Somatic Symptom (Somatoform), Factitious, Conversion and Dissociative Disorders

Somatic Symptom Disorder (also known as Somatization Disorder)

- Illness of multiple somatic complaints in multiple organ systems that occur over a period of several years and results in significant impairment, treatment seeking or both.
- The disorder is chronic and is associated with significant psychological distress, impaired social and occupational functioning, and excessive medical help-seeking behavior.

Somatic Symptom Disorder Diagnostic Criteria 300.82 DSM-V (ICD 10: F45.1)

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

B. Excessive thoughts, feelings, or 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. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

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

Somatic Symptom Disorder Diagnostic Criteria 300.82 (F45.1) DSM-V (cont.)

Specify if:

With predominant pain (previously Pain Disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:

Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified 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).

Epidemiology

- Lifetime prevalence 1-2%
  - Women 0,2 -2%
  - Men 0,2%
  - Women : men = 5-20 : 1
- In population of GP patients 5-10%!
- Little education, low income, onset < 30 years
- 66% have identifiable psychiatric symptoms
- Commonly associated personality traits: avoidant, paranoid, self-defeating, obsessive-compulsive

Etiology

- Psychosocial factors
  - Form of social communication:
    - to avoid obligations (e.g. going to work)
    - to express emotions (e.g. anger at a spouse)
    - to symbolize feeling/belief (e.g. pain in the gut)
- Analytic perspective
  - Repressed instinctual impulses
- Behavioral perspective
  - Parental teaching
  - Parental example
  - Ethnic mores
- Unstable homes, history of physical abuse

Etiology

- Biological factors
  - Characteristic attention and cognitive impairments ➔ faulty perception and assessment of somatosensory inputs
    - Excessive distractibility
    - Inability to habituate to repetitive stimuli
    - Grouping of cognitive constructs on an impressionistic basis
    - Lack of selectivity
    - Decreased metabolism in frontal lobes in the nondominant hemisphere

Etiology

- Genetics
  - SD occurs in 10-20% of first degree relatives
- Cytokines
  - Contribute to some nonspecific symptoms
    - Hypersomnia
    - Anorexia
    - Fatigue
    - Depression

Clinical features

- Many somatic complaints – most common are:
  - Nausea & vomitting
  - Difficulty swallowing
  - Pain in arms and legs
  - Shortness of breath
  - Amnesia
  - Complications of pregnancy and menstruation
- Long, complicated medical history

Somatization disorder case report

- Susan was a 15-year-old girl with a 2-year history of body aches, fatigue, fevers (reported but not documented), headaches, diarrhea, nausea, joint pain, dysuria, and irregular menses. Her mother stated that she had chronic fatigue syndrom (CFS).

Somatization disorder case report

- During multiple medical clinic visits, Susan repeatedly had normal findings on physical and extensive laboratory examinations.
- The patient repeatedly denied stressors, psychological trauma, and/or victimization despite assessments by an adolescent medical specialist and a psychiatrist.

Somatization disorder case report

- While being evaluated by neurology department personnel for her headaches, Susan became completely mute.
- Following a negative medical workup, she was admitted to a psychiatry inpatient unit, where she began talking upon arrival.
- During this admission, she disclosed that her stepbrother had been sexually abusing her and her mother's boyfriend had physically abused her for several years. Gambling and domestic violence in the home were also identified.

Somatization disorder case report

- Susan was placed in foster care, resulting in some decrease in her somatic complaints. Susan subsequently recanted her previous allegations of physical and sexual abuse to child protective services.
- Despite family court involvement, she was allowed to return home and was lost to follow-up.

Somatization disorder case report

- Susan met the criteria of **somatic symptom disorder** with at least 6 months of recurrent aches and pains, pain with urination, nausea, and constipation.
- Chronic fatigue syndrome was in the differential diagnosis. It was felt that her somatic complaints were a reflection of her distress from secretly living with incest, physical abuse, and domestic violence.

Treatment

- Single physician as primary caretaker
- Regularly scheduled brief visits
- Avoid additional lab tests and diagnostic procedures
- Treat somatic complaints **as emotional expressions**
- Psychotherapy decreases the rate of hospitalizations
- Psychopharmacotherapy only for comorbid psychiatric disorders (e.g. depression, anxiety)

Conversion Disorder
(Functional Neurological Symptom Disorder)

- Illness of symptoms or deficits that affect voluntary motor or sensor functions that suggest another medical condition but is judged to be due to psychological factors, because the illness is preceeded by conflicts or other stressors.

Conversion Disorder
(Functional Neurological Symptom Disorder)

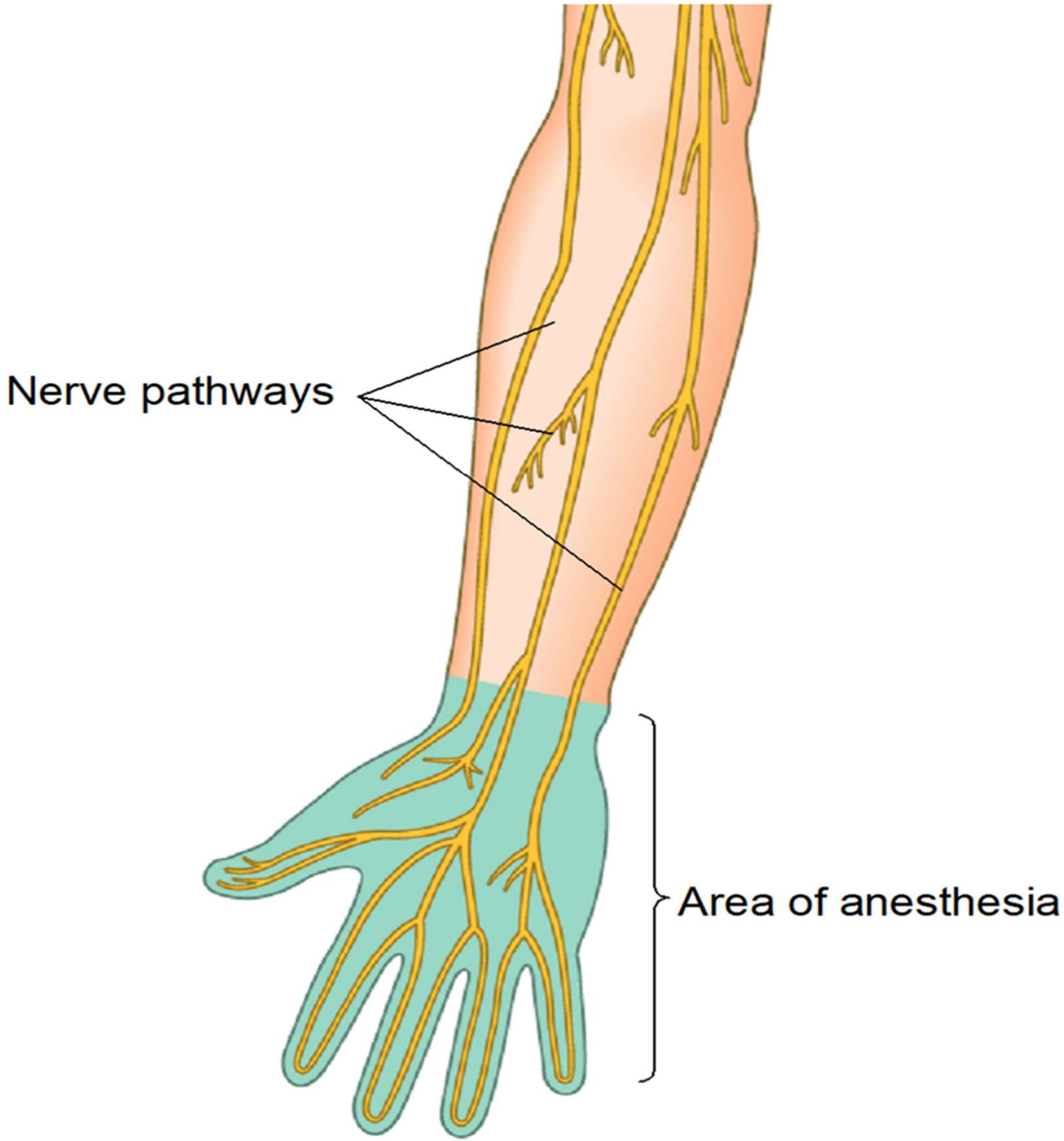
Originally described as „hysteria” by **J.M.Charcot** in the XIXth century

- Unexplained physical malfunctioning without any physical or organic pathology.
- Develops in the presence of evidence that the symptoms solve or express

a psychologic conflict or need.

Conversion Disorder
(Functional Neurological Symptom Disorder)

- The symptoms often simulate neurologic disease but conform to the patient's notion of body function rather than to the rules of neuroanatomy (e.g. glove anaesthesia).
- Medical evaluation yields no evidence of diagnosable disease.


Nerve pathways
Area of anesthesia

Conversion Disorder
DSM-V Diagnostic Criteria

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder.

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Specify if:

- Acute: Symptoms present for less than 6 months
- Persistent: Symptoms occurring for 6 months or more

Specify if:

- With psychological stressor (specify stressor)
- Without psychological stressor

Symptoms are:

- Not **intentionally** produced
- Not due to substances
- Not limited to pain or sexual symptoms

- Onset of symptoms is temporarily related to a stressful life event
- The person experiencing conversion disorder is not distressed by sudden paralysis or blindness ("La Belle Indifference")
- Retain most normal functions, but without awareness of this ability (e.g., "blind" person doesn't bump into things, "paralyzed" person doesn't have atrophy of limb)

Gain

- Primarily psychological
- Not
  - Social
  - Monetary
  - Legal

Epidemiology

- 11-300/100,000 population
- Women : men = 2-10 : 1
- Onset – late childhood to early adulthood
- Common in rural populations
- Patients with
  - low IQ
  - from low socioeconomic groups
  - military personnel exposed to combat situations

Clinical features

Most common symptoms

- Paralysis
- Blindness
- Mutism

Sensory symptoms

- Anesthesia
- Paresthesia
- Deafness
- Blindness
- Tunnel vision

Motor symptoms

- Abnormal movements
  - Gross rhtymical tremors
  - Choreiform movements
  - Tics
  - Jerks
- Gait disturbance
- Weakness
- Paralysis, paresis
- Pseudoseizures

Case report

- A 46-year-old housewife was referred by her husband's psychiatrist to a clinical psychologist for assessment.
- In the course of discussing certain marital conflicts that he was having with his wife, the husband had described "attacks" of dizziness that his wife experienced that left her quite incapacitated.

Case report

- During the assessment, the wife described being overcome with feelings of extreme dizziness, accompanied by slight nausea, four or five nights per week.
- During these attacks, the room around her would take on a “shimmering” appearance, and she would have the feeling that she was “floating” and unable to keep her balance.

Case report

- Inexplicably, the attacks almost always occurred at about 4pm.
- She usually has to lie down on a couch and often did not feel better until 7-8pm.
- After recovering, she generally spent the rest of the evening watching television; more often that not she would fall asleep in the lounge room, not going to bed until 2-3am.

Case report

- The patient had been pronounced physically fit by her general practitioner, a neurologist and an ear-nose-throat specialist on more than one occasion.
- Hypoglycemia had been ruled out by glucose intolerance testing.

- When asked about her marriage…

Case report

- ….she described her husband as a tyrant, frequently demanding and verbally abusive of her and their four children.
- She admitted that she dreaded his arrival home from work each day, knowing that he would comment that the house was a mess and the dinner, if prepared, not to his liking.

Case report

- Recently, since the onset of her attacks, when she was unable to make dinner, he and the four kids would go to McDonalds or the local pizza parlour.
- After that, he would settle in to watch TV in the bedroom, and their conversation was minimal.
- In spite of their troubles, the patient claimed that she loved and needed her husband very much.

Discussion of “Dizziness”

- The woman complains of a variety of symptoms (dizziness, nausea, visual disturbance, loss of balance) that all suggest a physical disorder; but examinations by a number of medical specialists have failed to detect a general medical condition that could account for the symptoms.
- The two possible diagnoses are
    1) an undiagnosed physical condition or
    2) a mental disorder.
- The context in which these symptoms occur suggests the role of psychological factors in their development; **they occur at virtually the same time each day, closely associated with her husband’s arrival home from work;**

Case report

- The husband's angry tirades and verbal abuse are undoubtedly stressful.
- Although the symptoms resemble those of a panic attack, there is no evidence that they occur unexpectedly, thus ruling out Panic Disorder.

Case report

- The disorder, therefore, is a *Conversion Disorder*– a mental disorder with symptoms that suggest a neurological or general medical disorder. The symptoms are linked to an alteration in sensory functioning.

And one more case…

- Three months ago, a 25-year-old woman's 65-year-old father had a stroke that paralyzed the right side of his body. The woman tells her physician that she has recently begun to experience numbness and tingling on the side of her body. She relates this alarming symptom in a calm and thoughtful way. Physical examination, laboratory testing, and neuroimaging reveal no evidence of pathology.

And one more case…

- This case illustrates several aspects of functional neurological symptom disorder.
- First, the patient has a dramatic neurological symptom (numbness and tingling) without adequate physical cause.
- Second, the symptoms appeared suddenly after a stressful life event (her father's illness).
- Typically, patients with this disorder unconsciously model their symptoms on those of a person close to them (use of identification as a defense mechanism).
- Finally, the woman shows "*la belle indifference*"- she appears relatively unconcerned about the symptom.

Treatment

Psychotherapy

- Insight-oriented
- Supportive
- Behavioral
- Focused on issues of stress and coping
- Hypnosis
- Relaxation exercises

Illness Anxiety Disorder (once known as Hypochondriasis)

- General and nondelusional preoccupation with fears of having **a serious disease** based on the misinterpretation of bodily symptoms.
- This preoccupation causes significant distress and impairment in one's life.
- It is not accounted for by another psychiatric or somatic disorder.

Illness Anxiety Disorder Diagnostic Criteria 300.7 (F45.21) DSM-V

A. Preoccupation with 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 doctor appointments and hospitals).

Illness Anxiety Disorder Diagnostic Criteria 300.7 (F45.21) DSM-V (cont.)

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, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

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.

Etiology – 4 theories

1. Augmentation and amplification of somatic sensations
   - Low tolerance of physical discomfort
   - Faulty cognitive scheme ➔ misinterpretation of bodily sensations
2. Request for admission to the sick role
3. Variant of depression or anxiety disorder
4. Aggressive and hostile wishes toward others are transferred into physical complaints

Treatment

- Frequent, regularly scheduled physical examinations
- SSRI
- Psychotherapy
  - Group
  - Individual
    - Insight-oriented
    - Behavior-cognitive
    - Hypnosis

Case report

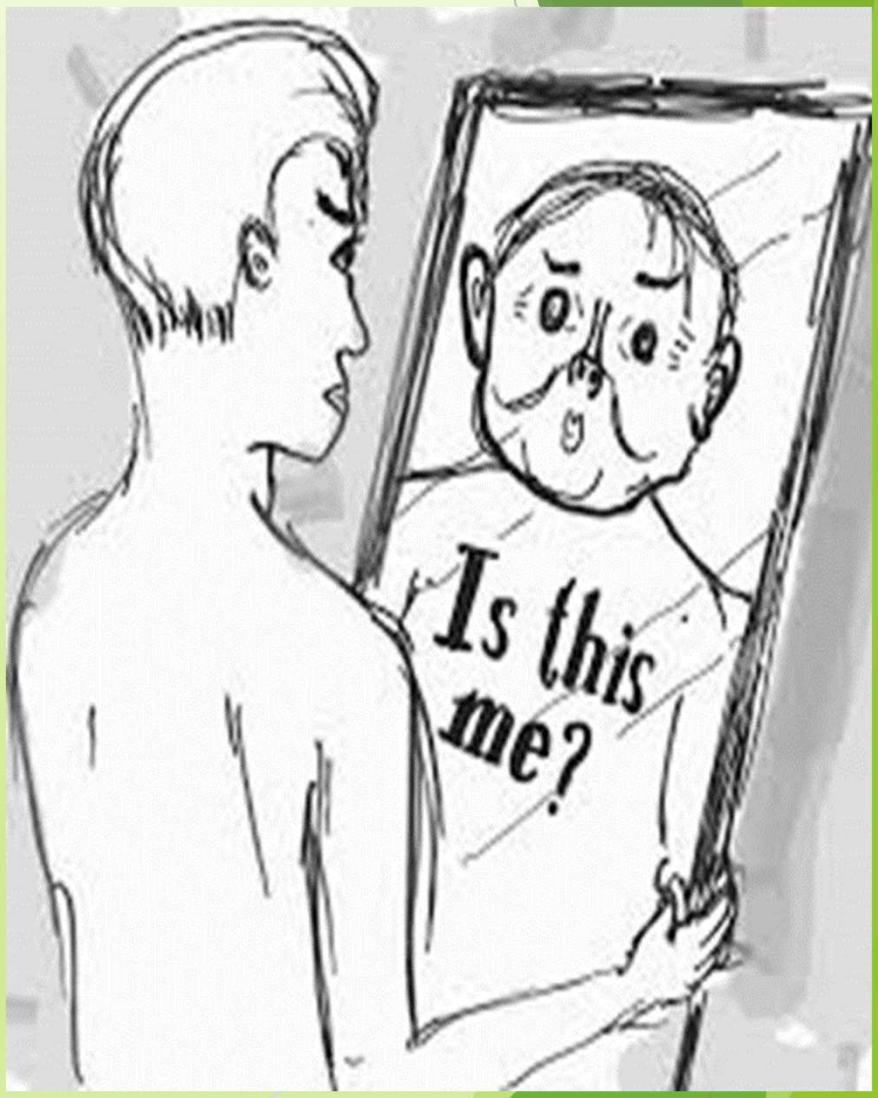
- Jennifer was a mildly anxious and depressed 13-year-old adolescent girl who feared the possibility of having cancer.
- She became convinced she had cancer when her breast development was asymmetrical. She felt her hair was falling out, and, in her mind, this further confirmed her diagnosis.

Case report

- She was seen by her pediatrician, who reassured her that her symptoms were normal and provided her with information about her normal physical examination findings.
- Antidepressants improved her symptoms of depression and anxiety, and somatic complaints decreased with a combination of reassurance and **psychopharmacologic intervention.**

Body dysmorphic disorder

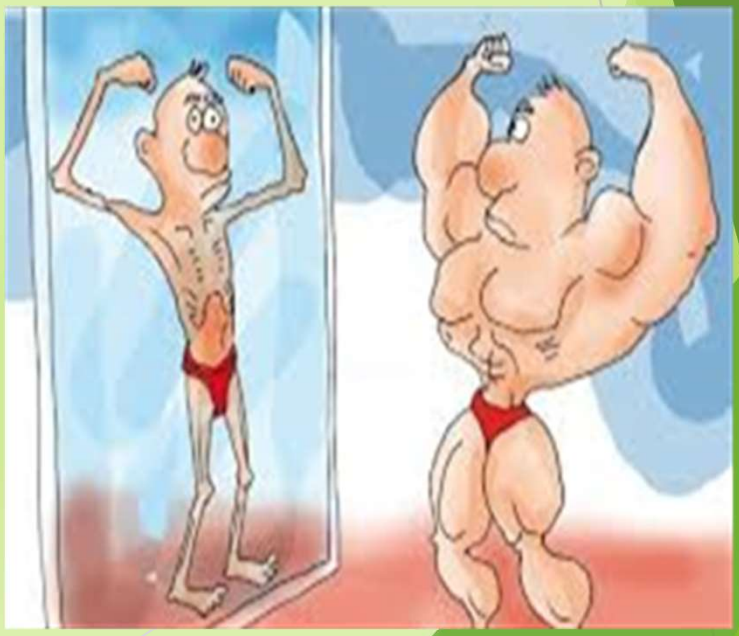
- Preoccupation with an imaginary defect in appearance (non-psychotic) that causes clinically significant distress or impairment in important areas of functioning.
- If a slight anomaly is present, the person's concern is excessive and bothersome.



Clinical features

Most common concerns involve:

- Skin
- Facial flaws (nose)
- Hair
- Breast
- Genitals
- Muscle mass (in men) ➔ „bigorexia”



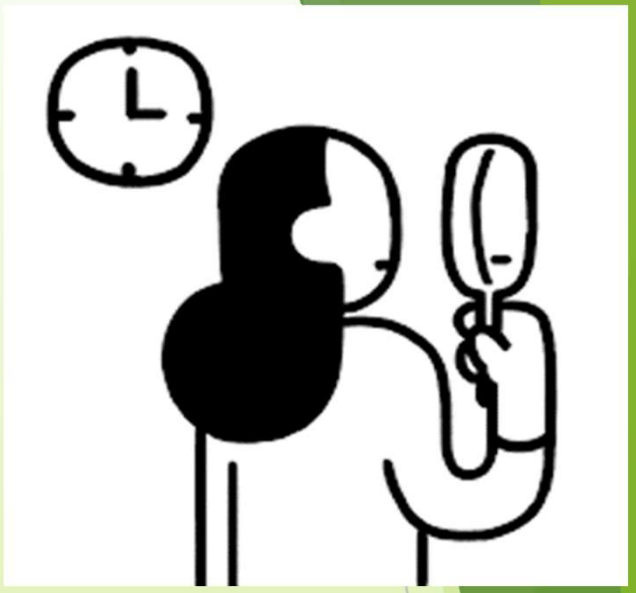
Treatment

Discouraging from surgical operation ➔ this will not resolve the problem!

Pharmacology:

- SSRI's
- Tricyclic antidepressants
- MAO inhibitors
- Pimozide
- Buspirone (as augmentation)
- Lithium (as augmentation)
- Methylphenidate (as augmentation)

Case report



- For 19-year-old James, the simple act of looking in a mirror is torture. Ever since a friend made a casual comment about his appearance, James has been **obsessed** with the size and shape of his nose. "It's just not right... it just doesn't fit my face" he will state.

Case report

- James is unable to be reassured that there is nothing objectively wrong with his nose and will spend at least an hour per day checking himself in various reflections. He has begun to consult with cosmetic surgeons about the possibility of rhinoplasty.

Pain disorder

- The presence of, and focus on, pain in one or more body sites and is severe enough to come to clinical attention.
- Psychological factor is significantly involved in the pain symptoms.
- It is associated with other psychiatric disorders, epsecially depression and anxiety disorders.
- Patients often make repeated visits to doctors for diagnosis or pain relief; subsequent substance abuse/narcotic addiction not uncommon.
- Onset is bimodal: in adolescence and early adulthood and in the 4^{th} and 5^{th} decades of life.

Clinical features

- Various locations of pain:
  - Lower back, head, face, pelvic region…
- Long history of medical care
- Preoccupation with the pain
- Abuse or dependence on analgesics
- Major depression in 25-50%
- Depressive symptoms in 60-100%

Treatment

- Pharmacotherapy
  - Antidepressants (SSRI's, TCA's)
  - Amphetamine – as SSRI augmentation
- Psychotherapy
- Biofeedback
- Hypnosis
- Transcutaneous nerve stimulation
- Dorsal column stimulation
- Nerve blocks
- Surgical ablations

Case report

- Sheila was a 9-year-old girl evaluated for possible rheumatoid arthritis. She woke up with pain in one knee, which caused her to limp through her day at school. Findings from her medical workup were negative, and the pain shifted to her other leg.

Case report

- Social history revealed that her maternal grandfather, who had a limp caused by an old hip injury, had died 3 weeks before the onset of symptoms.
- Sheila was close to him and felt guilty for not playing checkers with him during their last visit. The pain persisted for 10 days. The pain gradually decreased and resolved with supportive medical evaluation and family attention.

Factitious disorder

Simulating, inducing or aggravating

illness, often inflicting painful,

deforming or even life-threatening

injury on self or on those under

patient's care (once called *by proxy*)

Gain ➔ emotional *care and attention* that comes with playing the role of a patient.

Factitious Disorder
Diagnostic Criteria 300.19 (F68.10)

Factitious Disorder Imposed on Self

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
B. The individual presents himself or herself to others as ill, impaired, or injured.
C. The deceptive behavior is **evident** even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify:

- Single episode
- Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Factitious Disorder Imposed on Another (Previously Factitious Disorder *by Proxy*)

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
B. The individual presents another individual (victim) to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
Note: The perpetrator, not the victim, receives this diagnosis.
Specify.

- Single episode
- Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Etiology

- Psychodynamic interpretation:
  - Childhood abuse and deprivation resulted in frequent hospitalizations (escape from traumatizing circumstances)
  - Rejecting mother, absent father unable to form close relation.
  - Masochistic personality traits
- Defense mechanisms: repression, identification with aggressor, regression, symbolization

Clinical manifestation

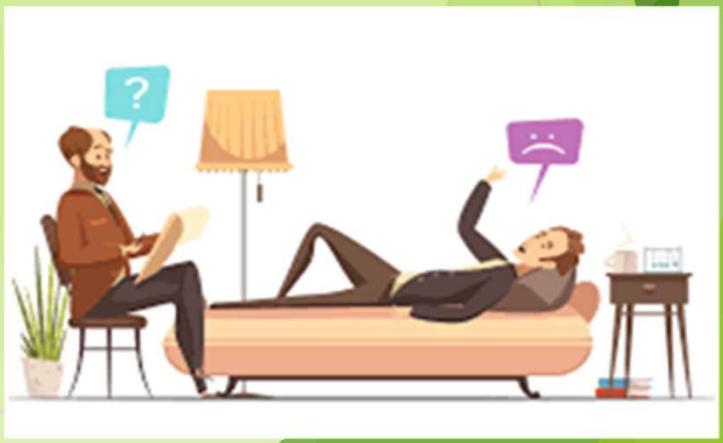
- Intentional production or feigning of physical or psychological signs or symptoms
- The motivation is to assume the sick role
- External motivation for the behavior (economic, legal etc.) or improving physical well-being **is absent**

Types

- FD with predominantly psychological signs and symptoms
- Chronic FD with predominantly physical signs and symptoms (**Münchhausen's syndrome**, hospital addiction, polysurgical addiction, professional patient syndrome)
- FD with combined psychological and physical signs and symptoms

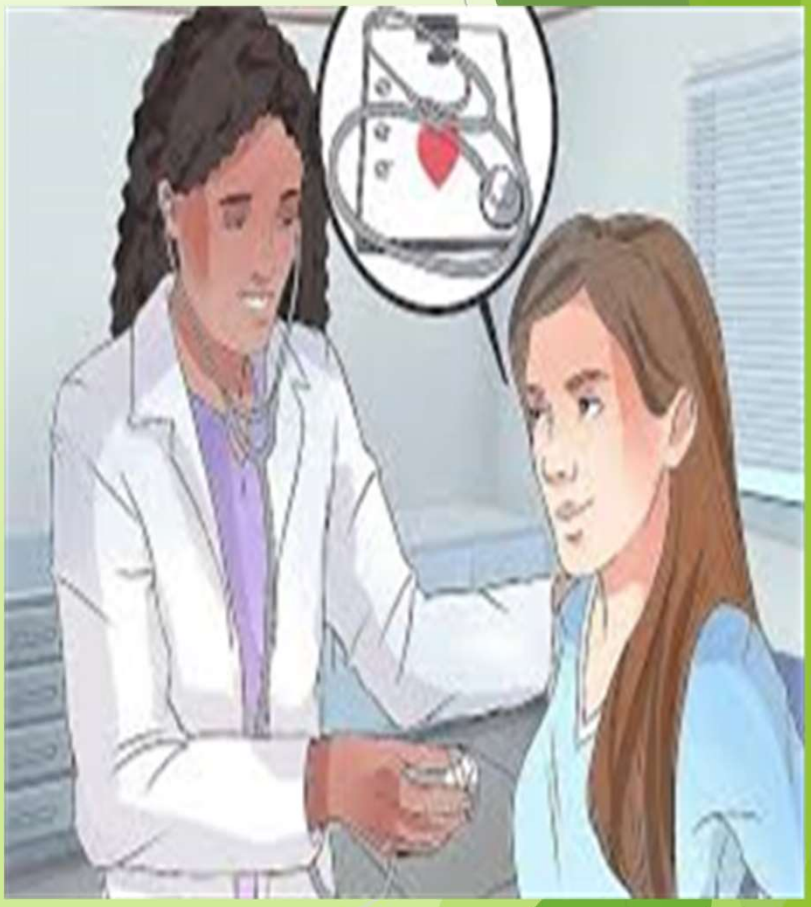
Treatment

- Reduce the risk of morbidity and mortality
- Address the underlying emotional needs or psychiatric diagnosis
- Be mindful of legal and ethical issues
- Co-operation of physicians/surgeons and psychiatrists
- **No evidence** for effectivenes of psychotherapy or pharmacotherapy whatsoever…



Case report

- A 23-year-old patient named Sarah complained to her doctor of chronic intermittent diarrhea. Her family confirmed her symptoms. A test for phenolphthalein (an ingredient that used to be common in laxatives) was positive, suggesting that Sarah was inducing her symptoms.
- During the course of therapy, Sarah subsequently acknowledged that she enjoyed the attention she received while in the sick role.



Factitious illness imposed on another (*by proxy*) case example:

- A 9-month-old infant named Samuel was admitted almost monthly to the children's hospital with complaints of bloody diarrhea.
- This was never witnessed until the mother brought the diaper to clinic that contained a bloody red streak with a small amount of guaiac-negative stool in the middle of it.

Factitious illness imposed on another (*by proxy*) case example:

- Examination of the blood revealed that it was mother's type, and it was thought to be menstrual blood. The mother left the hospital against medical advice stating that she needed a better medical opinion.
- It was discovered that the child was admitted to another hospital, and a report was made to Child Protective Services.

And one more case…

A 39-year-old woman takes her 6-year-old son to a physician's office. She says that the child often experiences episodes of breathing problems and abdominal pain. The child's medical record since birth shows many office visits and four abdominal surgical procedures that have resulted in crosshatched abdominal scarring, although no abnormalities were ever found.

When the doctor confronts the mother with the suspicion that she is fabricating the illness in the child, the mother angrily grabs the child and leaves the office immediately.

And one more case…

This clinical presentation is an example of factitious disorder imposed on another. The mother has faked the child's illness for attention from medical personnel. This faking has resulted in multiple surgical procedures in which no abnormalities were identified, resulting in a "grid abdomen."

Because she knows she is lying, the mother becomes angry and quickly leaves the office when she is confronted with the truth.

And one more case…

Factitious disorder imposed on a child is a form of child abuse. Therefore, the first thing the physician should do is notify the appropriate state social service agency to report this suspicion. Delaying action could result in further injury or even death to the child.

The child probably has no knowledge of his mother's behavior.

Malingering

- Malingering involves the intentional reporting of physical or psychological symptoms in order to achieve personal gain.
- Common external motivations include avoiding the police, receiving room and board, obtaining narcotics, and receiving monetary compensation.
- Note that malingering is not considered to be a mental illness.

Malingering

- Patients usually present with multiple vague complaints that do not conform to a known medical condition.
- They often have a long medical history with many hospital stays.
- They are generally uncooperative and refuse to accept a good prognosis even after extensive medical evaluation.
- Their symptoms improve once their desired objective is obtained.

Case report

A 37-year-old patient claims that he has frequent episodes of „seizures”, starts on medications, and joins an epilepsy support group. It becomes known that he is doing this in order to collect social security disability money.

Diagnosis?

Case report

Malingering

- In contrast, in factitious disorder, patients look for some kind of unconscious emotional gain by playing the “sick role,” such as sympathy from the physician.
- The fundamental difference between malingering and factitious disorder is in the intention of the patient; in malingering, the motivation is external, whereas in factitious disorder, the motivation is internal.

Review of Distinguishing Features

- **Somatic symptom disorder:** Patients *believe* they are ill and do not intentionally produce or feign symptoms.
- **Factitious disorder:** Patients intentionally produce symptoms of a psychological or physical illness because of a desire to assume the *sick role*, not for external rewards.
- **Malingering:** Patients intentionally produce or feign symptoms for *external rewards*.

Dissociative disorders

- The essential feature of dissociative disorders is a disruption in the **usually integrated** functions of **consciousness, memory, identity or perception** of the environment.
- The disturbance may be sudden or gradual, transient or chronic.

Dissociative amnesia

- Inability to remind important personal information, usually of traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness.
- Not related with substances or other psychiatric disorders (acute stress disorder, PTSD, other dissociative disorders).
- No findings in physical condition.
- Clinically significant distress or impairment in important areas of functioning.

Dissociative Amnesia
Diagnostic Criteria 300.12 (F44.0) DSM-V

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.

Dissociative Amnesia
Diagnostic Criteria 300.12 (F44.0) DSM-V

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, 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.

Treatment

- Cognitive therapy
- Hypnosis
- Group psychotherapy

Case report

- The patient was a 19-year-old male military service member who was hospitalized on two separate occasions after he was found to have toxic salicylate levels.
- Both times, he presented to a primary care clinic with complaints of nausea, disequilibrium, labored breathing, diaphoresis, and hemetemesis.
- Laboratory evaluations revealed toxic salicylate levels, but the patient denied ingesting any medication, denied memory loss, and was without psychiatric complaint.

Case report

- He was admitted to the psychiatric ward, where he was noted to be polite but anxious, appearing inhibited, and avoiding most interpersonal contact.
- He continued to deny ingestion of aspirin, despite physical signs and laboratory evidence of overdose.
- At the time of his second hospitalization, he reported finding an empty aspirin bottle in his room. He was also more aware of some of his current stressors.
- He shared that he had joined the military after September 11 with a sense of patriotism and the fantasy of serving with „heroes”.
- He had not anticipated the difficulty he would have separating from his family, nor the disappointment he would experience upon finding that his military peers did not meet his expectations of the idealized hero.

Case report

- He disclosed that he had previously witnessed an assault on his roommate by other service members, who had then made threats against his life.
- Poisoning was considered, but was unlikely since the perpetrators were in jail pending trial.
- The patient underwent psychological testing to assist in diagnosis. The Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2) indicated that he was experiencing a significant level of distress.

Case report

- The validity profile suggested over-reporting of symptoms, which was thought to be related to an **inability to express** his needs in a *more sophisticated* manner.
- There was a low probability that he was feigning symptoms, and the most prominent theme involved feelings of interpersonal rejection and alienation.

Case report

- The patient was discharged from the inpatient psychiatric ward with an diagnosis of dissociative amnesia and an diagnosis of avoidant personality disorder.
- He remained unable to recall details of the ingestions while hospitalized and in the months that followed, and was eventually discharged from active duty service with no further psychiatric history.

Depersonalization disorder

- Persistant or recurrent feeling of detachment or estrangement from one's self, as if one is an outside observer.
- Reality testing remains intact.
  - Reality testing is the ability to assess a situation for what it is, rather than the way we wish or fear them to be. Example: **"I just failed my first midterm. That means I am going to fail the rest of my midterms".** Reality: One poorly written midterm doesn't necessarily mean your remaining midterms will be failures.
- Causes clinically significant distress or impairment in important areas of functioning.
- Not due to substances or other psychiatric condition.

Depersonalization/Dereallzation Disorder DSM-V Diagnostic Criteria 300.6 (F48.1)

A. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:

1. Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g.,perceptual alterations, distorted sense of time, unreal or absent self, emotional and/or physical numbing).

2. Derealization: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).

Depersonalization/Derealization Disorder DSM-V Diagnostic Criteria 300.6 (F48.1)- cont.

B. During the depersonalization or derealization experiences, reality testing remains intact.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).
E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttrau matic stress disorder, or another dissociative disorder.

Treatment

- Pharmacotherapy
  - SSRI antidepressants (?)
  - Mood stabilizers (?)
  - Neuroleptics (?)

- But no evidence for effectiveness of drugs was found…

- Psychotherapy
- Stress management strategies
- Distraction techniques
- Relaxation training
- Reduction of sensory stimulation
- Physical exercise

Dissociative fugue

- Sudden, unexpected **travel** away from home or one's place of work, with inability to recall it.
- Confusion about personal identity or assumption of a new identity (partial or complete)
- Causes clinically significant distress or impairment in important areas of functioning
- Not due to substances or other psychiatric condition

DSM-V 300.13 (F44.1)**Dissociative fugue:** Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

Treatment

- Eclectic **psychotherapy**
- Hypnosis
- Pharmacologically facilitated interviews (e. g. with benzodiazepines)
- Patients may act impulsively, may have suicidal thoughts and tendencies!

Case report

- Last year a Westchester County lawyer – a 57-year-old husband and father of two, Boy Scout leader and churchgoer – left the garage near his office and disappeared.
- Six months later he was found living under a new name in a homeless shelter in Chicago, not knowing who he was or where he came from.
- Library searches and contact with the Chicago police did not help the man. His true identity was uncovered through an anonymous tip to "America's Most Wanted."
- But when he was contacted by his family, he had no idea who they were…

Dissociative identity disorder

- Previously known as a „Multiple Personality Disorder”, is characterized by presence of two or more different identities or personality states that recurrently take control of the individual’s behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

Dissociative Identity Disorder
DSM-V Diagnostic Criteria 300.14
(ICD-10: F44.81)

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 in identity involves 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.

Dissociative Identity Disorder DSM-V Diagnostic Criteria 300.14 (F44.81)

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.

Note: In children, the symptoms are not better explained by 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).

Etiology

- Severe experiences of early childhood trauma in 85-97% of patients.

Also:

- Much more common at women
- Typically in late adolescence and early adulthood (mean age 30 years)

Clinical features

- Disturbed affect modulation
  - Mood swings
  - Depression
  - Suicidal tendencies
  - Generalized irritability
- Impaired impulse control that causes…
  - Risk taking behavior
  - Substance abuse
  - Inapropriate, self-destructive behavior
- Anxiety, panic attacks
- Eating disorders
- Somatization, conversion

Treatment

- **Psychotherapy**
  - Analytic
  - Cognitive - behavioral
  - Hypnosis
  - Systemic
- **Pharmacotherapy**
  - SSRI, TCA, MAO-I
  - ß-blockers
  - Clonidine (alpha-2 agonist)
  - Anticonvulsants
  - Benzodiazepines (for a short period of time)
  - Naltrexone might be helpful in coping with self-injurious behaviors

Case report

- ‘Julia’ presents a classic case of multiple personality disorder. She describes how she has been’losing time’ since she was a child.
- She once came round in an unfamiliar classroom to discover that a chunk of nearly two years had gone missing.
- Another time she found herself in a scummy bar talking to a guy who seemed to know her an awful lot better than she knew him.

Case report

In therapy, her alternate personalities began to emerge…

- Elizabeth was the administrator who kept some order among the Inside People.
- George was the burly protector who came out in moments of danger.
- Joanne was the playful 12-year-old.
- Sandi was the terrified four-year-old, trapped at the moment of abuse.
- In all, Julia had nearly **100 selves (!),** although many were not much more than fragments, having merely labels like Noise or no names at all.

Case report

- As therapy began to reveal these others to her, it appeared the splitting had been caused by a childhood of extreme physical and sexual abuse involving her mother, father and brother.
- Julia had contained these experiences by dividing them up among a cast of characters.
- Now she needed to break down the barriers of amnesia and make herself whole once more.

1. A 34-year-old woman comes to the physician with the chief complaint of abdominal pain. She states that she has been reading on the internet and is convinced that she has ovarian cancer. She says that she is particularly concerned because the other physicians she has seen for this pain have all told her that she does not have cancer, and she has been having the pain for over 8 months. She reports that she has undergone pelvic examinations, ultrasounds, and other diagnostic work-ups, all of which have been negative. She tells the physician that she is initially reassured by the negative tests, but then the pain returns and she becomes convinced that she has cancer again. She notes that she has taken so much time off from work in the past 8 months that she has been reprimanded by her boss. Which of the following is the most likely diagnosis?

a. Pain disorder

b. Malingering

c. Factitious disorder

d. Ilness Anxiety disorder (Hypochondriasis)

e. Conversion disorder

d. Ilness Anxiety disorder (Hypochondriasis)

2. Which of the following courses of action is most likely to be helpful in the case of the woman in the vignette above?

a. Refer the patient to psychotherapy.

b. Start the patient on an antidepressant.

c. Have the patient see a primary care physician at regular intervals.

d. Begin a diagnostic work-up for ovarian cancer.

e. Start the patient on an antipsychotic for her delusional belief.

a. Refer the patient to psychotherapy.

3. A 43-year-old man comes to the physician with a 3-month history of nervousness and excitability. He states that he feels this way constantly and that this is a dramatic change for his normally relaxed personality. He notes that on occasion he becomes extremely afraid of his own impending death, even when there is no objective evidence that this would occur. He notes that he has lost 20 lb and frequently has diarrhea. On mental status examination, he is noted to have pressured speech. On physical examination, he is noted to have a fine tremor and tachycardia. Which of the following disorders is this patient most likely to have?

a. Hyperthyroidism

b. Hypothyroidism

c. Hepatic encephalopathy

d. Hyperparathyroidism

e. Hypoparathyroidism

a. Hyperthyroidism

4. A 43-year-old man is admitted to the neurology service after he went blind suddenly on the morning of admission. The patient does not seem overly concerned with his sudden lack of vision. The only time he gets upset during the interview is when he is discussing his mother's recent death in Mexico—he was supposed to bring his mother to the United States, but did not because he had been using drugs and did not save the necessary money. Physical examination is completely negative.

Which of the following is the most likely diagnosis?

a. Conversion disorder

b. Hypochondriasis

c. Factitious disorder

d. Malingering

e. Delusional disorder

a. Conversion disorder

5. A 43-year-old woman comes to the emergency room with a temperature of 38.3°C (101°F) and a large suppurating ulcer on her left shoulder. This is the third such episode for this woman. Her physical examination is otherwise normal, except for the presence of multiple scars on her abdomen. Which of the following is the most likely diagnosis?

a. Malingering

b. Somatoform disorder

c. Borderline personality disorder

d. Factitious disorder

e. Body dysmorphic disorder

d. Factitious disorder

6. A 28-year-old business executive sees her physician because she is having difficulty in her new position, because it requires her to do frequent public speaking. She states that she is terrified she will do or say something that will cause her extreme embarrassment. The patient says that when she must speak in public, she becomes extremely anxious and her heart beats uncontrollably. Other than in these performance situations, she does not find herself anxious generally. The most probable diagnosis is:

a) Generalized anxiety disorder
b) Social phobia
c) Hyperthyroidism
d) Adjustment disorder
e) Somatoform disorder

b. social phobia

7. The most appropriate treatment in her condition would be:

- a. Fluoxetine daily
- b. Propranolol prn (as needed, as required, pro re nata)
- c. Bupropion daily
- d. Olanzepine daily
- e. Clonazepam prn

a. Fluoxetine daily