Dissociative disorders

Done by: Abdelhadi Okasha

Topics discussed in this lecture

1- Introduction: What is disassociation?
What is ego defense?
2- Types of Dissociative disorders:
a- depersonalization/derealization disorder (Difference between psychosis & disassociation)
b- dissociative amnesia (Definition/ Types)
c- dissociative identity disorder.
3- Diagnosis
4- Treatment

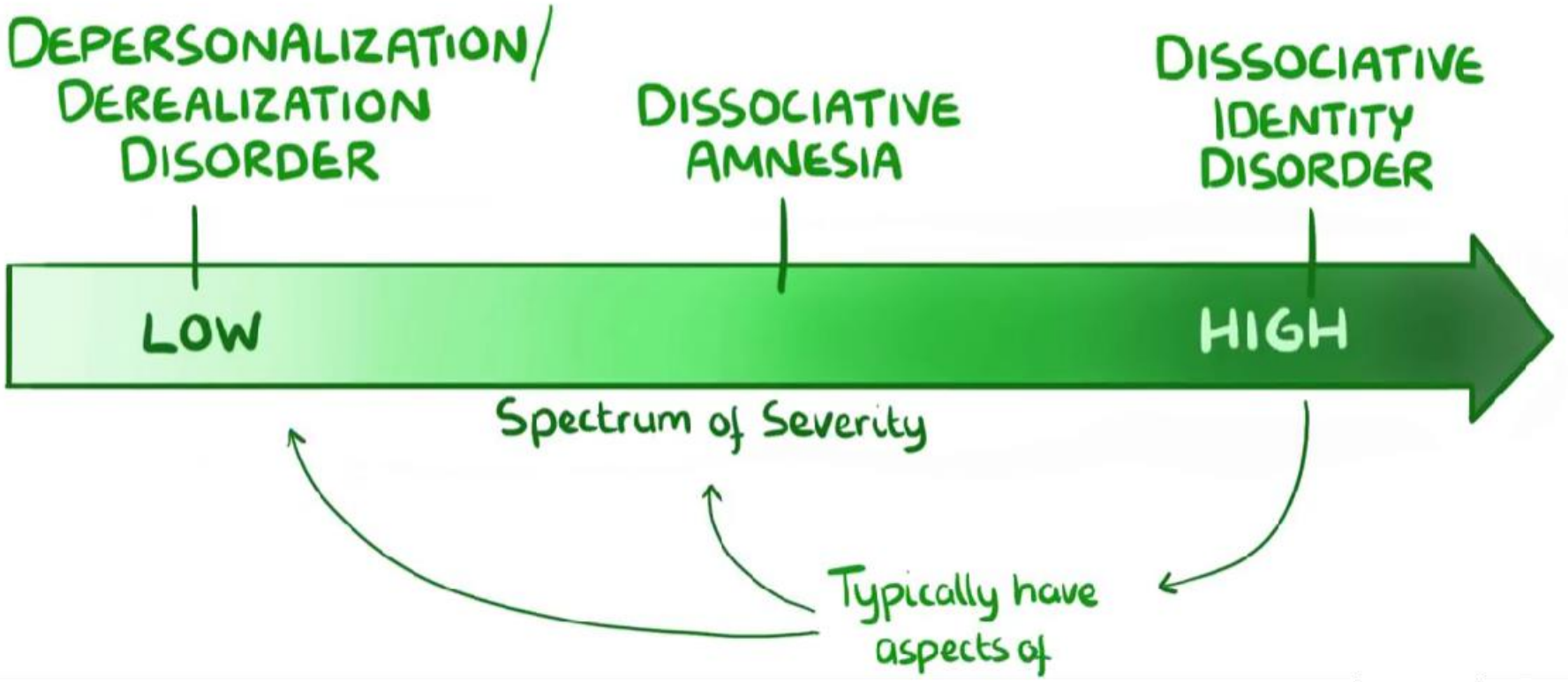
1- Introduction: What is disassociation?

- Detachment from reality, Feeling “like I was outside my own body”
- A mild common example: driving on a car. One minute you got in your car, and the next minute you’ve arrived at your destination, but you can’t actually remember the details of the drive. This is an example of normal, everyday dissociation, a term that describes a mental state of disconnection from what’s going around you. This daydream-like state doesn’t normally last very long, and most people can snap out of it if something or someone requires their attention
- More severe forms are considered medical problems: Often associated with psychological trauma, and they are considered as a type of **EGO DEFENSE**

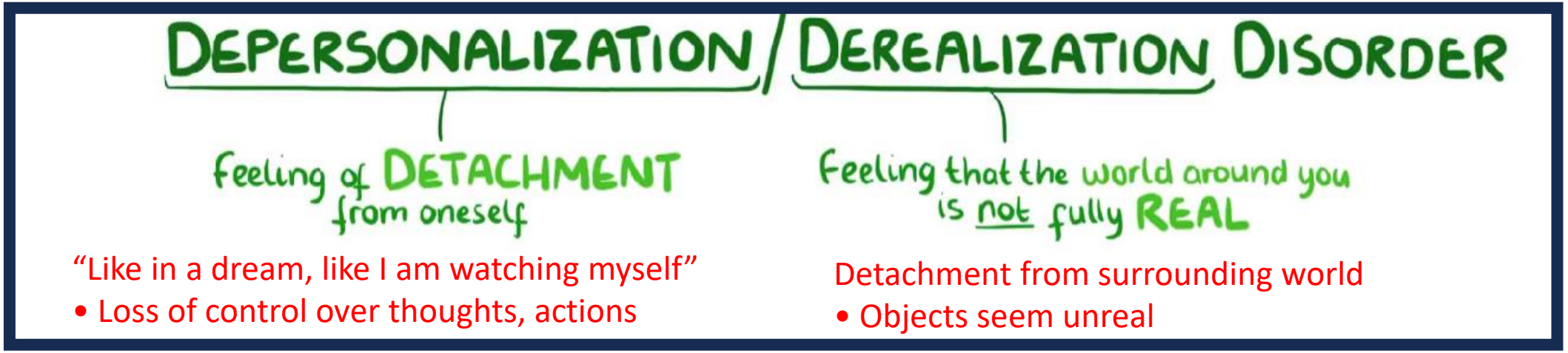
What is ego defense?

- Freudian Psychology
  - Id - desire
  - Superego – societal rules, morality
  - Ego - mediator between id and superego
- Ego Defenses : Adjustments in reality perception (e.g. Acting Out/ Displacement/ disassociation)

2- Types of Dissociative disorders:



a- depersonalization/derealization disorder

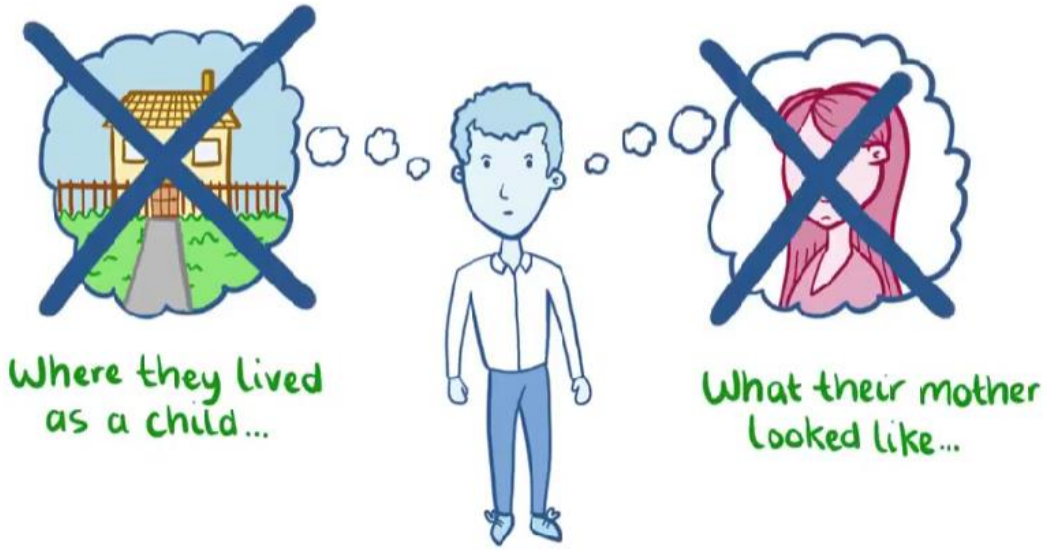


- Often triggered by trauma
- Must cause significant distress/impairment
- Intact reality testing
- Differentiates from psychosis: Patient aware that sensations are not real

disassociation	psychosis
The patient knows that what he is seeing, feeling, etc. is unreal	Loss of perception of reality, patient suffers from delusions (e.g. Somatic delusions/ Persecutory delusions)

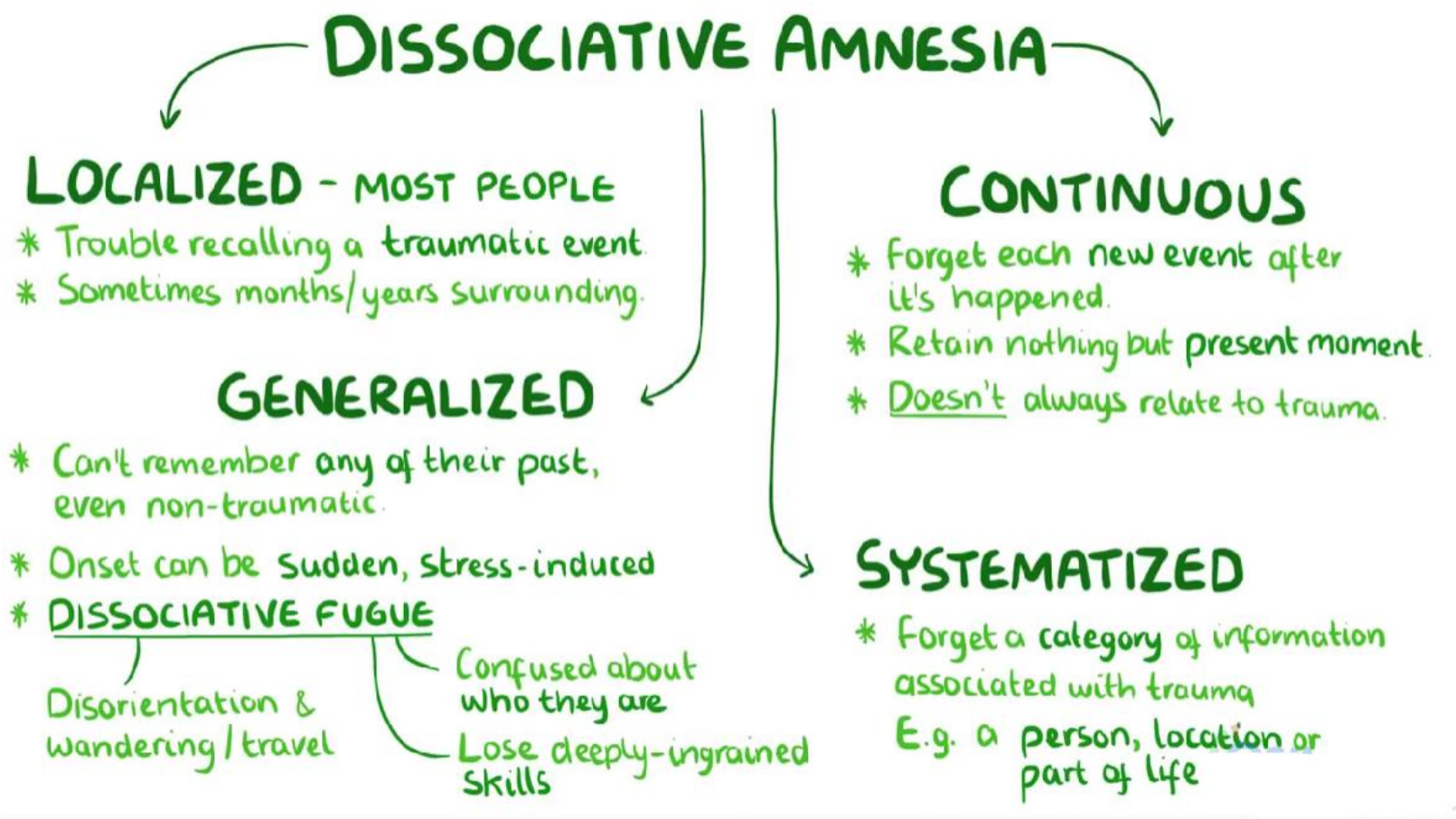
b- dissociative amnesia : Definition

- Dissociative amnesia is when a person blocks out or forgets important personal information that most people would remember for a lifetime.



- Usually follows major trauma/stress
- Potentially reversible (memories may come back)
- Patient not bothered by lack of memory
- Amnesia not explained by another cause

b- dissociative amnesia :Types



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b- dissociative amnesia :Types

- Dissociative Fugue : Subtype of dissociative amnesia
  - Fugue = Latin for flight or flee
  - Sudden travel/wandering in dissociated state
  - Example: Manager fired from work goes missing, Found in another state working under different name, No recollection of prior job

c- dissociative identity disorder.

- Also called multiple personality disorder
- More common in women
- Associated with childhood trauma/abuse
- Especially sexual abuse, often before age 6
- Most common presentation: Two or more distinct identities “Personality states” : Alterations in behavior, memory, thinking/ Observed by others or reported by patient/ Gaps in memory about events / Symptoms cause distress or problems in functioning

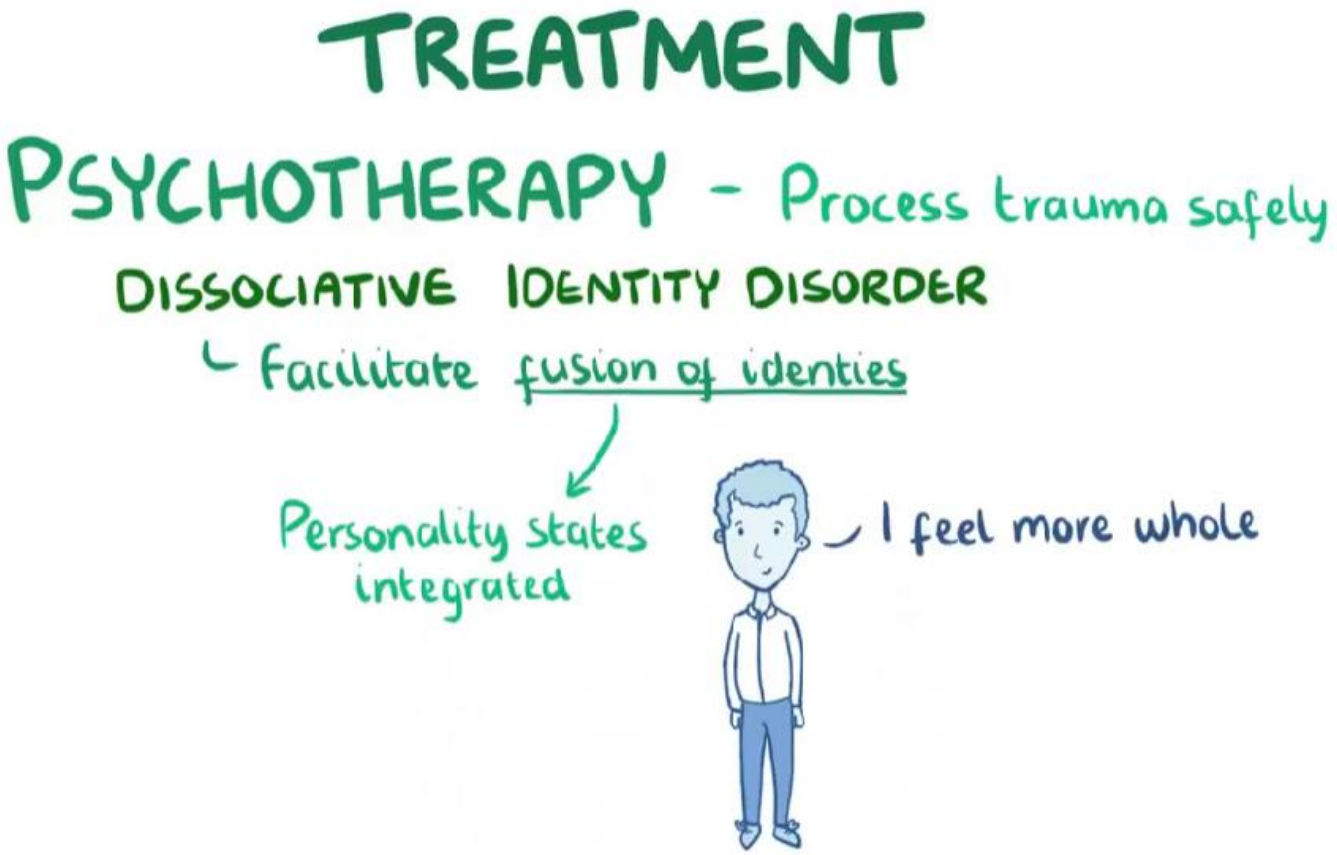
3- Diagnosis

DIAGNOSIS - TRICKY!

DIFFERENTIALS:

* **SUBSTANCE INTOXICATION**
  - Hallucinogens (E.g. LSD)
  - Dissociative drugs (E.g. PCP, Ketamine)
* **SEIZURES**
* **BRAIN TRAUMA**
* **DEMENTIA**
* **ANXIETY DISORDER** – Impaired sense of { IDENTITY, TIME, SENSATION } Mins - hours vs. months - years

4- Treatment


TREATMENT
PSYCHOTHERAPY - Process trauma safely
DISSOCIATIVE IDENTITY DISORDER
└ Facilitate fusion of identies
Personality states integrated
I feel more whole

Somatization disorders

Done by: Abdelhadi Okasha

Topics discussed in this lecture

1- Introduction: What is Somatization? Somatic symptom disorder
Differentiate between Somatization, factitious & real disease
2- Risk factors
3- Presentation
4- Management
5- Similar to somatization: Illness Anxiety Disorder/ La belle indifference/ Factitious Disorder on Self or others/ Malingering

1- Introduction: What is Somatization? Differentiate between Somatization, factitious & real disease

- Somatization: Physical symptoms not explained by medical disease
- Factitious: Falsely created symptoms for gain

2- Risk factors

- Female gender
- Less education
- Minority status
- Low socioeconomic status

3- Presentation

- Symptoms: Pain/ Gastrointestinal symptoms /Cardiopulmonary symptoms /Neurologic symptoms /Dyspareunia & dysmenorrhea/ anxiety and depression about symptoms/ Excessive time and energy devoted to symptoms/ Persistent (usually more than six months)

4- Management

- Avoid debating if symptoms are psychiatric or medical
- Do not challenge belief that symptoms are medical
- Regular visits with same physician
- Limit tests and referrals
- Reassure patient that serious medical diseases are ruled out
- Set goals of functional improvement
- Psychotherapy

5- Similar to somatization

- Illness Anxiety Disorder: Preoccupation with having undiagnosed illness, where there is mild or no somatic symptoms, Anxiety about health, Repeatedly checking for signs of illness, Present for at least six months
- La belle indifference: Patient shows lack of concern (indifference) about symptoms
- Factitious Disorder on Self or others: Done consciously out of desire for attention, patient may feign illness or aggravate genuine illness, the patient often willing to go for tests/surgeries
  → Risk factors: Female gender, Unmarried, Prior or current healthcare worker !
- Malingering: Done for secondary (external) gain & ends when secondary gain achieved