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LEARNING OBJECTIVES

After reading this chapter, students should be able to:

8.1 Describe the overarching characteristics of dissociative disorders.
8.2 Distinguish between normal and abnormal forms of dissociation.
8.3 Name and describe cultural forms of dissociation.
8.4 Identify the symptoms of dissociative amnesia.
8.5 Demonstrate knowledge of prevalence, comorbidity, course, and gender and cultural differences for this disorder.
8.6 Describe the neurological factors that play a role in dissociative amnesia.
8.7 Explain the differences between the dissociation and neodissociation theories.
8.8 Specify the social factors that play a role in dissociative amnesia.
8.9 Identify the symptoms of depersonalization-derealization disorder.
8.10 Demonstrate knowledge of prevalence, comorbidity, course, and gender and cultural differences for this disorder.
8.11 Identify the role of brain systems and neural communication in depersonalization-derealization disorder.
8.12 Describe the psychological and social factors that affect depersonalization-derealization disorder.
8.13 Identify how the neurological, psychological, and social factors interact in depersonalization-derealization disorder.
8.14 Identify the symptoms of dissociative identity disorder.
8.15 Demonstrate knowledge of prevalence, comorbidity, course, and gender and cultural differences for this disorder.
8.16 Explain the criticisms of the dissociative identity disorder diagnosis.
8.17 Describe the neurological factors that affect dissociative identity disorder.
8.18 Identify the psychological and social causes of dissociative identity disorder.
8.19 Compare and contrast the posttraumatic stress and sociocognitive models.
8.20 Recognize the debates about dissociative identity disorder.

8.21 Identify neurological, psychological, and social treatments for dissociative identity disorder.

8.22 Describe the interactions among the neurological, psychological, and social treatments for dissociative identity disorder.

8.23 Describe the characteristics of the somatic symptom disorders.

8.24 Distinguish the somatic symptom disorder of factitious disorder from others.

8.25 Identify the symptoms of somatic symptom disorder.

8.26 Demonstrate knowledge of prevalence, comorbidity, course, and gender and cultural differences for this disorder.

8.27 Describe the neurological, psychological, and social factors and interactions that influence somatic symptom disorder.

8.28 Identify the symptoms of conversion disorder.

8.29 Highlight the criticisms of the DSM criteria of conversion disorder.

8.30 Demonstrate knowledge of prevalence, comorbidity, course, and gender and cultural differences for this disorder.

8.31 Describe the neurological, psychological, and social factors and interactions that influence conversion disorder.

8.32 Identify the symptoms of illness anxiety disorder.

8.33 Describe the debate about the change from DSM-IV-TR’s diagnosis of hypochondriasis to DSM-5’s diagnosis of illness anxiety disorder.

8.34 Compare and contrast illness anxiety disorder and anxiety disorders.

8.35 Describe the neurological, psychological, and social factors and interactions that influence illness anxiety disorder.

8.36 Describe the neurological, psychological, and social factors and their interactions in the treatment of the somatic symptom disorders.

**KEY TERMS**

**Hysteria:** An emotional condition marked by extreme excitability and bodily symptoms for which there is no medical explanation.

**Dissociation:** The separation of mental processes—such as perception, memory, and self-awareness—that are normally integrated.

**Amnesia:** Memory loss, which in dissociative disorders is usually temporary but, in rare cases, may be permanent.

**Identity problem:** A dissociative symptom in which a person is not sure who he or she is or may assume a new identity.

**Derealization:** A dissociative symptom in which the external world is perceived or experienced as strange or unreal.

**Depersonalization:** A dissociative symptom in which the perception or experience of self—either one’s body or one’s mental processes—is altered to the point of feeling like an observer, as though seeing oneself from the “outside.”

**Dissociative disorders:** A category of psychological disorders in which consciousness, memory, emotion, perception, body representation, motor control, or identity are dissociated to the point where the symptoms are pervasive, cause significant distress,
and interfere with daily functioning.

**Dissociative amnesia:** A dissociative disorder in which the sufferer has significantly impaired memory for important experiences or personal information that cannot be explained by ordinary forgetfulness.

**Depersonalization-derealization disorder:** A dissociative disorder, the primary symptom of which is a persistent feeling of being detached from one’s mental processes, body, or surroundings.

**Dissociative identity disorder (DID):** A dissociative disorder characterized by the presence of two or more distinct personality states, or an experience of possession trance, which gives rise to a discontinuity in the person’s sense of self or agency.

**Somatic symptom disorders:** A category of psychological disorders characterized by symptoms about physical well-being along with cognitive distortions about bodily symptoms and their meaning; the focus on these bodily symptoms causes significant distress or impaired functioning.

**Somatic symptom disorder (SSD):** A somatic symptom disorder characterized by at least one somatic symptom that is distressing or disrupts daily life, about which the person has excessive thoughts, feelings, or behaviors.

**Conversion disorder:** A somatic symptom disorder that involves sensory or motor symptoms that are incompatible with known neurological and medical conditions.

**Illness anxiety disorder:** A somatic symptom disorder marked by preoccupation with a fear or belief of having a serious disease in the face of either no or minor medical symptoms and excessive behaviors related to this belief.

**CHAPTER GUIDE**

**Chapter Introduction**

- Dr. Joseph Breuer diagnosed Anna O. with *hysteria*, an emotional condition marked by extreme excitability and bodily symptoms for which there is no medical explanation.

- **Dissociative disorders** are a category of psychological disorders in which perception, consciousness, memory, or identity are dissociated to the point where the symptoms are pervasive, cause significant distress, and interfere with daily functioning. The chief symptom is *dissociation*, the separation of mental processes that are normally integrated.

- **Somatic symptom disorders** are a category of psychological disorders characterized by symptoms about physical well-being along with cognitive distortions about bodily symptoms and their meaning; the focus on these bodily symptoms causes significant distress or impaired functioning.

**LEARNING ACTIVITY 8.1: Who Is Anna O.?**

**Objective:** To describe the case of Anna O. and show how her case relates to dissociative and somatic symptom disorders.
CHAPTER 8  Dissociative and Somatic Symptom Disorders

Time: 20–30 Minutes

Directions: Ask students to look up two Web sites that contain information about Anna O.’s background, symptoms, and treatments.

This exercise will highlight the key findings about Anna O. and how these findings relate to dissociative and somatic symptom disorders.

Summary: Students will see the symptoms of dissociative and somatic symptom disorders.

Questions to Students and Discussion: Describe Anna O.’s background. What symptoms did she experience? What types of treatments were used to help her? What information would you like to know more about if you were treating Anna O.? What information surprised you?

I. DISSOCIATIVE DISORDERS

A. Dissociative Disorders: An Overview

The disorders:

• May arise suddenly or gradually
• Can be brief or chronic
• Have four types of symptoms:
  i. Amnesia or memory loss
  ii. Identity problems in which a person does not know who he/she is or takes on a new identity
  iii. Derealization, in which the environment seems strange and unreal
  iv. Depersonalization, in which the person feels like he/she is an observer of his/her life
• Have three diagnostic categories:
  i. dissociative amnesia
  ii. depersonalization-derealization disorder
  iii. dissociative identity disorder

1. Normal Versus Abnormal Dissociation

• Occasional dissociating is normal and part of everyday life.
• Dissociation can also be part of religious or cultural rituals (such as the possession trance).
• Dissociative experiences can be part of other psychiatric disorders.
• To be considered abnormal, symptoms must be pervasive, and cause distress and impairment.
• Only 2% of the U.S. population reports abnormal dissociation.

2. Cultural Variations in Pathological Dissociation

• Dissociative symptoms vary by culture. (Example: in Indonesia and Malaysia, people may experience fleeting episodes of profanity, amnesia,
and a trancelike state—symptoms known as \textit{latah}.)

\section*{B. Dissociative Amnesia}

1. \textbf{What Is Dissociative Amnesia?}

   - \textit{Dissociative amnesia} is a dissociative disorder in which the sufferer has significantly impaired memory for important experiences or information that cannot be explained by ordinary forgetfulness. [See Table 8.1]
   - Dissociative amnesia takes several forms:
     i. \textit{Generalized amnesia}: one forgets his/her entire life; a very rare condition.
     ii. \textit{Selective amnesia}: one can remember only some parts of a period of time.
     iii. \textit{Localized amnesia}: memory is lost for a specific period of time and often triggered by a stressful event. [See Table 8.2 and Case 8.1]
       - The subtype \textit{dissociative fugue} also involves sudden, unplanned travel, in which case it usually includes the generalized form of amnesia.
       - In some cultures a set of symptoms similar to fugue is called running syndrome, which typically involves the sudden onset of a trancelike state, fleeing, exhaustion, sleep, and amnesia about the experience. (Pibloktoq in native Arctic people, grisi siknis among the Miskito, and amok in Western Pacific cultures.)
       - Prevalence is rare; lifetime prevalence unknown.
       - Depression, anxiety, and substance use comorbidity may be present. Amnesia that results from substance use is not diagnosed as dissociative amnesia.
       - Children or adults can develop this disorder.
       - There may be one or many episodes. Episodes may resolve quickly or persist.
       - No gender differences are reported, but the diagnosis may be culture-related and was unknown prior to 1800.

\begin{center}
\textbf{MEDIA RECOMMENDATION 8.1: Case Examples of Dissociative Amnesia}
\end{center}

\textbf{Objective:} To illustrate the lived experience of dissociative amnesia.

\textbf{Time:} 2 Minutes

\textbf{Video and Discussion:} 10 Minutes

\textbf{Discussion Only:} 8 Minutes

\textbf{Watch Online:} Visit http://www.youtube.com/watch?v=23Pum-7-pyM or search YouTube using the search terms “dissociative amnesia” and “NBC News.”

This NBC news clip focuses on localized amnesia due to childhood sexual abuse.

\textbf{Summary:} Students will learn about how memories are recovered and how a therapist can influence them.
Questions to Students and Discussion: What type of dissociative amnesia is featured in this clip? Why did one survivor discredit his memories while another one confirms hers? What controversies surround these types of memories?

2. Understanding Dissociative Amnesia

Our understanding of dissociative disorders is hampered by a scarcity of research and only general theories that do not characterize specific mechanisms adequately.

a. Neurological Factors: Brain Trauma?

The neurological factors that affect dissociative amnesia are not clear.

(1) Brain systems:

Prolonged stress damages the hippocampus (brain structure that stores new information in the memory) and thus it does not operate well under new stress. However, this can’t explain all cases.

b. Psychological Factors: Disconnected Mental Processes:

The dissociation and neodissociation theories focus on traumatic experiences as the cause of dissociation. Both have some support from research.

(1) Dissociation theory:

• Dissociation theory argues that traumatic experiences cause arousal and cognitive dysfunction, which causes memory to be dissociated from other aspects of cognition.
• The theory provides a broad explanation but does not outline specific mechanisms.

(2) Neodissociation theory:

Neodissociation theory proposes that in some cases, such as trauma, cognitive systems can operate independently of the executive monitoring system and thereby render information stored inaccessible to conscious recall.

(3) Social Factors: Indirect Effects:

• People with a dissociative disorder report childhood physical or sexual abuse almost three times more often than the general population.
• Trauma may not directly cause dissociative symptoms but may lead to them by triggering anxiety.

C. Depersonalization-derealization disorder

People with depersonalization-derealization disorder experience a persistent feeling of being detached from their thought processes or body.

1. What Is Depersonalization-Derealization Disorder? [See Tables 8.3 and 8.4 and Case 8.2]

• The person has a persistent feeling of being detached from his/her mental processes, body, or surroundings, but reality testing is intact.
• Both depersonalization and derealization may be present or only one may be experienced.
• There may be a lack of emotional reaction to events, a feeling of being swept along by events and lacking control, or a sense of “going crazy.”
• Prevalence is unknown but estimated to be extremely low, under 3%. There is no gender difference in prevalence.
• Symptoms of anxiety and anxiety disorders, and major depressive disorder are common comorbidities.
• Average age of onset is 16, and onset after 40 is very rare. A wide range of events may be triggers, including trauma, depression, panic, extreme stress, or use of psychoactive drugs including marijuana and alcohol.
• Episodes of depersonalization or derealization can last from hours to years.
• About one-third of people with the disorder have episodes interspersed with periods of normal experience, one-third have continuous symptoms, and one-third start as episodic and progress to continuous symptoms.

MEDIA RECOMMENDATION 8.2: Living with Depersonalization-Derealization Disorder

Objective: To learn about the lived experience of depersonalization-derealization disorder.

Time: 6 Minutes

Video and Discussion: 15 Minutes

Discussion Only: 9 Minutes

Watch Online: Visit https://www.youtube.com/watch?v=O6amjA7zAe0 or search YouTube using the search term “living with depersonalization-derealization disorder.”

This short clip features the personal experience of someone who has depersonalization-derealization disorder.

Summary: Students will learn about what it is like to live with depersonalization-derealization disorder. In particular, the person highlights symptoms of feeling outside of herself and feeling in a “dreamlike” state. She also discusses possible causes of depersonalization, such as trauma or drug abuse.

Questions to Students and Discussion: How does this young woman describe depersonalization-derealization disorder? What other disorders can one experience in addition to depersonalization-derealization disorder? What are the possible causes of this disorder?

2. Understanding Depersonalization-Derealization Disorder
Because the disorder is rare, there is little research.

a. **Neurological Factors:**
   A convergence of studies provides evidence that this disorder arises in part from disruptions of emotional processing in the brain.

   (1) **Brain systems:**
   - Individuals with depersonalization-derealization disorder have high levels of activity in the frontal lobes, which can suppress emotional processing and might create the sense of emotional detachment patients report. Some studies have shown that brain areas normally activated when remembering words that name emotions are not activated in patients with this disorder.
   - A PET study found unusual activation (too high or too low) in parts of the brain involved in different phases of perception, the temporal and parietal lobes.

   (2) **Neural communication:**
   Persons with this disorder produce less than normal amounts of norepinephrine, associated with autonomic nervous system activity. The stronger the symptoms, the lower the norepinephrine levels.

b. **Psychological Factors: Cognitive Deficits:**
   - Problems range from short-term memory to impaired spatial reasoning, but the root cause of these problems appears to be difficulty focusing and sustaining attention.
   - It is unclear whether the attention problems are the cause or the effect of the disorder, and in cases with comorbid depression or anxiety, whether the problem arises from the comorbid disorder.

c. **Social Factors: Childhood Emotional Abuse:**
   - Stressful events such as severe and long-lasting emotional abuse seem to play a particularly important role in triggering depersonalization-derealization disorder.
   - The perception of threatening social interactions and new environments can make the symptoms worse.

d. **Feedback Loops in Understanding Depersonalization-Derealization Disorder:**
   One hypothesis is that a significant stressor (often social) triggers neurological events (in the frontal lobes) that suppress normal emotional responses. After this the mismatch between the perceived intensity of the stress and the lack of emotional arousal may cause a feeling of unreality. This may be seen as evidence of mental illness, leading to incorrect and catastrophic thoughts about the symptoms that create more anxiety and further episodes, sensitizing the individual to be hypervigilant for possible symptoms.

### D. Dissociative Identity Disorder

- Formerly known as multiple personality disorder.
- Possibly the most controversial of all DSM-5 disorders.

1. **What Is Dissociative Identity Disorder?** [See Tables 8.5 and 8.6 and Case 8.3]
   - **Dissociative identity disorder (DID)** is the presence of two or more distinct
personality states (sometimes referred to as *alters*), or an experience of being “possessed” that leads to a discontinuity in a person’s sense of self and ability to control his or her functioning.

- In some cases, the personality states have separate characteristics, history, names, mannerisms, and even medical problems.
- Recurrent gaps in recall not consistent with ordinary forgetting are also a diagnostic criteria.
- The diagnosis does not apply if the features are part of cultural or religious practice; better explained by imaginary playmates in children; or caused by substance use or medical conditions.
- Prevalence is estimated by some surveys to be about 1%; some researchers view this as a significant overestimate.
- Comorbidities include mood, anxiety, substance-related, PTSD, and personality disorders.
- It can be difficult to distinguish DID from schizophrenia or bipolar disorder.
- Because of its rarity and the length of time prior to diagnosis, there is no accurate information about age of onset.
- The course is usually chronic.
- It is equally prevalent in males and females.
- It is observed only in some Western cultures and was extremely uncommon before the 1976 television movie *Sybil*, which was promoted as a “true case” of what was then called multiple personality disorder.

### 2. Criticisms of the DSM-5 Criteria

Criticisms of the DID diagnosis include:

- The diagnosis of DID does not define “personality states,” which makes it difficult to differentiate between “normal” mood fluctuations or emotional states such as angry outbursts and a “personality state” different from the person’s usual state. Normal emotional fluctuations could be pathologized by these criteria.
- DID is easy to role-play, making it difficult to distinguish from malingering. A disorder that is easy to fake calls the validity of the diagnostic category into question.
- There is difficulty in differentiating DID from rapid cycling bipolar disorder because both involve sudden changes in mood and demeanor.

### 3. Understanding Dissociative Identity Disorder

Research findings at odds with one another fuel the controversy about the validity of the diagnosis. Much of the research focus has been influenced by the number of people diagnosed with DID who report severe, chronic child abuse.

a. **Neurological Factors: Alters in the Brain?**

   1. **Brain systems:**
      - EEGs indicate that a patient with DID recognizes words learned when the learning took place while they were experiencing a different personality state. In other words, there does appear to be
access to information between different personality states.

- PET scans have indicated there is different neural activity between two different personality states when one is aware of past trauma and one is not. Areas known to be activated by autobiographical information are only active in the personality state that was aware of the information. HOWEVER, the studies did not include an appropriate control group. Self-hypnosis can also alter brain activity.

2) Genetics:
Although not a study of DID itself, researchers using a questionnaire found that almost half of the variance in the presence of abnormal dissociations can be attributed to genes.

b. Psychological Factors:
Patients with DID are highly hypnotizable and can easily dissociate.

c. Social Factors: A Cultural Disorder?
- Other cultures have an extremely low or zero prevalence rate of DID (Examples: India and China).
- In other cultures such as Uganda, DID symptoms are attributed to culturally sanctioned possession trance, and not seen as a disorder.
- Prior to 1976, DID prevalence was even lower than it is today. It began to increase after the movie Sybil, promoted as a real case, aired.

d. Feedback Loops in Understanding Dissociative Identity Disorder: Two Models for the Emergence of Alters:
The posttraumatic and sociocognitive models are two models of dissociative identity disorder based on the feedback loops among neurological, psychological, and social factors.

1) The posttraumatic model:
- Because of frequent episodes of abuse and coping through dissociation, the child’s dissociated state can develop its own memories, identity, and way of interacting with the world, thus becoming an alter.
- Possibly supporting this theory, sleep research has shown that sleep deprivation increases the likelihood of experiencing dissociative symptoms in healthy volunteers, and that improved sleep reduces dissociative symptoms in patients with dissociation. Continued sleep deprivation leads to difficulties with memory and attention, also symptoms of DID. The alteration of sleep cycles due to traumatic experience may therefore play a role in DID.
- However, if the posttraumatic model is correct there should be more cases of childhood DID, and this has not been documented. Studies of abused children have found increased ability to dissociate, but not the presence of alters.
- Most adults diagnosed with DID have not obtained evidence to corroborate childhood abuse or trauma.

2) The sociocognitive model:
- This model proposes that social interactions between the therapist and patient influence beliefs and expectations of the patient that foster
behavior consistent with symptoms of DID.
- Cultural cues such as movies, books, and interviews with people describing their DID may also influence these beliefs and behaviors.
- The model is plausible in part because hypnosis was commonly used to bring out alters and it has been demonstrated that suggestible patients can unconsciously develop alters and accompanying neurological changes from promptings of a therapist.
- Prompting may take the form of leading questions such as, “Have people come up to you who know you, but are strangers to you?” Then, showing special interest in “yes” answers can shape patients’ behaviors and beliefs.
- No documented case of DID occurring outside of therapy has been found in published studies of the disorder.

4. The Debate About Dissociative Identity Disorder
- People do present in treatment with these symptoms. The issue debated is how DID arises and continues in a given patient.
- Does the increased prevalence result from cultural and sociocognitive influences or from improved assessment procedures?
- Have all people diagnosed with DID experienced severe childhood trauma, and why do most severely abused children not develop DID?

E. Treating Dissociative Disorders
Generally dissociative amnesia improves without treatment; since these disorders are so rare, little is known about the most effective treatments.

1. Targeting Neurological Factors: Medication
Medication is not generally used to treat symptoms of dissociative disorders, but they may be given for a comorbid disorder or for anxiety or mood symptoms that arise in response to the dissociative symptoms.

2. Targeting Psychological and Social Factors: Coping and Integration
- Psychological treatments focus on helping clients reinterpret symptoms to decrease stress and avoidance, increase stress-management skills, and address the dissociated memories or identities.
- The posttraumatic model maps each alter’s personality, recovers memories of abuse, and integrates the alters.
- The sociocognitive model advises against mapping alters or trying to recover abuse memories. It recommends using learning principles to extinguish patients’ mention of alters. Treatment focuses on current problems rather than past trauma.
- Hypnosis is sometimes used by therapists employing the posttraumatic model to help the patient learn and integrate alters. This is controversial because of possible therapist suggestion and patient susceptibility.
- Reducing possible traumatic stress is also a helpful treatment.

3. Feedback Loops in Treating Dissociative Disorders
- Examining feedback loops in the use of hypnosis and the posttraumatic model of
treatment, we see that hypnosis has a social factor; the patient must be willing to
go along. It brings about changes in brain activity, a neurological factor, which
may play a role in integrating stored information, a psychological factor.

II. SOMATIC SYMPTOM DISORDERS

A. Somatic Symptom Disorders: An Overview

- Somatic symptom disorders are a category of psychological disorders
  characterized by symptoms about physical well-being, along with cognitive
distortions about bodily symptoms and their meaning; the focus on these bodily
symptoms causes significant distress or impaired functioning. Somatic
symptom disorders are “rule out” diagnoses because clinicians must clarify
whether the symptoms do indeed suggest a medical problem. [See Table 8.7]
- Symptoms must cause impairment and distress, and are involuntary.
- Somatic symptom disorders, in general, are rare, but they are the most
  common type of psychological disorder diagnosed in medical settings.
- Hippocrates described somatic symptoms as caused by a wandering uterus
  (hystera, from the Greek word hysteria, meaning “uterus”). Hysteria was often
  used to refer to bodily symptoms that lack a medical explanation; in addition,
  patients with hysteria typically describe their symptoms dramatically.
- Somatic symptom disorders are different from factitious disorder, in which
  people intentionally induce symptoms for attention.
- Somatic symptom disorders all feature a bodily preoccupation and symptom
  amplification.

B. Somatic Symptom Disorder

1. What Is Somatic Symptom Disorder (SSD)?

- Patients must have at least one somatic (bodily) symptom that is distressing or
disrupts daily life, about which they have excessive thoughts, feelings, or
behaviors. [See Tables 8.8 and 8.9 and Case 8.4]
- The one symptom can be pain.
- SSD is not diagnosed unless the response to the symptoms is more extreme than
  would be expected.
- Prevalence is about 5 to 7% of the general population and is a serious problem in
  medical settings, where SSD patients use three times as many outpatient services
  and cost nine times as much to treat. Women are more likely to have SSD, or report
  bodily symptoms.
- Comorbidities are often present and most frequently include an anxiety (especially
  panic) disorder or depression. SSD is associated with increased risk of developing a
  substance-related disorder when benzodiazepines or narcotics are used for relief.
- Onset can be from childhood to older adulthood.
- The course may fluctuate in location or intensity but does not usually disappear.
- Patients with SSD may be extremely sensitive to medication side effects.
- Symptoms vary across cultures; prevalence is higher in some ethnic groups.

2. Understanding Somatic Symptom Disorder

a. Neurological Factors: Genetics:
A large-scale twin study found that genetic effects may account for as much as half of the variability in SSD, but the exact role of genetics is unclear. Temperament and other heritable factors are influenced by genetics and may play a role in the development of SSD.

Family characteristics appear to have no consistent relationship to the development of SSD.

b. Psychological Factors: Misinterpretation of Bodily Signals and Coping:
- Mental processes such as attention may focus on bodily sensations, leading to symptom amplification and catastrophic thinking.
- Faulty beliefs about the meaning of bodily sensations also contribute.
- Somatic symptoms may serve as a coping strategy by distracting from other stressors, such as the death of a loved one.

c. Social Factors: Observational Learning and Culture:
- Social learning:
  - People with SSD may have developed this behavior through observational learning because many people with SSD have had an ill parent.
  - Operant conditioning may reinforce illness behavior.
- Cultural influences on symptoms:
  - Somatic symptoms may be an acceptable form of expressing helplessness.

d. Feedback Loops in Understanding Somatic Symptom Disorder:
Genetic predisposition (neurological factor) may cause misinterpretations of bodily symptoms (psychological factor) that are then reinforced by family members (social factor). [See Figure 8.1]

C. Conversion Disorder [See Figures 8.2 and 8.3; Tables 8.10 and 8.11; and Case 8.5]

Conversion disorder involves sensory or motor symptoms that are not compatible with known neurological or medical conditions. It is sometimes referred to as functional neurological symptom disorder because the symptom involves the functioning of some aspect of the nervous system, but not to a medical cause.

1. What Is Conversion Disorder?
- Symptoms of this disorder are not faked or developed consciously.
- Symptoms cause distress and impairment.
- Conversion disorder symptoms are limited to sensory and motor symptoms that appear to be neurological but do not follow neurological pathways. [See Figure 8.2]
- All possible medical causes must be ruled out to receive a conversion disorder diagnosis.
- People with conversion disorder may react in very different ways to their symptoms; some seem indifferent while others respond dramatically.
- Persistent conversion disorder is very rare, from .001 to .005% in the general population and up to 5% of referrals to neurologists.
- Comorbidity of major depressive disorder is found in up to 85% of people diagnosed with conversion disorder. A neurological disorder may also be present.
Onset can be at any time in life, typically after a significant stressor such as loss of a loved one or physical injury.

Course may be brief, but between 25 and 67% have a recurrence within 4 years.

It is two to three times more common among women.

It is more common among those with lower SES, in rural locations, and those with less knowledge about psychological and medical concepts.

It is more common in developing than industrialized countries.

Small “epidemics” have been reported in countries undergoing cultural change or significant stress.

a. Three Types of Symptoms in Conversion Disorder:
   1. **Motor symptoms** that become worse when the person focuses attention on them. (Examples: tics or jerks, muscle spasms, swallowing problems, staggering, and paralysis sometimes referred to as pseudoparalysis, which can involve severe muscle weakness)
   2. **Sensory symptoms** that do not follow an actual nerve pathway. (Examples: blindness, double vision, deafness, auditory hallucinations, and lack of feeling on the skin)
   3. **Seizures** that can include loss of consciousness with uncontrollable spasms of large muscles. Often referred to as nonepileptic seizures because they are not neurological in origin and usually do not respond to seizure medications. They are likely to occur when others are present.

2. Criticisms of the DSM-5 Criteria
   - Some researchers argue that conversion disorder is just a variant of SSD since they both are bodily expressions of psychological distress.
   - Other researchers believe that conversion symptoms are more like dissociative symptoms that disrupt sensory or motor functioning.

3. Understanding Conversion Disorder
   a. Neurological Factors: Not Faking It:
      1. **Brain systems:**
         - Clinicians must rule out the possibility that the client is faking his/her symptoms.
         - Neuroimaging has found that activity in the brain is different for those who fake motor symptoms than for those with conversion disorder.
         - Researchers compared brain activation in clients reporting sensory deficits in one limb and not the other. The “normal limb” registered pain (in the thalamus, the anterior cingulate cortex, the insula, and part of the frontal lobe). In the deficit limb, these structures were not activated and some areas were deactivated (the primary and secondary areas of the somatosensory cortex and parts of the parietal and frontal lobes). [See Figure 8.3]
         - Chronic pain can lead to sensory deficits that can be seen reflected in fMRI scans.
• Other studies have shown abnormal functioning in the brain areas that interpret sensation and manage other brain areas (often executive functions), rather than abnormal functioning in areas that register sensations.

b. Psychological Factors: Self-Hypnosis?
• There is no generally accepted explanation for how psychological factors might produce the selective bodily symptoms.
• One theory suggests those with conversion disorder may unintentionally hypnotize themselves so that they are not consciously aware of the sensations in some part of their body or suggest to themselves that they have certain symptoms.
• Support for this argument is that people with conversion disorder are unusually hypnotizable and the areas of the brain activated by hypnotically induced paralysis is similar to those activated by paralysis in patients with conversion disorder.

c. Social Factors: Stress Response:
Life stressors such as combat can trigger conversion disorder and the greater the stressor, the more severe are the conversion symptoms.

D. Illness Anxiety Disorder [See Table 8.12 and Case 8.6]

In DSM-IV the diagnosis of hypochondriasis was similar to this diagnosis. Hypochondriasis included people without any significant medical symptoms and those with an excessive response to at least one medical symptom—this latter group is now classified as having somatic symptom disorder.

Some currently question why, if illness anxiety is so different from worries about actual symptoms, it is not grouped with anxiety disorders.

1. What Is Illness Anxiety Disorder?
• Illness anxiety disorder is a preoccupation with a fear or belief of having a serious disease in the face of no or minor medical symptoms and includes excessive behaviors related to this belief.
• Patients with illness anxiety disorder strongly believe something is medically wrong despite reassurance from physicians.
• Patients with illness anxiety disorder have poor insight into their condition and are preoccupied with health problems.
• Symptoms must cause distress or impairment for at least 6 months.

2. Illness Anxiety Disorder, Anxiety Disorders, and OCD: Shared Features
• Symptoms of illness anxiety disorder include high levels of fear and anxiety, perceived danger, avoidance of certain stimuli, and obsessive thoughts about illness.

3. Understanding Illness Anxiety Disorder
As a new diagnosis in DSM-5, most research is related to the DSM-IV diagnosis of hypochondriasis and has examined psychological factors. More research on neurological and social factors is needed.

a. Neurological Factors:
   (1) Neural communication:
In some cases, serotonin may not function correctly. There is only indirect evidence based on the observation that SSRIs can improve symptoms.

(2) Genetics:
One twin study suggested a contribution of genetics to hypochondriasis.

b. Psychological Factors: Catastrophic Thinking About the Body:
- Psychological factors that contribute to illness anxiety disorder include biased reasoning that seeks evidence of health threats and fails to consider evidence that they are minimal or nonexistent.
- Attentional bias focuses on unpleasant sensations, particularly on functioning body parts such as the stomach or heart and ambiguous sensations.
- Sensations are misinterpreted as abnormal or pathological, and behaviors that temporarily reduce anxiety, such as checking blood pressure, serve to maintain faulty beliefs and are themselves maintained by negative reinforcement (temporary reduction of anxiety).
- Catastrophizing is a common error in thinking for those with this disorder.

c. Social Factors: Stress Response:
- Stressful events were shown to trigger the similar DSM-IV diagnosis of hypochondriasis.
- People with DSM-IV diagnosis of hypochondriasis reported experiencing more stressors than those without the disorder.
- Attention from caretakers may unintentionally reinforce symptoms.

E. Treating Somatic Symptom Disorders [See Figure 8.4 and Table 8.13]
Clinicians target factors individually or in combination, but cognitive-behavioral therapy is generally the treatment of choice.

1. Targeting Neurological Factors
- There is a lack of rigorous research on neurologically based treatments.
- SSRIs or St. John’s wort may treat the anxiety-related symptoms but these usually return when the medication is stopped.
- Biofeedback may be used to target muscle tension.

2. Targeting Psychological Factors: Cognitive-Behavior Therapy
- Cognitive-behavioral therapy (CBT) is the treatment of choice.
- CBT methods vary with the symptoms of the different disorders.
- Cognitive methods focus on identifying and modifying irrational thoughts and shifting attention away from bodily symptoms.
- Behavioral methods focus on decreasing compulsive behaviors and overcoming avoidance of social and other activities.

3. Targeting Social Factors: Support and Family Education
- Feeling that someone understands one’s pain and distress is in itself an important form of social support.
• Identifying how symptoms affect interactions with others and interventions that relieve social stressors are helpful.
• Family therapy may be used to modify possible reinforcements for the dysfunctional behaviors and to learn how to reinforce positive change.

4. Feedback Loops in Treating Somatic Symptom Disorders
• CBT provides new ways to interpret sensations, modify thoughts, and cope with stress, which in turn can decrease bodily symptoms (a neurological factor) and the attention paid to them (a psychological factor).
• Neurological factors targeted by biofeedback and medication can affect the type and quality of attention paid to bodily sensations and help change the meaning given to them (psychological factors).
• A supportive relationship with the therapist and improved response from family members and others (social factors) can reduce stress (a neurological factor) and reduce cognitions and behaviors that maintain symptoms (psychological factors). [See Figure 8.4]

III. FOLLOW-UP ON ANNA O.
• Anna’s symptoms do not fit into any one single disorder in this chapter. Today she would probably be diagnosed with more than one disorder.
• Anna’s symptoms cleared up near the end of her treatment with Breuer, but she had a major relapse after their final session, and he refused to treat her anymore.
• Her history for the next 6 years is largely unknown except that she was hospitalized several times for her addictions to the morphine and chloral hydrate Breuer had prescribed for her.
• Despite Breuer’s negative prognosis, she went on to accomplish great things. Bertha Pappenheim (her real name) became a social worker, director of an orphanage, and founder of a home for unwed mothers and dedicated herself to teaching the women there skills to support themselves and their children. She strove to improve the lives of poor women and children for the rest of her life.
• It is important to note that her life illustrates that having a psychological disorder was not then a personal disaster nor a signal that life had to become constrained and unrewarding—nor is it today.

ADDITIONAL READINGS
Journal Articles

Dissociative and Somatic Symptom Disorders Books and Memoirs

The book features several cases of “hysteria” as seen through the eyes of Breuer and Freud.
This book is discussed throughout this chapter.

This comprehensive book highlights personal accounts, research, and treatments for depersonalization-derealization disorder.

**ADDITIONAL MEDIA RECOMMENDATIONS**

This film shows how illness anxiety disorder and mood disorders can overlap. The film focuses on a cartoonist who struggles with health issues, relationships, and depression.

**WEB SITES**

Depersonalization Support Community: *This is not an endorsement of the site as a treatment resource.* Chat rooms, treatments, support, and links for people with depersonalization-derealization disorder. This is a peer-developed and peer-monitored site only. http://www.dpselfhelp.com/forum/