness-related misinterpretations
  - Provide more substantial and sensitive reassurance
  - Stress management and coping strategies

Integrative model **of** causes of hypochondriasis




## Body Dysmorphic Disorder ("Imagined Ugliness")

- Overview and Defining Features
  - Previously known as dysmorphophobia
  - Preoccupation with imagined defect in appearance
  - Either fixation or avoidance of mirrors
  - Suicidal ideation and behavior are common
  - Often display ideas of reference for imagined defect
- Facts and Statistics
  - More common than previously thought
  - Seen equally in males and females, with onset usually in early 20s
  - Most remain single, and many seek out plastic surgeons
  - Usually runs a lifelong chronic course

## Body Dysmorphic Disorder: Causes and Treatment

- Causes
  - Little is known; though this disorder tends to run in families
  - Shares similarities with obsessive-compulsive disorder
  - Detachment from the trauma and negative reinforcement seem critical
- Treatment
  - Treatment parallels that for obsessive compulsive disorder
  - Medications (i.e., SSRIs) that work for OCD provide some relief
  - Exposure and response prevention is also helpful
  - Plastic surgery is often unhelpful

## Somatoform Disorders: Theory and Therapy

- The psychodynamic perspective
  - somatizing as conflict resolution
  - uncovering conflict
- The behavioral and sociocultural perspectives
  - the sick role
  - treatment by nonreinforcement
- The cognitive perspective
  - overattention to the body
  - treatment: challenging faulty beliefs
- The biological perspective
  - genetic studies
  - brain dysfunction
  - drug treatment

## Dissociative Disorders

- Overview
  - Involve severe alterations or detachments in identity, memory, or consciousness
  - Variations of normal depersonalization and derealization experiences
  - Depersonalization – Distortion is perception of reality
  - Derealization – Losing a sense of the external world
- Types of DSM-IV Dissociative Disorders
  - Dissociative amnesia is the inability to recall important personal information
  - Dissociative fugue involves extensive memory loss
  - Depersonalization disorder involves an alteration of a person's self-experience
  - Dissociative identity disorder (DID) involves the presence of two different identities (alters)

## Depersonalization Disorder

- Overview and Defining Features
  - Severe and frightening feelings of unreality and detachment
  - Such feelings and experiences dominate and interfere with life functioning
  - Depersonalization
    - a sense of strangeness or unreality in oneself
  - Derealization
    - a feeling of strangeness about the world
- Facts and Statistics
  - Comorbidity with anxiety and mood disorders is extremely high
  - Onset is typically around age 16
  - Usually runs a lifelong chronic course

## Depersonalization Disorder: Causes and Treatment

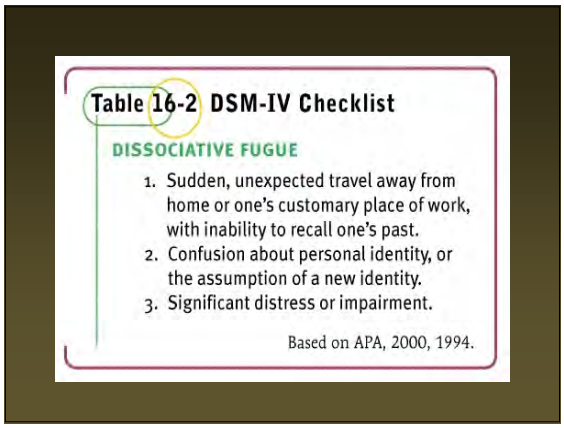
- Causes
  - Show cognitive deficits in attention, short-term memory, and spatial reasoning
  - Cognitive deficits correspond with reports of tunnel vision and mind emptiness
  - Such persons are easily distracted
- Treatment
  - Little is known

**Table 16-1 DSM-IV Checklist**

**DISSOCIATIVE AMNESIA**

1. One or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
2. Significant distress or impairment.

Based on APA, 2000, 1994.




## Dissociative Amnesia and Fugue: Causes and Treatment

- Facts and Statistics
  - Dissociative amnesia and fugue usually begin in adulthood
  - Both conditions show rapid onset and dissipation
  - Both conditions are mostly seen in females
- Causes
  - Little is known, but trauma and stress seem heavily involved
- Treatment
  - Persons with dissociative amnesia and fugue state usually get better without treatment
  - Most remember what they have forgotten

## Dissociative Trance Disorder: An Overview

- Overview and Defining Features
  - Symptoms resemble those of other dissociative disorders
  - Differs in important ways across cultures
  - Involves dissociative symptoms and sudden changes in personality
  - Symptoms and personality changes are often attributed to possession of a spirit
- Facts and Statistics
  - More common in females

## Dissociative Trance Disorder: Causes and Treatment

- Causes
  - Often attributable to a life stressor or trauma
  - Only abnormal if the trance is considered undesirable/pathological by the culture
- Treatment
  - Little is known

## Dissociative Identity Disorder

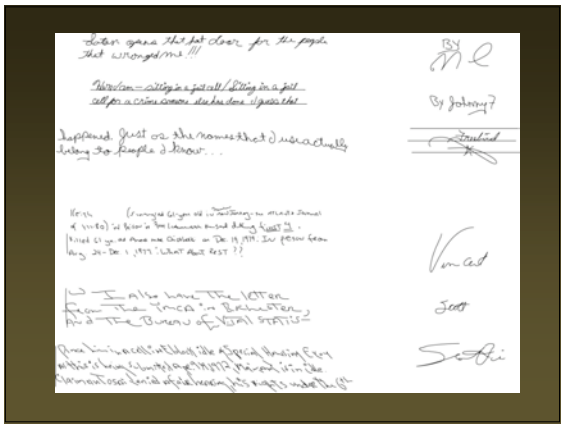
- Overview and Defining Features
  - Involves adoption of several new identities (as many as 100)
  - Identities display unique sets of behaviors, voice, and posture
- Unique Aspects of DID
  - Alters – Refers to the different identities or personalities in DID
  - Host – The identity that seeks treatment and tries to keep identity fragments together
  - Switch – Often instantaneous transition from one personality to another

**Table 16-3 DSM-IV Checklist**

**MULTIPLE PERSONALITY DISORDER (DISSOCIATIVE IDENTITY DISORDER)**

1. The presence of two or more distinct identities or personality states.
2. Control of the person's behavior recurrently taken by at least two of these identities or personality states.
3. An inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

Based on APA, 2000, 1994.



## Dissociative Identity Disorder

- Facts and Statistics
  - Average number of identities is close to 15
  - Ratio of females to males is high (9:1)
  - Onset is almost always in childhood
  - High comorbidity rates, with a lifelong chronic course

## Dissociative Identity Disorder: Causes

- Consciousness is normally a unified experience,consisting of cognition, emotion and motivation
- Stress may alter the fashion in which memories are stored resulting in amnesia or fugue
- Almost all patients have histories of horrible, unspeakable, child abuse
- Most are also highly suggestible
- DID is believed to represent a mechanism to escape from impact of trauma
- Closely related to PTSD

## Dissociative Identity Disorder: Treatment

- Psychoanalytic therapy seeks to lift repressed memories
- Hypnosis is used in the treatment of DID
- Goal of therapy for DID is to
  - Integrate the several personalities
  - Help each alter understand that he or she is part of one person
  - Identify and neutralize cues/triggers that provoke memories of trauma/dissociation
  - Treat the alters with fairness and empathy

## Diagnostic Considerations in Somatoform/Dissociative Disorders

- Separating Real Problems from Faking
  - The Problem of Malingering – Deliberately faking symptoms
- Related Conditions – Factitious disorders
  - Factitious disorder by proxy
- False Memories and Recovered Memory Syndrome

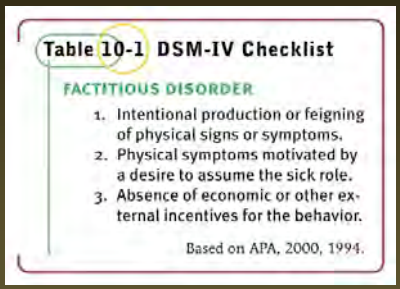


**Table 10-1 DSM-IV Checklist**

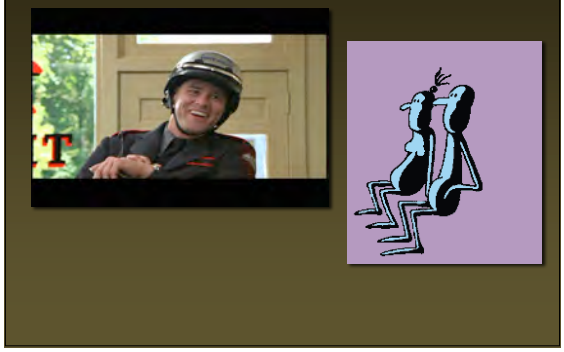
FACTITIOUS DISORDER

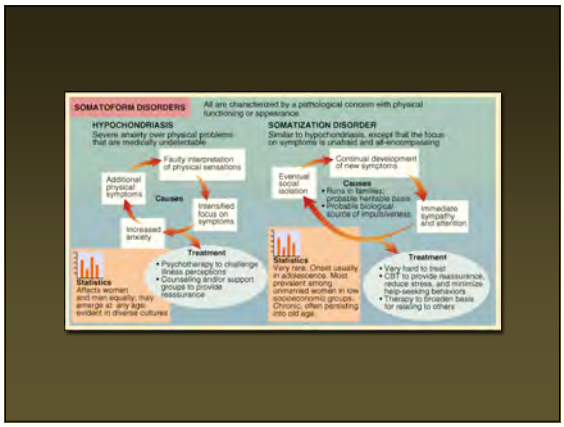
1. Intentional production or feigning of physical signs or symptoms.
2. Physical symptoms motivated by a desire to assume the sick role.
3. Absence of economic or other external incentives for the behavior.

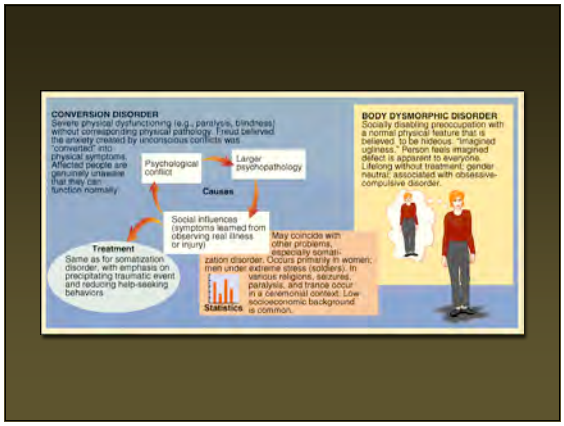
Based on APA, 2000, 1994.

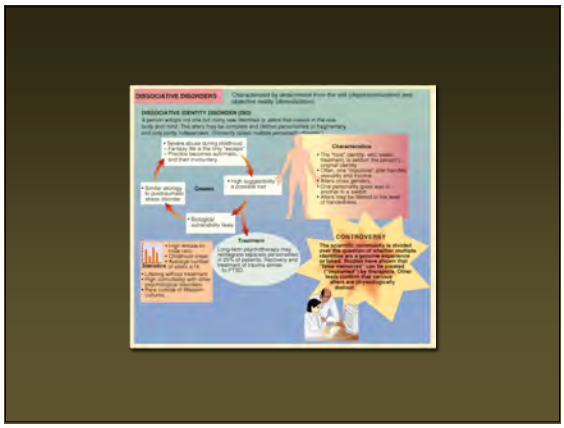
## Summary of Somatoform and Dissociative Disorders

- Features of Somatoform Disorders
  - Physical problems without on organic cause
- Features of Dissociative Disorders
  - Extreme distortions in perception and memory
- Well Established Treatments Are Generally Lacking




SOMATOFORM DISORDERS
All are characterized by a pathological concern with physical functioning or appearance.
HYPOCHONDRIASIS
Severe anxiety over physical problems that are medically undetectable
Faulty interpretation of physical sensations
Additional physical symptoms
Causes
Intensified focus on symptoms
Increased anxiety
Treatment
• Psychotherapy to challenge illness perceptions
• Counseling and/or support groups to provide reassurance
Statistics
Affects women and men equally; may emerge at any age; evident in diverse cultures
SOMATIZATION DISORDER
Similar to hypochondriasis, except that the focus on symptoms is unafraid and all-encompassing
Continual development of new symptoms
Eventual social isolation
Causes
• Runs in families; probable heritable basis
• Probable biological source of impulsiveness
Immediate sympathy and attention
Statistics
Very rare. Onset usually in adolescence. Most prevalent among unmarried women in low socioeconomic groups. Chronic; often persisting into old age.
Treatment
• Very hard to treat
• CBT to provide reassurance, reduce stress, and minimize help-seeking behaviors
• Therapy to broaden basis for relating to others


CONVERSION DISORDER
Severe physical dysfunctioning (e.g., paralysis, blindness) without corresponding physical pathology. Freud believed the anxiety created by unconscious conflicts was "converted" into physical symptoms. Affected people are genuinely unaware that they can function normally.
Psychological conflict
Larger psychopathology
Causes
Social influences (symptoms learned from observing real illness or injury)
Treatment
Same as for somatization disorder, with emphasis on precipitating traumatic event and reducing help-seeking behaviors
BODY DYSMORPHIC DISORDER
Socially disabling preoccupation with a normal physical feature that is believed, to be hideous. "Imagined ugliness." Person feels imagined defect is apparent to everyone. Lifelong without treatment; gender neutral; associated with obsessive-compulsive disorder.
May coincide with other problems, especially somati-
zation disorder. Occurs primarily in women; men under extreme stress (soldiers). In various religions, seizures, paralysis, and trance occur in a ceremonial context. Low socioeconomic background is common.
Statistics


DISSOCIATIVE DISORDERS
DISSOCIATIVE IDENTITY DISORDER (DID)
Causes
Characteristics
Treatment
CONTROVERSY


DEPERSONALIZATION DISORDER
Very rare; feelings of detachment are severe, frightening, and dominate the person's life. Some symptoms similar to those of panic disorder.
Dissociative Amnesia
• Generalized: Inability to remember anything. Comparatively rare.
• Localized: Inability to remember specific events (usually traumatic); common in war.
Dissociative Fugue
Memory loss accompanies an unplanned journey. Usually associated with an intolerable situation. Change of identity may parallel change of place.
Treatment
Usually self-correcting when current life stress is resolved. Otherwise, therapy focuses on retrieving lost information.
Dissociative Trance Disorder
Sudden changes in personality accompany trance or "possession." Prevalent worldwide, usually in a religious context.