DISSOCIATIVE DISORDERS

- Dissociation: disruption in the integrated sense of self, often develops after significant trauma particularly during childhood

	dx – dsm 5 criteria	epidemiology/ etiology	treatment	notes
Dissociative Amnesia	• inability to recall important autobiographical information (lapses in autobiographical memory) ,usually involving a traumatic or stressful event • dissociative fugue: Sudden, unexpected travel away from home, accompanied by amnesia for identity • Not due to the physiological effects of a substance, another medical or neurological or other mental condition • symptoms cause significant distress or impairment in daily functioning	• More in females • often develops after trauma	patient's safety Psychotherapy (supportive, CBT, hypnosis)	• Procedural memory (e.g., how to ride a bike) is preserved • can experience periods of flashbacks, nightmares, or behavioral reenactments of their trauma • comorbid major depressive disorder or persistent depressive disorder (dysthymia) & increased risk for suicide (amnesia resolves & overwhelming memories return) • rarely generalizes to complete memory loss, more commonly, a single period of time (localized amnesia) or certain events (selective amnesia) are forgotten
Depersonalization/ Derealization	• Pt experiences one or both: **depersonalization**: (detachment from one's self "out-of-body") / **derealization** (detachment from surroundings "in a dream or movie") • Reality testing remains intact during an episode, as opposed to during psychosis • Not due to the physiological effects of a substance, another medical or neurological or other mental condition • symptoms cause significant distress or impairment in daily functioning	• 1:1 • Mean age of onset is about 16 years • Increased incidence of comorbid anxiety disorders and major depression • After severe stress and trauma	Psychodynamic, supportive, CBT, hypnosis	• persistent but may wax and wane

DISSOCIATIVE DISORDERS

	dx – dsm 5 criteria	epidemiology/ etiology	treatment	notes
Dissociative Identity Disorder (DID)	• Disruption of identity manifested as two or more distinct personality states dominating at different times • Extensive memory lapses in autobiographical information, daily occurrences, and/or traumatic events • Not due to the physiological effects of a substance, another medical or neurological or other mental condition • symptoms cause significant distress or impairment in daily functioning	• Rare • More in females • childhood physical abuse, sexual abuse, or neglect, symptoms usually begins in childhood • High incidence of comorbid PTSD, disorders (major depressive, eating, borderline personality, and substance use) • More than 70% of pts attempt suicide	• Psychotherapy is the standard treatment • SSRIs (comorbid depressive / PTSD symptoms esp. hyperarousal) • Prazosin (nightmares) • naltrexone (self-injurious behaviors)	• fluctuating but chronic • Worst prognosis of all dissociative disorders • Psychotherapy aims: safety, stabilization, identity integration, and symptom reduction by working directly with traumatic memories
Other Specified Dissociative Disorder	• Identity disturbance due to prolonged and intense coercive persuasion (e.g., brainwashing, cult rituals) • Chronic and recurrent syndromes of mixed dissociative symptoms (w/out dissociative amnesia) • Dissociative trance: An acute narrowing or loss of awareness of surroundings (unresponsiveness, potentially with minor stereotyped behaviors (not part of a cultural or religious practice)) • Acute dissociative reactions to stressful events (lasting hours/days → 1 month)			symptoms of dissociation that cause significant distress or impairment of functioning, but do not meet the full criteria for a specific dissociative disorder

SOMATIC SYMPTOM AND FACTITIOUS DISORDERS

- Patients with somatic symptom disorders present with prominent physical symptoms, associated with significant distress or impairment in social, occupational, or other areas of functioning, may or may not have an associated medical condition (30% have medically unexplained symptoms)

	dx – dsm 5 criteria	epidemiology	treatment & prognosis	notes
Somatic symptom disorder	• 1 or more somatic symptoms (may be predominantly pain) that are distressing or result in significant disruption. • At least one of the following: (disproportionate and persistent thoughts about seriousness of symptoms / persistently high level of anxiety about health or / excessive time and energy devoted to these symptom) • Persistent state of being symptomatic (typically >6 months; symptoms may shift over time)	• More in females • Risk factors (old age, less educated, lower socioeconomic status, unemployment, traumatic experiences in childhood	• chronic and debilitating, may improve and then worsen under stress • pt should have regularly scheduled visits with a single primary care physician, to minimize unnecessary medical workups & treatments • physicians should recognize that pt's suffering is genuine, whether or not there is an identifiable medical cause. • Address psychological issues slowly. Pts will likely resist referral to a mental health professional	Pts frequently seek treatment from many doctors, often resulting in extensive lab work, diagnostic procedures, hospitalizations, and/or surgeries
Conversion disorder (functional neurological symptom disorder)	• At least one neurological symptom (altered voluntary motor or sensory function) • incompatibility bet. symptom & recognized neurological or medical conditions • Not better explained by another medical or mental disorder • Causes significant distress or impairment in social or occupational functioning or warrants medical evaluation • Common symptoms: Paralysis, weakness, blindness, mutism, sensory complaints (paresthesias), psychogenic nonepileptic seizures (PNES), globus sensation (globus hystericus or sensation of lump in throat).	• 2-3 times more common in females • Onset more in adolescents & early adulthood • High incidence of comorbid neurological, depressive, or anxiety disorders	• primary treatment is education about the illness (+ CBT with/out physical therapy if education alone is not effective) • While patients often spontaneously recover, the prognosis is poor (Symptoms may persist, recur, or worsen in 40–66% of pts)	• Pts often have an abrupt onset of their neurological symptoms (blindness, etc.) but appear unconcerned *(la belle indifference)* • Conversion-like presentations in elderly patients have a higher likelihood of representing an underlying neurological deficit.

SOMATIC SYMPTOM AND FACTITIOUS DISORDERS

	dx – dsm 5 criteria	epidemiology	treatment & prognosis	notes
Illness anxiety disorder	• Preoccupation with having or acquiring a serious illness • No or mild somatic symptoms • High level of anxiety about health • Performs excessive health-related behaviors or exhibits maladaptive behaviors • Persists for at least 6 months (the specific illness that is feared may change over time • Not better explained by another mental disorder (such as somatic symptom disorder).	• males = females • Avg age onset 20-30 • 2/3 have coexisting major mental disorder	• Regularly scheduled visits with one primary care physician • Psychotherapy (primarily CBT). • Comorbid anxiety and depressive disorders should be treated with (SSRIs) or other appropriate psychotropic medications • Chronic but episodic • Can result in significant disability • Up to 60% of pts improve significantly. • better prognosis if: fewer somatic symptoms, shorter duration of illness, no childhood physical punishment.	
Psychological factors affecting other medical conditions	• A medical symptom or condition (other than mental disorder) is present. • Psychological or behavioral factors adversely affect medical condition (influencing course or treatment, constituting an additional health risk factor, influencing the underlying pathophysiology, precipitating, or exacerbating symptoms or necessitating medical attention) • Psychological or behavioral factors are not better explained by another mental disorder	• Prevalence and gender differences are unclear. • Can occur across the lifespan.	• education and frequent contact with a primary care physician • SSRIs and/or psychotherapy (especially CBT) for underlying anxiety or depression	• Pt with psychological or behavioral factors (e.g., distress, coping styles, maladaptive health behaviors) adversely affecting a medical symptom or condition. • Examples include anxiety worsening asthma, denial that acute chest pain needs treatment, and manipulating insulin doses in order to lose weight.

SOMATIC SYMPTOM AND FACTITIOUS DISORDERS

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Factitious disorder	• Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception • The deceptive behavior is evident even in the **absence of obvious external rewards** • Behavior is not better explained by another mental disorder, like delusional disorder or another psychotic disorder • Individual can present themself, or another individual (as in factitious disorder imposed on another) • Commonly feigned symptoms: Psychiatric (Hallucinations, depression), Medical (Fever (by heating the thermometer), infection, hypoglycemia, abdominal pain, seizures, hematuria)	• 1% of hospitalized pts. • more in females • Higher incidence in hospital & health care workers (learned how to feign symptoms) • + personality disorders • Many pts have a history of illness & hospitalization, childhood physical or sexual abuse	• Collect collateral information from medical providers and family • Collaborate with primary care physician and treatment team to avoid unnecessary procedures • may require confrontation in a nonthreatening manner; however, patients who are confronted may leave against medical advice and seek hospitalization elsewhere • Repeated and long-term hospitalizations are common	• Pts assume the role of a sick patient. They often do this in a way that can cause legitimate danger (central line infections, insulin injections, etc.). • The **absence of external rewards is a prominent feature of this disorder** • Münchhausen syndrome is an older name for factitious disorder with predominantly physical complaints. **Münchhausen syndrome is intentionally producing symptoms in someone else who is under one's care (usually one's child)**
Malingering	Presentation: • usually multiple vague complaints that do not conform to a known medical condition • often have a long medical history with many hospital stays. • generally uncooperative and refuse to accept a good prognosis even after extensive medical evaluation • Symptoms quickly improve or resolve once the desired objective is obtained	• Common in hospitalized pts • More common in males	• Neuropsychological testing to identify feigned or exaggerated cognitive symptoms., like TOMM (Test of Memory Malingering) • Work with the patient to manage their underlying distress, if possible • Gentle confrontation may be necessary (pts who are confronted may leave hospital Against Medical Advice (AMA) & seek treatment elsewhere.	• Intentional / conscious reporting of physical or psychological symptoms **to achieve secondary (external) gain**. (like avoiding incarceration, receiving room and board, obtaining narcotics, receiving monetary compensation) • not considered a psychiatric condition