of the early sexual trauma. He believed (with Breuer) that cure would come by transforming these unconscious memories into conscious ones. However, Freud (1905/1953) quickly withdrew from the idea that early experiences of *actual* sexual abuse were necessarily involved and instead proposed that adult psychological problems were caused by consciously unacceptable sexual *fantasies* from childhood. The reasons for Freud's change in thinking have been debated at length, although his own explanations included his unwillingness to accept the idea that the victimisation of children was a common occurrence and that his own father would have been a perpetrator if the theory was correct (Gleaves & Hernandez, 1999). He also claimed that he had been unable to bring any cases to successful completion by attempting to uncover unconscious memories of abuse. An alternative explanation, proposed by Masson (1998), is that Freud knew he was right the first time but lacked the moral courage to stand up to the scientific community. Whatever his reasons, in the revised psychoanalytic view, symptoms result from an unconscious conflict, with the symptom symbolically expressing the unconscious desire as well as the prohibition of it. According to this view, for instance, when a man who witnesses his wife's flirtatious behaviour with a friend develops a paralysis of the arm, the symptom is providing an expression of his wish to hurt the friend and/or his wife (an unacceptable aggressive impulse) while preventing him from doing so and punishing him for the thought. Although Freud's ideas still have some influence, particularly his elucidation of the unconscious, in the last 50 years attention has increasingly been drawn to the role of cognitive and affective factors, and of the doctor–patient interaction, in the development and perpetuation of somatic symptom and related disorders. Interestingly, it is his earliest so-called seduction theory that is now having the greatest influence on contemporary understandings of dissociative disorders in which early trauma is theorised to play a crucial role.

LO 5.3 Somatic symptom and related disorders

THE DIAGNOSIS OF SOMATIC SYMPTOM AND RELATED DISORDERS

The range of somatic symptom and related disorders contained in the *DSM-5* is shown in Table 5.1. These disorders have in common the fact that affected individuals experience prominent somatic symptoms (or concerns about somatic symptoms) that are associated with significant distress or impaired functioning. In contrast to previous editions, and in a marked historical shift, the *DSM-5* no longer emphasises the notion that the individual's somatic symptoms are without medical explanation and are attributed to psychological causation. This change is based on the rationale that it can sometimes be very difficult to distinguish whether a symptom is caused by a physical disease or a psychological mechanism. In addition, symptoms that at one point in time appear not to have a medical basis may in fact reflect limitations in medical knowledge regarding the causes of these symptoms (Duddu, Isaac, & Chaturvedi, 2006). Indeed, it has even been suggested that the case of Anna O may not have been an example of hysteria after all but a form of epilepsy. Factors that help to identify the somatic symptom and related disorders as mental disorders (rather than medical conditions) include the number and persistence of symptoms, the degree of bodily preoccupation, the intensity of illness-worry, the forceful seeking of medical or other healthcare and the poor quality of the patient–health-system relationship.

SOMATIC SYMPTOM DISORDER

Somatic symptom disorder is characterised in the *DSM-5* as a condition in which the individual experiences one or more distressing or debilitating somatic symptoms accompanied by abnormal thoughts, feelings and/

TABLE 5.1 The main somatic symptom and related disorders in the *DSM-5*

Somatic symptom disorder
• One or more somatic symptoms that are distressing and disrupting to life • Excessive thoughts, feelings or behaviours related to the somatic symptoms or health concerns • State of being symptomatic is persistent • May specify: – with predominant pain – persistent (severe symptoms and impairment and longer than 6 months) – mild, moderate or severe—based on somatic symptoms and psychopathology (thoughts, feelings and behaviours)
Illness anxiety disorder
• Preoccupation with having or acquiring a serious illness • Somatic symptoms are not prominent • High level of health anxiety • Excessive health-related behaviours • Illness preoccupation present for at least 6 months
Conversion disorder (functional neurological symptom disorder)
• One or more symptoms of altered voluntary motor or sensory function • Incompatible with recognised neurological or medical condition • Causes significant distress or impairment • May specify: – acute (<6 months) or persistent (>6 months) – with or without psychological stressor – specific symptom type (e.g., with weakness or paralysis, abnormal movements, attacks or seizures)
Psychological factors affecting other medical conditions
• A medical condition is present • Psychological or behavioural factors adversely affect the medical condition
Factitious disorder
• Falsification of physical or psychological symptoms, or induction of injury or disease, in oneself or others • The individual presents him/herself or another individual (the victim) to others as ill, impaired or injured • The deception does not appear to have any external reward (e.g., compensation payment)

Source: Adapted from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Copyright 2013, American Psychiatric Association.

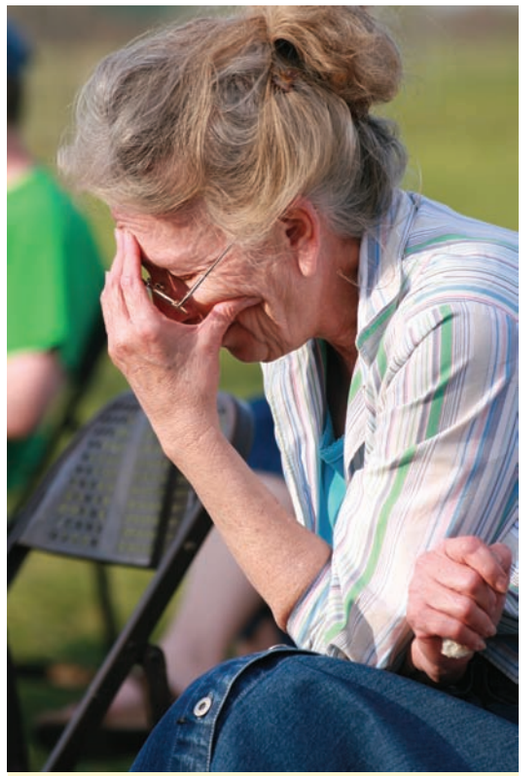
or behaviours in relation to these somatic symptoms (APA, 2013). These abnormal reactions to the somatic symptom/s include:

1. disproportionate and persistent thoughts about the seriousness of one's symptoms
2. persistently high levels of anxiety about one's health or symptoms
3. spending excessive time and energy devoted to these symptoms or health concerns (e.g., excessive healthcare utilisation).

Examples of the somatic symptoms experienced by individuals with somatic symptom disorder include pain, gastrointestinal symptoms (e.g., nausea, bloating, vomiting or food intolerances) and neurological symptoms (e.g., paralysis, impaired coordination or loss of consciousness). These symptoms have typically been present for at least six months (although not all symptoms need to have been present at the same time).

'Somatic symptom disorder with predominant pain' refers to those individuals with the disorder for whom pain is their primary somatic symptom. This disorder is similar to conversion disorder in that it involves a neurological symptom. On the other hand, pain entails the experience of excess, in contrast to conversion disorder, which is most commonly a loss of function. Depression and anxiety are almost always present with chronic pain and perhaps make pain sensations worse (Henningsen & Lowe, 2006). Certainly the negativity and hopelessness seen in depression make the suffering worse (Loeser, 2000).

Given that somatic symptom disorder was only introduced in the *DSM-5,* little is known about the validity of this new diagnostic category (Dimsdale et al., 2013). However, grave concerns have been expressed about the probable overdiagnosis of the disorder given that only one somatic symptom is required to be present to meet the diagnostic criteria (Frances & Chapman, 2013).



For some individuals with somatic symptom disorder, the predominant symptom is physical pain (such as headache) that causes significant distress and impaired functioning, along with abnormal thoughts, feelings or behaviours regarding the pain.

ILLNESS ANXIETY DISORDER

Most individuals experiencing abnormal levels of anxiety regarding their health (hypochondriasis) meet criteria for somatic symptom disorder. However, individuals who are preoccupied with having or acquiring a serious illness *in the absence of experiencing marked somatic symptoms* would be diagnosed according to the *DSM-5* with illness anxiety disorder (APA, 2013). The patient may worry about a number of different symptoms and/or diseases or may be fixated on a single organ or disease, as in so-called cardiac neurosis or cancer phobia. For such individuals, if a medical condition is present, or they are at risk of developing a medical condition, their level of preoccupation is excessive. Such individuals experience high levels of anxiety about health and engage in excessive health-checking behaviours (e.g., repeatedly checking body parts for lumps) or avoidance of health checks. The individual's health concerns persist (last for more than six months) despite appropriate reassurance (which includes appropriate medical examination and investigation) and must not be better explained by another mental disorder (e.g., if the illness anxiety is of delusional intensity, it will be part of a psychotic disorder).

affect
Experience of feeling or emotion.

Research indicates that there are a number of elements to illness anxiety. These include disturbances in perception (hypersensitivity regarding bodily sensations), **affect** (anxiety regarding illness), cognition (beliefs regarding the threat or reality of serious disease) and behaviour (excessive help and reassurance seeking) (Longley, Watson, & Noyes, 2005). A danger is that the frequent presentation of patients with illness anxiety to doctors may result in a tendency for doctors to be dismissive of these patients' complaints instead of properly investigating them. In this manner, doctors may fail to diagnose actual medical illness. On the other hand, over-investigation may help to maintain a misguided illness conviction on the part of the patient.

conversion disorder
Disorder marked by a sudden loss of functioning in a part of the body (such as blindness) without an identifiable medical cause.

sensory disturbance
Disturbance of sensation.

CONVERSION DISORDER

Conversion disorder (also known as functional neurological symptom disorder) is a classic disorder whose definition has not changed much over time. It refers to the rather dramatic situation where there is a disturbance in one or more aspects of the individual's motor or sensory functioning (such as paralysis, blindness, gait [walking] disturbance or difficulty swallowing). The disturbance cannot be explained in terms of another medical or mental disorder. For instance, the area of **sensory disturbance** is not consistent with the anatomical distribution of nerves, nerve conduction studies are normal and muscle reflexes are present and

identity alteration This most extreme experience refers to objective behaviours indicating that the individual has assumed alternative identities at different times.

be associated with some personality disorders. However, when the dissociative experience is the primary presenting problem and/or when the person experiences the more severe identity alteration, the individual is diagnosed with a dissociative disorder.

THE DIAGNOSIS OF DISSOCIATIVE DISORDERS

The primary dissociative disorders as listed in the *DSM-5* are shown in Table 5.8 (APA, 2013).

TABLE 5.8 The main features of the *DSM-5* dissociative disorders

Depersonalisation/derealisation disorder
Persistent depersonalisation (a feeling of being detached from one's mental processes, e.g., as if an observer) or derealisation (experiences of unreality or detachment with respect to surroundings, e.g., as if in a dream)
Dissociative amnesia
The predominant symptom is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too excessive to be explained by ordinary forgetfulness. It may also occur with **dissociative fugue**, which refers to sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past and confusion about one's personal identity or assumption of a new identity.
Dissociative identity disorder
The presence of two or more distinct identities or personality states that recurrently take control of the person's behaviour; in some cultures, this may present as pathological possession. There is an inability to recall important personal information too extensive to be explained by ordinary forgetfulness.
For all disorders, the disturbance: • causes significant distress or impairment of functioning • is not fully explained by a medical condition (e.g., head trauma, epilepsy) or the direct effects of a substance, and is not intentionally produced or feigned • is not better explained by another mental disorder (e.g., posttraumatic stress disorder).

Source: Adapted from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), Copyright 2013, American Psychiatric Association.

dissociative fugue Dissociative disorder in which a person undergoes a sudden, unexpected journey away from home and assumes a new identity, with amnesia for the previous identity.

depersonalisation disorder Dissociative disorder characterised by frequent episodes of feeling detached from one's own body and mental processes that cause significant distress or interference with one's ability to function.

dissociative amnesia Dissociative disorder entailing loss of memory for important facts about a person's own life, usually of a stressful or traumatic nature.

DEPERSONALISATION/DEREALISATION DISORDER

The central characteristic of **depersonalisation/derealisation disorder** is persistent or recurrent episodes of depersonalisation, derealisation, or both. In most cases, both are actually present. The depersonalisation may be experienced as feelings of detachment or estrangement from one's self, such as feeling like an automaton (acting automatically and without volition) or as if in a dream. The derealisation may be experienced as if one's surroundings are unreal. The diagnosis requires that these experiences are persistent or recurrent as well as causing significant distress and/or impairment in functioning. In fact, the distress may be profound, with the person feeling as if s/he is the 'walking dead' (Simeon, 2004, p. 345).

DISSOCIATIVE AMNESIA

Dissociative amnesia, sometimes referred to as 'psychogenic amnesia', involves a loss of memory of significant personal information, usually of a traumatic or stressful event. Consciousness may not appear affected at the time of the event but afterwards there is complete or partial amnesia for the event. The *DSM-5* notes that episodes of dissociative amnesia can be localised, selective, generalised, systematised or continuous. Localised refers to forgetting what happened during a certain period although remembering previous and subsequent events (e.g., a victim of an assault may not remember anything that occurred some minutes before, during and after the attack). With selective amnesia, the individual may recall some but not all features of a specified event or circumstance (e.g., a victim of a violent armed robbery may recall some of the events that transpired but not other obvious features that would be expected to be highly memorable). Generalised amnesia involves amnesia for all or most personal information, including one's name, personal