

Quiz

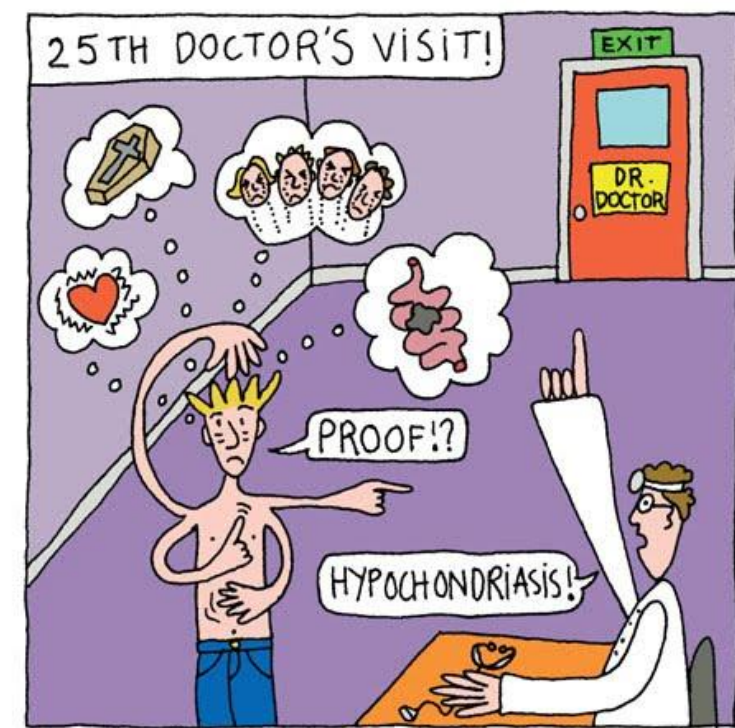






DISSOCIATIVE AND SOMATOFORM DISORDERS

FUNCTIONAL DYSTONIA NEADS
MYOCLONUS CONVERSION
Non-Epileptic Seizures DISORDER
Functional Neurological Disorder
FND FMD T DISASSOCIATIVE
D PAIN R DISORDER
D CD E FATIGUE
M O R SPEECH
UNITED FOR A CHANGE



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Basic definition

- ▶ Dissociative disorders
 - ▶ Disruption of and /or discontinuity in the normal integration of consciousness, memory, perception identity, emotion, body representation ,motor control and behavior that cannot be explained by injury or disease process.

Dissociative Disorder

- 1-No evidence of a physical disorder that can explain the presenting symptoms.
- 2- Convincing associations in time between the symptoms of the disorder and stressful events, problems or needs.



Dissociative identity disorder



Diagnostic features-

- ▶ presence of 2 or more distinct personality states or an experience of possession.
- ▶ Recurrent dissociative amnesia
- ▶ Sense of self and Sense of agency
- ▶ Bodies feel different (like a child, huge or muscular or opposite gender)
- ▶ Can be associated with dissociative fugue, non epileptic seizures, amnesia etc

Dissociative Amnesia

Diagnostic features

- ▶ Inability to recall important autobiographical information that -

1) should be successively stored in memory and (2) ordinarily would be readily remembered.

It can be-


- ▶ Localised amnesia or
- ▶ Selective amnesia or
- ▶ Generalised amnesia or
- ▶ Systematized amnesia or
- ▶ Continuous amnesia

Dissociative Fugue: Symptoms & Characteristics

- ▶ **DSM-IV-TR criteria:** person suddenly moves away from home and assumes a new identity, with little or no memory of one's previous identity or past
- ▶ A person travels away from home abruptly and unexpectedly **and** is unable to recall some or all of his/her past
- ▶ May assume a partially or completely new identity
- ▶ **Prevalence:** very rare – 0.2%

Depersonalization / Derealization Disorder: Characteristics

- ▶ **Depersonalization:** feeling detached or estranged from your thoughts or body; e.g. feeling like an outside observer, a robot; feeling like you're in a dream, watching a movie
- ▶ **Reality testing** remains intact during periods of depersonalization

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- ▶ **Derealization:** lose sense of external world; e.g. people seem mechanical or dead; things seem dreamlike, or seem to change size &/or shape
 - ▶ Occasional experiences of depersonalization are common – 1/2 of all adults have a single brief episode of depersonalization
 - ▶ Symptoms must be so severe, persistent, and frequent that they cause significant distress or impairment in functioning

Disorder	Prevalence	Development and course	Risk factors	Culture related issues
Dissociative identity disorder	1- 1.5% , 1.6% in males 1.4% in females	Associated with childhood trauma or abuse, Onset can be at any age	Environmental-physical or sexual abuse, childhood abuse or neglect, other traumatic events	Rural areas in developing countries, certain religious groups
Dissociative amnesia	1.8%, 1% in males and 2.6% in females	Onset is sudden Duration can range from min to decades May decline with age Observed in children adolescent , adults	Environmental-traumatic experiences, physical or sexual abuse, childhood abuse, stress Removal from traumatic circumstance bring rapid return of memory	In Asia, America, middle-east other dissociative symptoms may associate with amnesia. Highly restrictive social traditions precipitants do not involve frank trauma

Disorder	Prevalence	Development and course	Risk factors	Culture related issues
Depersonalization/derealization disorder	2% , Gender ratio 1:1	<p>Mean age is 16years, can start in early or middle childhood</p> <p>Less than 20% have onset after 20years</p> <p>Onset after 40years is rare</p> <p>Exacerbation can be triggered by stress, low mood or anxiety, reduced sleep or other physical factors</p>	<p>Environmental-severe stress, anxiety, depression and illicit drug use.</p> <p>Emotional abuse or neglect physical or sexual abuse, domestic violence, mentally ill parent, childhood abuse, body impairment</p> <p>Temperament – harm-avoidant temperament, immature defenses, disconnection and overconnection schemata</p>	<p>They are volitionally induced as a part of meditative practices in many religions but some individual lose control over them and develop fear and aversion for related practices</p>

Dissociative Disorder- Clinical presentation

- ▶ Patient develop typical symptoms of known physical illnesses without an evidence of any organic pathology.
- ▶ The symptoms can mimic any known physical illness but detailed examination does not reveal any physical illness.
- ▶ commonest sensory symptoms are anesthesia, paraesthesia, blindness or deafness, either partial or complete.

Dissociative Disorder- Clinical presentation

- ▶ Commonest motor symptoms are paralysis of various parts of the body , abnormal involuntary movements.
- ▶ The usual visceral symptoms are vomiting, belching spells, hiccoughs, coughing spell, difficulty in breathing.
- ▶ Anxiety symptoms

Dissociative Disorder- Management

- ▶ Removal of the hysterical symptoms with suggestion and psychological support.
- ▶ Explain nature of illness to patient and family considering their belief.
- ▶ To cut out secondary gain
- ▶ Understand the primary, secondary and tertiary gains.

Dissociative Disorder- Management

In **chronic stressors** Detailed assessment of -----

- ▶ Childhood history
- ▶ Coping skills of patient.
- ▶ Family dynamics and any possible role models.
- ▶ Belief of family members towards illness.
- ▶ Personality assessment.
- ▶ Perpetuating factor.
- ▶ Interpersonal relationship.
- ▶ Identify secondary gain.
- ▶ Rule out anxiety disorders and depression.

Dissociative Disorder- Management

- ▶ Benzodiazepines and SSRIs
- ▶ To prevent the relapse of dissociative symptoms, it is important to identify the stress and help the patient to discuss and cope with the situation.



SOMATOFORM DISORDERS

DSM-IV-TR Diagnoses

Somatoform Disorders

Somatization

Pain disorder

Hypochondriasis

Conversion disorder

Body dysmorphic disorder

DSM-5 Diagnoses


Somatic Symptom Disorders

Complex somatic symptom disorder

Illness anxiety disorder

Functional neurological disorder

DSM-IV-TR somatization, pain disorder, and hypochondriasis are combined into one category of complex somatic symptom disorder in DSM-5. A small proportion of people with hypochondriasis will meet criteria for illness anxiety disorder. Body dysmorphic disorder is placed in the depressive-compulsive and related disorders chapter in DSM-5.



Somatic symptom disorder

Somatic Symptom Disorder

Diagnostic Criteria

300.82 (F45.1)


- A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
 - 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
 - 2. Persistently high level of anxiety about health or symptoms.
 - 3. Excessive time and energy devoted to these symptoms or health concerns.
- C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).


Specify if:

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

Specify if:

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

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- 6 or more months of non delusional preoccupation with fears of having or the idea that one has a serious disease based on the person's misinterpretation of bodily symptoms
 - This preoccupation causes significant distress and impairment in one's life

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- Prevalence estimated to be 4to6 percent but may be as high as 15 %.
 - Commonly appears in persons 20 to 30 years of age
 - Male=female
 - Occurs in about 3 percent of medical students usually in the first two years

Clinical features



- Patients believe that they have a serious disease that has not been detected and they cannot be persuaded the contrary
- May transfer their belief to another disease
- Convictions persist despite negative lab tests
- Accompanied by symptoms of depression and anxiety and commonly coexists with a depressive or anxiety disorder

Treatment



- Frequent regularly scheduled physical examinations help reassure patients that they are not abandoned and their complaints are taken seriously
- Group psychotherapy provides the social support that seems to reduce their anxiety and their clinic visits
- Pharmacotherapy is useful only when a patient has an underlying drug-responsive psychiatric condition

ILLNESS ANXIETY DISORDER




- Preoccupation with having or acquiring a serious, undiagnosed medical illness
- Most individuals with hypochondriasis are now classified as SSD however a minority of cases now fall under IAD
- Somatic symptoms are not present or if present , are of mild intensity.
- This diagnosis also applies to those who in fact have a medical illness but their anxiety is out of proportion

Clinical features




- Patients believe that they have a serious disease that has not been detected and they cannot be persuaded the contrary
- As time progresses they may transfer their belief to another disease
- Their convictions persist despite negative laboratory tests

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- Patient use to examine himself/herself repeatedly.
 - They are often addicted to internet searches about their illness
 - Often accompanied by symptoms of depression and anxiety and commonly coexists with a depressive or anxiety disorder

Treatment



- Patients usually needs psychiatric treatment
- Frequent regularly scheduled physical examinations help reassure patients that their not abandoned and their complains are takes seriously
- Group psychotherapy
- Other forms of psychotherapy -hypnosis and CBT
- Pharmacotherapy



Conversion disorder (Functional neurological symptom disorder)

Conversion disorder




- The conversion of psychological energy to a corporal symptom
- An illness of symptoms or deficits that affect voluntary motor or sensory functions
- It suggests another medical condition but that is judged to be caused by psychological factors because the illness is preceded by conflicts or other stressors

Epidemiology



- Incidence is estimated to be 2-5/100000 per year
- 2-3 times more common in females.
- Onset has reported throughout life. Non epileptic attacks peaks in 3rd decade and motor symptoms have their peak onset in 4th decade.
- Most common among rural populations, low IQ, low socioeconomic groups

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- ▶ Commonly associated with MDD ,SZC and social anxiety disorder.
 - ▶ Common in certain culture.

Risk and prognostic factors

- ▶ Temperamental- Maladaptive personality traits
- ▶ Environmental – abuse, neglect , stressful events
- ▶ Genetic and physiological – presence of neurological disease that cause similar symptoms

Positive prognostic factors- short duration of symptoms, acceptance of diagnosis, young age.



Table 13.4-1
Common Symptoms of Conversion Disorder

Motor Symptoms	Sensory Deficits
Involuntary movements	Anesthesia, especially of extremities
Tics	Midline anesthesia
Blepharospasm	Blindness
Torticollis	Tunnel vision
Opisthotonos	Deafness
Seizures	Visceral Symptoms
Abnormal gait	Psychogenic vomiting
Falling	Pseudocyesis
Astasia-abasia	Globus hystericus
Paralysis	Swooning or syncope
Weakness	Urinary retention
Aphonia	Diarrhea

(Courtesy of Frederick G. Guggenheim, M.D.)

Treatment



- Resolution Is usually spontaneous
- The most important feature of the therapy is the relationship with a caring and confident therapist
- Telling such patients that their symptoms are imaginary often makes them worse
- Hypnosis anxiolytics and behavioral relaxation exercises
- Psychoanalysis and insight oriented psychotherapy



THANK YOU