UNIT 4 SOMATOFORM DISORDER AND DISSOCIATIVE DISORDER

Structure

4.0 INTRODUCTION

Let us go for an embarrassing memory. Let us remember a situation where you were humiliated in front of your classmates or colleagues for a reason which was not entirely your fault, but, yes, partially due to some lapse of yours. You were anxious of course, but not only simply anxious. You were wishing that it had never happened. How could you ever be so foolish? What would you like best now? Have a magic and have the memory of the event obliterated from everybody's brain? Something unusual to happen at the moment so that everybody's attention is directed away from you? May be if you can put forth an excuse, may be of a severe disease, you could

plea not guilty? The two disorders we would study in this unit involves this kind of wish fulfilling mechanism to wipe away the difficulty in handling an emotionally difficult situation.

In the earlier three units you have learnt about different types of Anxiety disorders. In all those disorders the anxiety in response to stressful situation was the most prominent symptom. In the present unit you would learn about two groups of disorders where stressful situation is not responded to by overt expression of anxiety. Both of these two groups of disorders involve attempts on the part of the person to *escape the unpleasant stressful situation by using particular intrapsychic mechanism*. The overt anxieties are not present, but are replaced by either physical symptoms or distorting the relation between self and reality by selective modification of memory and identity. These are, respectively, the Somatoform Disorders and the Dissociative Disorders. You would also read case studies exemplifying the typical symptoms. The names of all case studies are fictitious and all important identifying information has been changed to maintain anonymity of the persons.

As you encounter persons suffering from these two groups of disorders, you may discover a dramatic expression of the symptoms. But you must not presuppose that these people are necessarily faking or 'malingering'. The dramatisation occurs at a level below the consciousness, and the person, at her conscious level actually feels only whatever she reports. This process makes it a challenge for the mental health professional to differentiate Somatoform and Dissociative Disorders from Malingering and intentional falsification. While in children the symptoms are often transient, in adults these disorders may take a chronic and disabling form.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Define somatoform disorders;
- Describe the types and symptoms of somatoform disorders;
- Explain the aetiology of somatoform disorders;
- Elucidate the treatment of somatoform disorders;
- Define dissociative disorders;
- Describe the types and symptoms of dissociative disorders;
- Explain the aetiology of dissociative disorders; and
- Elucidate the treatment of dissociative disorders.

4.2 SOMATOFORM DISORDERS: SYMPTOMS AND CLINICAL FEATURES

When you have been under considerable stress, you may have experienced bodily symptoms like headache or gastric problem. The psychological pain seems to take a physical or somatic form. This is quite common in children and not so uncommon among adults. Teachers in junior schools are well aware of how frequently children develop symptoms like stomach ache and nausea in response to academic or interpersonal stress. Again, you may have seen or heard stories of people fainting whenever they encounter any stress. Sometimes they may be simply faking the

symptoms to draw attention or to avoid immediate embarrassment. But many a times they truly experience the bodily pain or truly lose consciousness. These may be examples of Somatoform Disorders.

Somatoform disorders refer to a group of disorders where the person reports physical complaints characteristic of bodily dysfunction. But investigation usually fails to elicit any actual physical defect. In this unit you would learn about the symptoms and clinical features of five major types of Somatoform Disorders, namely,

- Somatisation Disorder
- Pain Disorder
- Hypochondriasis
- Conversion Disorder
- Body Dysmorphic Disorder

4.2.1 Somatisation Disorder

You may recognise Somatisation disorder by the presence of multiple physical symptoms at different locations of the body. DSM IV –TR mandates that that it must begin before 30 years of age. There must be at least 4 pain symptoms in different sites of the body (foe example, head, neck, back etc.), at least 2 gastrointestinal symptoms (like diarrhoea, nausea etc.), 1 sexual symptom other than pain (for example erectile dysfunction, lack of desire) and 1 pseudoneurological symptom (for example fainting). Adequate medical investigation must have been made to exclude all known organic origin of the symptoms.

The symptoms of Somatisation disorder are vague. The person often goes for doctor shopping and frequent hospitalisation. Sometimes as a result of unwarranted faulty treatment and invasive interventions, actual physical symptoms may occur to complicate the issue. Depression and anxiety may accompany the Somatisation symptoms.

A Case Study of Somatisation Disorder: Rina is a 24 year old middle class married woman. She had lost her mother in her childhood and has been reared up by her father. Before her marriage she suffered from migraine and frequent cold. After marriage she had encountered difficulty at her in-laws house. Her mother-in-law expected her to take some household responsibilities which she could not complete due to her frequent headache. She disliked her mother-in-law and wished her dead. Her husband was initially supportive of her, but gradually became irritated due to her constant complaints. Rina became depressed and developed pain in her neck and back which prevent her from sitting straight for long. Her headache has become more frequent and severe. She also has frequent sore throats. She developed problem of digestion and often had diarrhoea and nausea. Her hand trembles at the slightest provocation and she had fainted a few times after quarrelling with her husband. Her sexual desire is on the wane and she complains of pain during intercourse. Her husband is very dissatisfied with the state of affairs and is contemplating divorce.

4.2.2 Pain Disorder

You may find that some people experience persistent pain in certain specific areas of the body. No physical cause can usually be identified through investigations. Even if some organic problem is observed, it is inadequate to explain the stated subjective degree of pain. The psychological factors are recognised as significant precipitator of the pain symptom.

A Case Study of Pain Disorder: Joseph is a 17 year old manual labourer from a tribal area, working in the city. He is the oldest of three siblings. His father was also a labourer but lost his job due to alcoholism. Joseph had too often seen the plight of his mother at home. In their village, Joseph often stayed away from home and wandered around the forests. He had also attended school which he liked, especially because of a teacher who loved him. Joseph wanted to study in the school and had an ambition of working in an office. As his father lost his job, Joseph's mother asked him to go for work. One of his father's friends has arranged the same job for him. Joseph hated leaving school, but ultimately had to agree. He did not like the work he had to do, but did it for six months. Then one day he fell from a pile of bricks and hurt his ankle. Treated by a doctor he recovered, but developed a pain the back. He attributed it to the fall and said that it had been neglected by the doctor. The pain increased and he had to leave the job. He had seen doctors who had investigated the probable cause of pain. But nothing was found to explain it. Now he sits idly at home while his younger brother goes for work.

4.2.3 Hypochondriasis

Hypochondriasis is characterised by fear of physical disease. You may have come across persons who suspect that they have serious diseases like cancer and cardiac problems. Investigations however reveal that no organic pathology is present. While many of us may occasionally read some bodily discomfort as a sign of some serious problem, the person with hypochondriasis is quite convinced about the presence of the disease.

DSM IV –TR states that preoccupation with fear of contracting or having a serious disease is the main criterion of Hypochondriasis. The conviction is based on misinterpretation of some transitory bodily symptom. For example a person may interpret a sore throat as the first sign of throat cancer.

You will often find the persons with Hypochondriasis at the doctor's door. But the assurances of the doctor as to the absence of any pathology do not change their conviction. Rather they change doctor frequently and start the investigations afresh. Often the disease they imagine is a fatal one like cancer, severe cardiac problem or HIV / AIDS. Such persons often read medical bulletins, self diagnose themselves and also try to treat themselves. The treatment modes can be magical or semi scientific.

How would you differentiate between Somatisation disorder and Hypochondriasis? In the first place severity of conviction of a fixed diagnosis is greater in Hypochondriasis. Secondly, Hypochondriasis is not necessarily about many disorders, but like Pain disorder may be located in one or two sites.

A Case Study of Hypochondriasis: Dinesh, 35, an upper-middle class educated employed man from a metropolitan city had an affair with a girl who later turned out to be a sophisticated prostitute. Dinesh learnt it the hard way and was both heartbroken and appalled. That was about six years back. He was afraid that he might have contracted HIV, and after much deliberation, consulted a doctor who recommended blood test. Dinesh turned out to be negative, to his immediate relief. However, this assurance seemed to be short lived, as he never came to believe permanently that he was not afflicted with HIV. After the first testing, he had a bout of severe cold which he attributed to the same undetected virus. He had read plenty of information on HIV / AIDS and had learnt that a positive finding on the blood test ensures that you have HIV, but a negative finding may be misleading. He went for retesting and was again found negative. Now he interprets every little stomach upset and feverish

feeling as indicative of HIV. He spends the whole evening scrutinizing his body looking for swollen glands and skin rashes. He goes to doctors for every small ailment, though he does not always reveal his suspicion about HIV. He insists on being treated with strong antibiotics as he believes that he has low immunity. He rejects those doctors who prefer to treat with lesser medicines or recommends natural cure.

4.2.4 Conversion Disorder

You must have heard about hysteria. The word comes from the Greek word 'hysteros' which means the womb. It was wrongly believed at one time that hysteria occurs only in women because of their suppressed sexual desire. The most common symptom was fainting or paralysis of the limbs under psychosocial duress. Sigmund Freud's concept of the unconscious emerged from his treating of patients with hysteria. His patient Anna O, a young lady with paralysis, has been famous in the history of Psychology and Psychoanalysis for being key to Freud's understanding of the nature of the unconscious.

Presently, the word hysteria is no more in scientific use. Conversion disorder is the term that comes closest to hysteria. In Conversion disorder the person suffers from a real disability – often loss of a sensory or voluntary motor function. DSM IV –TR states that the symptoms would imply a neurological condition. However upon examination no neurological problem would be found. Some common examples of Conversion are partial paralysis, blindness, deafness and pseudoseizures. DSM IV – TR further states that psychological factors should be judged to be associated with the symptom, as these symptoms often develop after severe conflict or other stressors.

You need to be aware of the signs that distinguish Conversion disorder from real neurological problems. You may wonder why you need to know these, because the neurological investigation itself would establish the validity or invalidity of the disorder. However, we know only a very small part of our brain functions and it is possible that we may have missed some indication in the physical tests. Therefore you must be able to cross check the diagnosis with functional signs as well. In the first place, the Conversion symptoms are often preceded by a stressor, though the person is unaware of and even denies any connection. Secondly, the symptoms may be in contradiction to what would have been expected from a neurological perspective. For example, in 'glove anesthesia', the person feels her hands numbed up to the wrist, while the nerves run up to the arm, and any true neurological problem would affect the entire nerve. This may be induced by hypnosis. Third, there seems to be a peculiar lack of concern and anxiety that should have happened in case of a real loss of function. A blind person seems unconcerned about his sudden loss of vision. This lack of apparent concern is known as 'la belle indifference'. Finally, the paralysis may be selective in time and space. A person with a paralysed leg may be able to move the legs during sleep.

A Case Study of Conversion Disorder: Akhtar, a 30 year old man from a middle class family was an employee of a Government Undertaking. His job was to supervise the loading and unloading of goods by the workers. He happened to be on the factory floor when an accident took place resulting in many workers getting wounded. Akhtar was also hurt in the face and on the head and became unconscious. Later on he was treated duly and declared fit by the Medical Board of the Company. However, from after a few days of the accident, Akhtar had been telling that he had become blind. He was tested thoroughly by the doctors who declared that there is nothing wrong either in the peripheral (at the level of the eyes) or central (in the brain)

mechanisms of his vision. Akhtar sticks to his claim, and considers himself unfit for joining his job. He walks with the help of his mother and has to take her help in all matters like finding the shirt and guiding him to the items of food. He stays at his home and spends time in front of the TV saying that he cannot see, but he can listen to the music and conversations and he enjoys that. He wants compensation for his disability and is planning to sue against the Company.

4.2.5 Body Dysmorphic Disorder

Is your friend so concerned about the shape of his ears that he wears his hair long and tries to hide his ears under locks of hair? Body Dysmorphic Disorder refers to the undue concern over body features. According to DSM IV –TR it is defined as unnecessary preoccupation with an imagined or exaggerated defect in appearance.

This imagined defect may be anywhere as for example the person may have an diea that his nose is too large etc., big nose, small ears, skin blemishes, shape of the breasts or genitalia, too fat or too thin limbs and so on. Sometimes you may detect a slight real anomaly or lack of proportion, but in the person's own judgment it has been magnified many times.

You may find the person with Body Dysmorphic Disorder often viewing oneself in the mirror and asking others for opinion about the slightest change in that part of her body. However these assurances do not help them to get out of the problem. She also tries to hide the defect under heavy make up or other accessories, or even go for plastic surgery. Unfortunately even plastic surgery does not always satisfy her.

A Case Study of Body Dysmorphic Disorder: Ratna believes that she has a 'too flat bone of nose'. At the age of 20 she is introvert and immensely soft spoken, particularly because she does not want to draw anybody's attention to her 'ugly nose'. She cannot speak to anybody spontaneously as she feels that everybody is looking at her nose and suppressing a big laugh. She looks at the mirror many times a day, and tries to pull her nose bone up. She sometimes covers her nose with her palm and evaluates her beauty minus the nose. Her parents have told her many times that her nose is perfectly within the normal range of sizes, but she is disconsolate. She has confided the problem to a friend who had assured her, but to no avail. She has developed the habit of placing her palm on the nose while forced to converse with anybody. It becomes difficult for other people to hear what she is saying and this makes her a poor socialiser. This in turn further reduces her self esteem and adds to her distress. She is thinking of visiting a plastic surgeon for remedy, but knows that she cannot afford the cost at the moment.

4.3 PREVALENCE OF SOMATOFORM DISORDERS

How common are the Somatoform disorders? Prevalence of the different types of Somatoform disorders is not the same. Somatisation Disorder usually begins in adolescence. It is more common in lower socio-economic class and among women. Lifetime prevalence is 0.2% to 2% in women and 0.2% in men. The prevalence of Pain Disorder in general population is not known. It is seen more often in women. Hypochondriasis is the most commonly seen Somatoform disorder, being present in 2% to 7% of the general population. It often starts in early adulthood and is equal in both sexes. Conversion Disorder was quite common at one time, but with knowledge of the dynamics of this disorder and with psychological sophistication of the general population, it has come down to less than .005% of the population. It is rare in the

urban educated group, and seen somewhat in the rural and low socio-economic status groups where knowledge of conversion as a defence is not available. It is seen more in women. The exact prevalence of the Body Dysmorphic Disorder is not known as many of us may have slight preoccupation with body parts. An estimated 2% to 5% of general population may have crossed the limit of normal preoccupation and may be said to be suffering from the disorder. It is equal across both sexes.

4.4 AETIOLOGY OF SOMATOFORM DISORDERS

The aetiology of all the somatoform disorders would be discussed together. You may learn about the biological and psychological factors in the section below.

4.4.1 Biological Factors

The biological factors, at least so far the present knowledge goes, are of less significance than the psychological factors in the aetiology of Somatoform disorders. There has been some overlap between OCD and Body Dysmorphic disorder, implying possible common genetic disposition. However, twin studies have not been able to provide strong biological evidence till date. At best a vulnerable personality may have been inherited.

4.4.2 Psychological Factors

Among the psychological factors, you would learn about the psychoanalytical approach, learning approach and cognitive approach. You would also know about the possible role of stressors and vulnerable personality.

i) **Psychoanalytical Approach:** At the basis of psychoanalytical approach to Somatoform disorders is the concept of unconscious conflict and gain. It is assumed that psychic pain and distress is projected onto the body for the purpose of some kind of advantage.

ii) **Primary Gain:** The primary gain helps to preserve the integrity of ego in the face of the stressful situation. It is often related to internal motivation. When any uncontrollable yet unacceptable sexual or aggressive impulse attempts to burst out, the ego is under threat of disruption. It tries to maintain control, and in that attempt may use repression whereby the emotion is disowned and an escape or a punishment may be arranged by projecting disability onto the body. Take for example the case of a girl who had to stay homebound for long due to his father's last illness. When her father expired she was free at last to move around at will. The realisation that she was happy at her father's death caused strong guilt in her. The next morning she could no longer move her leg and was supposedly paralysed. She had twofold advantage by being immobilised through paralysis. Her need for acknowledging the unacceptable emotion was prevented and she could also inflict upon herself a punishment for his guilt by not being able to move at all.

iii) **Secondary Gain:** The secondary gain is the interpersonal, social or material advantage later accrued from the symptom. Patients acquire a number of advantages as a result of being in the *sick role*, for example – being excused from obligations; receiving company of the beloved one, getting special attention etc. It is mostly unconscious, and results in some kind of secondary benefit. Such was the case of Akhtar stated earlier whose blindness might earn him a fat compensation. Thus it makes the disorder more persistent and resistant to treatment.

Both Conversion Disorder and some instances of Hypochondriasis can be explained by this view. Psychoanalytical approach offers similar explanation for the other Somatoform disorders. However, it fails to explain why Somatisation and Pain disorders are located at certain body parts. That is the content of somatising is less well explained by this approach. Fig.given below represents the psychoanalytical model of Somatoform disorder.

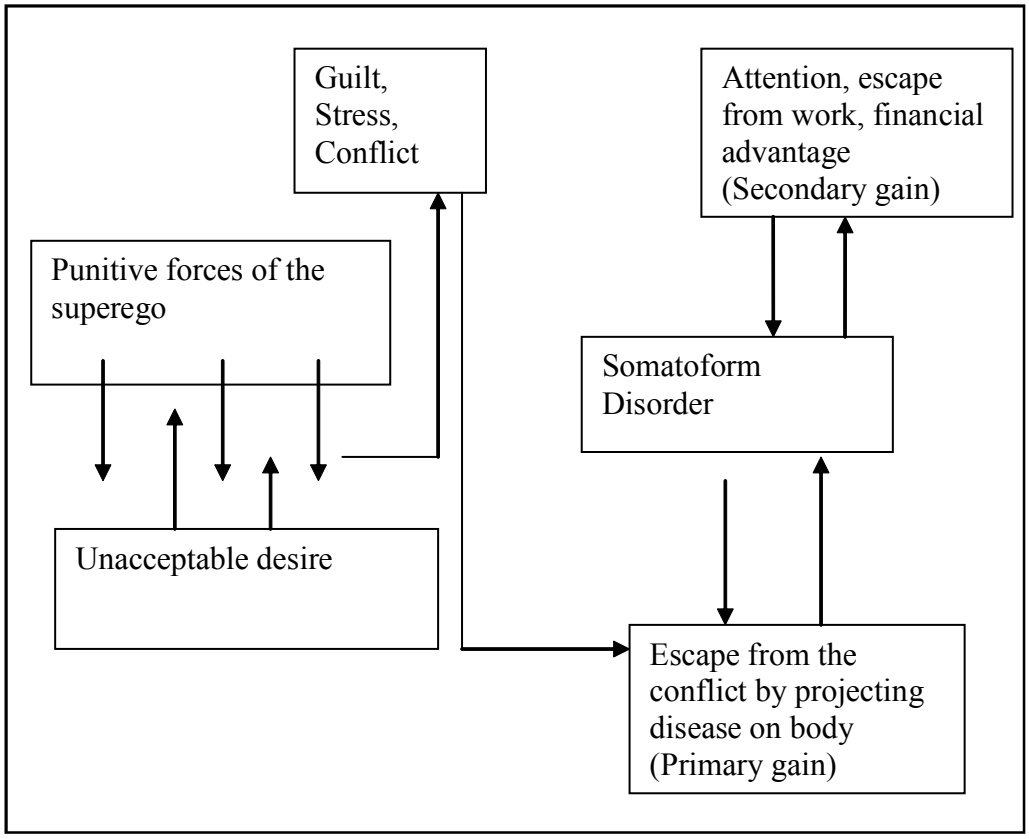

Fig.: Psychoanalytical model of Somatoform disorder

iv) **Learning Theory Approach:** The learning approach emphasises conditioning and modelling. If you look into the history of the persons with Somatoform disorder you may find that in their childhood and also in their immediate environment, the sick role has been reinforced in various ways. They might have been excused from heavy work or attention had been showered on them. In this sense, the concept of secondary gain is used in a different language by the learning theorists. You may also observe that in case of Hypochondriasis and Pain disorders there may have been a patient in the family who actually suffered from that disease. For example seeing a cancer patient at home may predispose one to believe that she also is suffering from cancer. Thus imitation and modelling seems to play a role.

v) **Cognitive Approach:** The cognitive approach to the aetiology of Somatoform disorders emphasises problems in information processing and cognitive bias. It has been observed that persons with Somatoform disorder selectively pay greater attention to and have selectively more accurate memory of bodily symptoms. They also tend to consider any passing mild symptom as catastrophic. The cognitive approach to Conversion disorder and Hypochondriasis suggests that the person reflects through the disorders only what she knows and expects in a particular disorder. For example in 'glove anaesthesia', the lack of knowledge about the nerves running through the hand is crucial. Thus these two disorders

come very close to deliberate malingering. However, most researchers agree that there is real difference of these diseases from malingering per se.

vi) **Vulnerable Personality and Life Events:** It has been found observed that persons who are more suggestible or have labile emotions are more vulnerable to certain types of Somatoform disorders, like Conversion disorder. Obsessive predisposition overlaps with Hypochondriasis and Body Dysmorphic Disorder. Often the person with vulnerable personality encounters some traumatic or stressful event and the disorder ensues as a result of the interaction.

4.5 TREATMENT OF SOMATOFORM DISORDERS

Treatment of Somatisation disorder is very difficult since the patient focuses on multiple loci of discomfort. One moderately effective treatment may be of a supportive kind. You may try to find a physician whom the person may visit regularly. This physician would check the client for the complaints but would not unnecessarily engage her in expensive investigations. There has been evidence that over long time the physical complaints subside to some extent. Cognitive therapy dealing with the secondary gain from the disorder may be used along with this supportive therapy.

Psychoanalysis and hypnotic therapy, directed toward unravelling the unconscious conflict has traditionally been used with Conversion disorder. From the behavioural perspective, non-reinforcement of sick role and reinforcement of normal movement / sensation may be helpful in some cases. You may also use cognitive restructuring approach to challenge secondary gains. You may also try to enhance coping skills and cognitive restructuring of the self. In the context of Conversion disorder, you must remember that in many cases spontaneous recovery occurs after a certain period when the primary gain has served its function.

Hypochondriasis, Body Dysmorphic disorder and Pain disorder are amenable to Cognitive Behavioural therapy. On the behavioural part, you may take help of the family for withdrawal of reinforcement of unwanted behaviour and introduce reinforcing desired behaviour. You may focus on the selective attention and cognitive bias toward specific bodily symptoms. The constant checking for bodily symptoms may be stopped through behavioural instruction. The belief about illness and utility of sick role may be challenged. You may also point out the misinterpretation, especially the tendency to catastrophize the bodily symptoms. Antidepressant medicine may be of moderate help in most of these cases.

Self Assessment Questions

1) What is the main difference between Somatisation disorder and Pain disorder?

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2) What is the cultural explanation of decrease in prevalence of Conversion disorder in recent years?

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3) What is the nature of cognitive bias in Somatoform disorders?

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4) Write *True* (T) or *False* (F) beside the statement

a) Behaviour therapy works best for Conversion disorder ( ).

b) Persons with Body Dysmorphic disorder often have first degree relatives with OCD ( ).

c) Somatisation disorder can be healed easily through insight therapy ( ).

4.6 DISSOCIATIVE DISORDERS: SYMPTOMS AND CLINICAL FEATURES

You must have seen films and read stories where, after a psychological shock, the hero seems to have lost his memory. He cannot recognise people. Nor can he remember his own identity. Then suddenly, after a chain of events that make up the story, his memory returns and everything ends happily. Such stories reflect, often in an exaggerated and over-simplified fashion, the essence of Dissociative Disorders.

The term 'dissociation' refers to the separation of the activities of a person from conscious awareness. While psychoanalysis has long since highlighted the irrational aspects of human mind, cognitive psychology has also been concerned in recent years with non-conscious processes. In this section you would learn about three major Dissociative disorders. These are:

1) Dissociative Amnesia and Fugue

2) Depersonalisation Disorder

3) Dissociative Identity Disorder

4.6.1 Dissociative Amnesia and Fugue

i) **Dissociative Amnesia:** Amnesia means inability to remember. Amnesia may appear as a psychological escape from stress. But it may be a symptom in many organic diseases also. Dissociative amnesia has been defined by DSM IV – TR as a disturbance in one or more episodes of life or inability to recall significant events.

How would you differentiate between the amnesia caused due to actual brain damage and due to psychological causes? Of course neurological investigation would give you the first lead. But there are other functional differences as well. When amnesia has an organic basis usually you will find that the person is unable to remember all or most of the recent or remote past, or is unable to retain newly acquired information. Contrarily in Dissociative amnesia, the person is unable to retrieve selective portions of personal history and that forgetting is

not explained by biological causes. This usually happens following some stressful condition. The information is not permanently lost. These can be retrieved by hypnosis, narcotic analysis and sometimes spontaneously.

Dissociative amnesia can be localised to a specific period of life or may be generalised over a major part of the person's life. It can be selective, that is specific events may be lost. It can be continuous also, that is nothing is remembered beyond a certain point. Localised and selective amnesia are more common.

ii) **Dissociative Fugue:** The word 'fugue' means flight. Dissociative fugue is a sudden unexpected travelling away from home or work. This is often accompanied with amnesia. You may find the person with fugue confused about personal identity and she may also assume a new identity. If you look into her case history you may discover that the fugue occurred after a stressful event which probably was difficult to handle staying in the same place. You know that even in Alzheimer's Dementia, which is an organic disease, people tend to wander away. The motive to flight along with absence of other symptoms of Dementia distinguishes Dissociative fugue from wandering in the Alzheimer's disease.

A Case Study of Dissociative Dememtia and Fugue: Bobby, 35, was a middle manager at the sales department of a private firm. For the last few months he was being consistently unable to reach the target and was receiving unpleasant feedback from the boss and the subordinates alike. At home also he was having marital problems. One day he did not come back home from work. His wife waited for him till midnight and then informed the police. After about seven days he was found wandering in a small town far off from the city. He was having an altercation with the local people near a tea shop where he had stopped for a cup of tea. He had identified himself as Navin, and affirmed that he was looking for a job. However he could not produce any identification or could not say anything about his past. The local people had been suspicious, held him back, and informed the police. When the police found Navin alias Bobby, he could not remember his identity or how he had reached this place. He was wearing the same dress he had on seven days back. However his orientation to the time and date was intact.

4.6.2 Depersonalisation Disorder

Sometimes, under duress, you may have felt somewhat detached from reality. As if what is happening is not true, or as if you are observing the sequence of events as an outsider. This is one mode of tolerating immense pain, used automatically by the human mind. Depersonalisation means feeling as if one is not oneself. Derealisation means as if what is happening around is not real. While this may happen to anybody under extreme conditions, if a person persistently and recurrently suffers from this kind of experiences, you may think of diagnosing her as suffering from Depersonalisation disorder.

During this disorder, the person feels herself detached from her body and own mental processes. However, reality testing remains intact, that is hallucination and delusions do not occur. The person feels strangely detached from the internal and external events. Some may imagine oneself floating above one's body. There is usually a dreamlike character in the flow of existence, and one might be puzzled at the isolated and unfamiliar nature of the environment.

A Case Study of Depersonalisation Disorder: Meena, 20, works as a maid servant in an affluent house. She had been there for about three years. The mistress of the

house had recently noted that sometimes, when instructed to do some job, Meena stands for a while in a strange manner and looks vaguely around. Sometimes she stumbles over things and goes away to any random direction. Since at other times Meena had been a lovable girl and had worked well, the mistress had come to look upon her with compassion. She suspected some epileptic problem and took Meena to a neurologist. There Meena reported that for the last few months she had been occasionally feeling 'out of the body', and as if 'having no control on her mind'. At those moments her thinking gets clouded and she can 'come back only by shaking herself violently'. No neurological problem was found in the investigations. Case history revealed that some time back she had fallen in love with a married man and knew that it was impossible to be united with him. Neither her own family, nor the family where she worked, would approve of this union. The symptoms had appeared after she had strictly forbidden the man to see her.

4.6.3 Dissociative Identity Disorder

The most well known example of Dissociative Identity Disorder is the story of Dr. Jekyll and Mr. Hyde. One was a philanthropist and the other a killer. How would you feel if you go to sleep in your night suit at night, and wake up in the morning to find yourself in completely different attire and your shoes clad with mud? You do not know what you did at night. If it happens for days, may be you are having a different personality at night.

Dissociative Identity disorder is the modern name of what was earlier known as Multiple Personalities. DSM IV – TR requires that to diagnose a person as suffering from Dissociative Identity disorder, you must ensure that she has at least two separate ego states (known as alters) and they would be in complete control of your thinking, feeling and acting for different periods of times. Sometimes these alters are in touch with each other; often at least one alter is unaware of the existence of another. Therefore gaps in memory are common signs. The existence of the different alters is persistent and recurrent and not introduced by any chemical substance. These alters may have different or even opposite nature; they may dress, eat, interact differently. Often the subordinate alter works at a covert level while the host or original personality is operating at the surface. In such cases, this subordinate alter is said to be co-conscious. Gradually this alter makes its presence felt, and at one point takes over the control from the host.

You may have seen the movies 'Three faces of Eve' or 'Sybil'. These are based on real documented cases of Dissociative Identity disorder. Evelyn had three alters and Sybil had sixteen. After prolonged treatment some of the alters may be integrated with the host.

A Case Study of Dissociative Identity Disorder: Munna was a young boy in his teens known to be an obedient, if not a very good student at school. He came from a middle class family and lived with his parents in a city. He was shy by nature and introvert, though good at games. At one point of time, his parents started observing that Munna was becoming fidgety and suppressive, unable to explain some of his time away from home. There were reports form the school that he was being absent while Munna could not remember anything. His parents suspected that Munna might be involved in addiction, and brought him to a psychiatrist. While being asked by the doctor about his activities, Munna suddenly spoke in a different tone and identified himself as Munim, a rough and tough fellow with an aggressive personality and lack of concern for social rules. Munim said that he knows all about Munna, the boy who feigns innocence. He bunked school and went to 'bad boys' to learn their ways to

fight the outer world. Munim also said that he had appeared to save Munna from his plight. Later on Munna revealed that as a small child he had witnessed gross physical and sexual torture of his mother by his father and grandparents. He was so afraid that he never let his parents know what he had seen. Upon asked, the parents admitted the truth of the family violence, which was dowry related and particularly poignant while Munna's grandparents were alive. Munna's parents patched up the relation after the older generation passed away and Munna grew up. Munim seemed to compensate for the suppressed aggression Munna had against his father's family.

4.7 PREVALENCE OF DISSOCIATIVE DISORDERS

The prevalence of Dissociative disorders in population is not well researched. Amnesia probably occurs in about 5% to 7% of the population. Fugue is much less common, about 0.2%. Depersonalisation disorder occurs in about 2% to 3%. Dissociative Identity disorder was once considered to be very rare. Later on its diagnosis has been influenced by the scientific culture of the time. Some doctors diagnose it more, some merge it with schizophrenia. It may be prevalent in 1% to 2 % of the population.

4.8 AETIOLOGY OF DISSOCIATIVE DISORDERS

4.8.1 Biological Factors

Like Somatoform disorder, biological factors are of secondary importance in Dissociative disorders also. At best a vulnerable personality with greater suggestibility may have some genetic implication.

4.8.2 Psychological Factors

The psychological causes are at the root of dissociative disorders.

i) **Psychoanalytic Approach:** The psychoanalytic explanation highlights the operation of the defences of repression and denial in amnesia and fugue. When certain unconscious conflicts are extremely painful, and no acceptable escape route is left open, the ego may take resort to repression, making the content of the conflict unavailable, at least temporarily. Another important defence mechanism is operative in all Dissociative disorders, which is isolation of emotion and event. This is most prominent in Depersonalisation disorder.

ii) **Behavioural Approach:** The learning approach attributes dissociation to the attempt of the person to avoid extreme stress. This dissociation is reinforced as it relieves the person from the stress. Sometimes they may self – hypnotize to go into the dissociated states.

iii) **Cognitive Approach:** The cognitive perspective suggests that selective memory deficits takes place. Usually the person's episodic or autobiographical memory is affected, leaving the semantic memory relatively intact. Some case reports imply that implicit memory is intact while explicit memory only is disturbed. For example, a man with dissociative amnesia may not be able to remember his wife's name. But if he is asked to guess the wife's name from a list of possible names he might strike on the right name.

4.8.3 Cultural and Social Factors

Some cultures tolerate or even encourage dissociative phenomena like possession

and trance. Disturbances of identity gain a support within the culture and are reinforced. There have been some indications that dissociated identity in the form of possession by spirit is more common in non-western cultures.

4.8.4 Vulnerable Personality and Stressful Life Events

There are substantial evidences that those with dissociative disorder underwent severe trauma in childhood. Some had experienced physical abuse; some others had been sexually abused or forced into incestual relations. Dissociative disorders are common in PTSD also, after natural or man made disasters. It has also been found that some persons are high in hypnotisability and they are more prone to develop Dissociative Identity disorder after a trauma.

4.9 TREATMENT OF DISSOCIATIVE DISORDERS

Dissociation is an escape from stress. Therefore, when you are dealing with a person with Dissociative amnesia and fugue, the first thing you must make sure is to keep her in a safe environment. If you can elicit from her case history the precipitating stressful event, you may assure her that she is safe from that danger. Sometimes, staying away from perceived danger leads to spontaneous recovery. Psychoanalytically oriented therapies and hypnotherapy may help to bring out the lost memory. Sometimes anxiolytic medicines are also used as adjunct to psychotherapy.

One word of caution here. Not all memories that are retrieved from the person with amnesia are reliable. You need to cross validate them from independent sources. And you must remember that simply reviving the memory is not the end of treatment. You need to work through the retrieved material so that the memories are properly contextualised.

There has been no systematic and controlled study about treating Depersonalisation Disorders. Antidepressants have been used, but there effectiveness is unknown. Hypnotherpay and training for self hypnosis may be of some use.

Dissociative Identity disorder has been claimed to be treated successfully by some therapists. Hypnotherapy and insight therapy have been used. The purpose of therapy is to integrate the personalities and convince each of them that there is no need to stay separate. The person needs to understand that coping can be done without splitting. As a therapist you need to be empathic toward each of the identities and deal with each on a fair level.

Self Assessment Questions

1) Define dissociation.

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2) What is dissociative fugue?

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3) State the difference between depersonalisation and derealisation.

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4) Write *True (*T) or *False* (F) beside the statement

a) Dissociative amnesia can be selective about certain events ( ).

b) In Dissociative Identity Disorder, the alters never know each other ( ).

c) During depersonalisation the reality testing is usually badly affected ( ).

4.10 LET US SUM UP

In this unit we have focussed specifically on Somatoform Disorders and Dissociative Disorders. . We have learnt the symptoms and clinical features of five Somatoform disorders, namely Somatisation disorder, Pain disorder, Hypochondriasis, Conversion disorder and Body Dysmorphic disorder. We have also learnt about three Dissociative disorders namely Dissociative amnesia and fugue, Depersonalisation disorder and Dissociative Identity disorder. The prevalence of these disorders in the general population and time of onset have also been discussed. We have learnt about their aetiologies in terms of biological and psychological factors. We have also known that there are persons with vulnerable personalities who are more prone to developing these disorders when they encounter a stressful situation. We have also been acquainted with some of the biological and psychological treatment approaches to these disorders. Psychoanalytically oriented treatment and insight therapies are more applicable for some of these disorders. Medicine has relatively little impact. Cognitive behavioural approach seems to be another option.

4.11 UNIT END QUESTIONS

1) Discuss the symptoms and clinical features of different types of somatoform disorders with case examples.

2) Discuss the prevalence of different somatoform Disorders.

3) Discuss the aetiological factors of somatoform Disorders.

4) Discuss the treatment options of somatoform Disorders.

5) Discuss the symptoms and clinical features of different types of dissociative disorders with case examples.

6) Discuss the prevalence of different dissociative disorders.

7) Discuss the aetiological factors of dissociative disorders.

8) Discuss the treatment options of dissociative disorders

4.12 GLOSSARY

Somatoform disorder : Somatoform disorders refer to a group of disorders where the person reports physical complaints characteristic of bodily dysfunction. But investigation usually fails to elicit any actual physical defect.

Dissociative disorder : Dissociative Disorders refers to a group of disorders where the activities of a person are separated from conscious awareness. One may forget one's own identity or feel detached from oneself.

Malingering : Malingering refers to deliberately imitating the symptoms of a physical or psychological disease with the purpose of some practical advantage.

La Belle Indifference : A state of mind in Conversion disorder where the person has lost some sensory or motor function suddenly, but the affective reaction to this loss is not as intense as it should be. Rather a kind of indifference is observed.

Primary gain : This term is used in connection with Somatoform Disorders, especially Conversion Disorder. It refers to the primary unconscious purpose that is served by the disorder. Its basic motive is to protect and maintain the integrity of the ego. When any uncontrollable yet unacceptable sexual or aggressive impulse attempts to burst out, the ego is under threat of disruption. In the attempt to maintain control, it may use repression. As a result, a physical symptom in the form of sudden loss of sensory or motor function is observed. It solves the dilemma at least temporarily.

Secondary gain : Secondary gain refers to the advantages one derives secondarily after any Somatoform disorder, especially Conversion disorder has taken place in the form of a physical illness. Usually getting attention, financial advantage or escape from work are the motives for secondary gain.

Amnesia : Amnesia refers to inability to remember all or certain parts of personal history and identity. It may occur in organic brain disorders like Dementia or in psychiatric conditions like Dissociation.

Fugue : The word fugue means flight. In Dissociative fugue the person suddenly wanders away from

work or home. This state is accompanied with amnesia.

Depersonalisation : Depersonalisation means feeling as if one is not oneself. The person seems detached from one's body and mind.

Derealisation : Derealisation is a dissociated state of mind where one feels what is happening around is not real.

Alter : In Dissociative Identity Disorder, two or more ego states may appear and be in complete control of one's thinking, feeling and acting for different periods of times. These ego states are known as alters.

4.13 SUGGESTED READINGS

Kaplan, H. I. & Sadock, B. J. *Synopsis of Psychiatry*. Philadelphia: Lippincott Williams.

Semple, D., Smyth, R., Burns, J., DArjee, R. & McIntosh, A. (2005) *Oxford Handbook of Psychiatry*. London: OUP.