

Somatoform and Dissociative Disorders

TOPIC OVERVIEW

Somatoform Disorders

Conversion Disorder
Somatization Disorder
Pain Disorder Associated with Psychological Factors
Hypochondriasis
Body Dysmorphic Disorder
What Causes Somatoform Disorders?
How Are Somatoform Disorders Treated?

Dissociative Disorders

Dissociative Amnesia
Dissociative Fugue
Dissociative Identity Disorder (Multiple Personality Disorder)
How Do Theorists Explain Dissociative Disorders?
How Are Dissociative Disorders Treated?
Depersonalization Disorder

Putting It Together: Disorders Rediscovered

LECTURE OUTLINE

- I. **SOMATOFORM AND DISSOCIATIVE DISORDERS**
 - A. In addition to disorders covered earlier, two other kinds of disorders are commonly associated with stress and anxiety—somatoform disorders and dissociative disorders
 - B. Somatoform disorders are problems that appear to be medical but are due to psychosocial factors

1. Unlike psychophysiological disorders, in which psychosocial factors interact with physical ailments, somatoform disorders are psychological disorders masquerading as physical problems
- C. Dissociative disorders are patterns of memory loss and identity change that are caused almost entirely by psychosocial factors rather than physical ones
- D. The somatoform and dissociative disorders have much in common:
 1. Both may occur in response to severe stress
 2. Both have traditionally been viewed as forms of escape from stress
 3. A number of individuals suffer from both a somatoform and a dissociative disorder
 4. Theorists and clinicians often explain and treat the two groups of disorders in similar ways

II. SOMATOFORM DISORDERS

- A. When a physical ailment has no apparent medical cause, physicians also may suspect a somatoform disorder
- B. People with somatoform disorder do not consciously want or purposely produce their symptoms
 1. They believe their problems are genuinely medical
- C. There are two main types of somatoform disorders: hysterical and preoccupation

III. WHAT ARE HYSTERICAL SOMATOFORM DISORDERS?

- A. People with hysterical somatoform disorders suffer actual changes in their physical functioning
 1. These disorders are often hard to distinguish from genuine medical problems
- B. It is always a potential that a diagnosis of hysterical disorder is a mistake and the patient's problem has an undetected organic cause
- C. DSM-IV-TR lists three hysterical somatoform disorders:
 1. Conversion disorder
 - a. In this disorder, a psychosocial conflict or need is converted into dramatic physical symptoms that affect voluntary or sensory functioning
 - (a) Symptoms often seem neurological, such as paralysis, blindness, or loss of feeling
 - b. Most conversion disorders begin between late childhood and young adulthood
 - c. They are diagnosed in women twice as often as in men
 - d. They usually appear suddenly and are thought to be rare
 2. Somatization disorder
 - a. People with somatization disorder have many long-lasting physical ailments that have little or no organic basis
 - (a) Also known as Briquet's syndrome
 - b. To receive a diagnosis, a patient must have a range of ailments, including several pain symptoms, gastrointestinal symptoms, a sexual symptom, and a neurological symptom
 - (a) Patients usually go from doctor to doctor in search of relief
 - (b) Patients often describe their symptoms in dramatic and exaggerated terms
 - (c) Most also feel anxious and depressed
 - c. Between 0.2 and 2 percent of all women in the United States experience a somatization disorder in any given year (compared with less than 0.2 percent of men)
 - d. The disorder often runs in families and begins between adolescence and young adulthood
 - e. This disorder lasts much longer than a conversion disorder, typically for many years
 - f. Symptoms may fluctuate over time but rarely disappear completely without psychotherapy
 3. Pain disorder associated with psychological factors

- a. Patients may receive this diagnosis when psychosocial factors play a central role in the onset, severity, or continuation of pain
 - b. Although the precise prevalence has not been determined, it appears to be fairly common
 - c. The disorder often develops after an accident or illness that has caused genuine pain
 - d. The disorder may begin at any age, and more women than men seem to experience it
- D. Hysterical vs. medical symptoms
- 1. It can be difficult to distinguish hysterical disorders from “true” medical conditions
 - a. Studies across the world suggest that as many as one-fifth of all patients who seek medical care may actually suffer from somatoform disorders
 - 2. Physicians sometimes rely on oddities in the patient’s medical picture to help distinguish the two
 - a. For example, hysterical symptoms may be at odds with the known functioning of the nervous system, as in cases of glove anesthesia
- E. Hysterical vs. factitious symptoms
- 1. Hysterical somatoform disorders are different from patterns in which individuals are purposefully producing or faking medical symptoms
 - a. Patients may be *malingering*, intentionally faking illness to achieve external gain (e.g., financial compensation, military deferment)
 - b. Patients may be manifesting a *factitious disorder*—intentionally producing or faking symptoms simply out of a wish to be a patient
 - 2. Factitious disorder
 - a. People with factitious disorder often go to extremes to create the appearance of illness
 - b. Many give themselves medications to produce symptoms
 - c. Patients often research their supposed ailments and are impressively knowledgeable about medicine
 - 3. Factitious disorder seems to be most common among people who:
 - a. As children received extensive medical treatment for a true physical disorder
 - b. Experienced family problems or physical or emotional abuse in childhood
 - c. Carry a grudge against the medical profession
 - d. Have worked as nurses, laboratory technicians, or medical aids
 - e. Have an underlying personality problem such as extreme dependence
 - 4. Munchausen syndrome is the extreme and long-term form of factitious disorder
 - a. In a related disorder, Munchausen syndrome by proxy, parents make up or produce physical illnesses in their children

IV. WHAT ARE PREOCCUPATION SOMATOFORM DISORDERS?

- A. Preoccupation somatoform disorders include hypochondriasis and body dysmorphic disorder
- B. People with these problems misinterpret and overreact to bodily symptoms or features
- C. Although these disorders also cause great distress, their impact on one’s life differs from that of hysterical disorders
- D. There are two main disorders:
 - 1. Hypochondriasis
 - a. People with hypochondriasis unrealistically interpret bodily symptoms as signs of serious illness
 - (a) Often their symptoms are merely normal bodily changes, such as occasional coughing, sores, or sweating
 - b. Although some patients recognize that their concerns are excessive, many do not
 - c. Patients with this disorder can present a picture very similar to that of somatization disorder
 - (a) If the anxiety is great and the bodily symptoms are relatively minor, a diagnosis of hypochondriasis is probably in order

- (b) If the symptoms overshadow the anxiety, they may indicate somatization disorder
 - d. Although this disorder can begin at any age, it starts most often in early adulthood, among men and women in equal numbers
 - (a) Between 1 and 5 percent of all people experience the disorder
 - e. For most patients, symptoms rise and fall over the years
- 2. Body dysmorphic disorder (BDD)
 - a. People with this disorder, also known as dysmorphobia, become deeply concerned over some imagined or minor defect in their appearance
 - (a) Most often they focus on wrinkles, spots, facial hair, swelling, or misshapen facial features (nose, jaw, or eyebrows)
 - b. Most cases of the disorder begin in adolescence but are often not revealed until adulthood
 - c. Up to 5 percent of people in the United States experience BDD, and it appears to be equally common among women and men

V. WHAT CAUSES SOMATOFORM DISORDERS?

- A. Theorists typically explain the preoccupation somatoform disorders much as they explain the anxiety disorders:
 - 1. Behaviorists = Classical conditioning or modeling
 - 2. Cognitive theorists = Oversensitivity to bodily cues
- B. In contrast, the hysterical somatoform disorders are widely considered unique and in need of special explanation
 - 1. No explanation has received much research support, and the disorders are still poorly understood
- C. The psychodynamic view
 - 1. Freud believed that hysterical disorders represented a conversion of underlying emotional conflicts into physical symptoms
 - 2. Because most of his patients were women, Freud centered his explanation on the psychosexual development of girls and focused on the phallic stage (ages 3–5)
 - a. During this stage, girls develop a pattern of sexual desires for their fathers (the Electra complex) while recognizing that they must compete with their mothers for his attention
 - b. Because of the mother's more powerful position, however, girls repress these sexual feelings
 - c. Freud believed that if parents overreacted to such feelings, the Electra complex would remain unresolved and the child would reexperience sexual anxiety through her life
 - d. Freud concluded that some women hide their sexual feelings in adulthood by converting them into physical symptoms
 - 3. Today's psychodynamic theorists take issue with Freud's explanation of the Electra conflict
 - a. They do continue to believe that sufferers of these disorders have unconscious conflicts carried from childhood
 - 4. Psychodynamic theorists propose that two mechanisms are at work in the hysterical disorders:
 - a. Primary gain—Hysterical symptoms keep internal conflicts out of conscious awareness
 - b. Secondary gain—Hysterical symptoms further enable people to avoid unpleasant activities or to receive sympathy from others
- D. The behavioral view
 - 1. Behavioral theorists propose that the physical symptoms of hysterical disorders bring rewards to sufferers
 - a. May remove individual from an unpleasant situation
 - b. May bring attention from other people
 - 2. In response to such rewards, sufferers learn to display symptoms more and more

3. This focus on rewards is similar to the psychodynamic idea of secondary gain, but behaviorists view them as the primary cause of the development of the disorder
- E. The cognitive view
 1. Some cognitive theorists propose that hysterical disorders are forms of *communication*, providing a means for people to express difficult emotions
 - a. Like psychodynamic theorists, cognitive theorists hold that emotions are being converted into physical symptoms
 - b. This conversion is not to defend against anxiety but to communicate extreme feelings
- F. The multicultural view
 1. Some theorists believe that Western clinicians hold a bias that sees somatic symptoms as an inferior way of dealing with emotions
 - a. The transformation of personal distress into somatic complaints is the norm in many non-western cultures
 - b. As we saw in Chapter 6, reactions to life's stressors are often influenced by one's culture
- G. A possible role for biology
 1. The impact of biological processes on somatoform disorders can be understood through research on placebos and the placebo effect
 - a. Placebos are substances with no known medicinal value
 - b. Treatment with placebos has been shown to bring improvement to many—possibly through the power of suggestion or through the release of endogenous chemicals
 2. Perhaps traumatic events and related concerns or needs can also trigger our “inner pharmacies” and set in motion the bodily symptoms of hysterical somatoform disorders

VI. HOW ARE SOMATOFORM DISORDERS TREATED?

- A. People with somatoform disorders usually seek psychotherapy only as a last resort
- B. Individuals with preoccupation disorders typically receive the kinds of treatments applied to anxiety disorders, particularly OCD:
 1. Antidepressant medication, especially selective serotonin reuptake inhibitors (SSRIs)
 2. Exposure and response prevention (ERP)
- C. Treatments for hysterical disorders often focus on the cause of the disorder and apply the same kind of techniques used in cases of PTSD, particularly:
 1. Insight—often psychodynamically oriented
 2. Exposure—Client thinks about traumatic event(s) that triggered the physical symptoms
 3. Drug Therapy—especially antidepressant medication
- D. Other therapists try to address the physical symptoms of the hysterical disorders, applying techniques such as:
 1. Suggestion—usually an offering of emotional support that may include hypnosis
 2. Reinforcement—a behavioral attempt to change reward structures
 3. Confrontation—an overt attempt to force patients out of the sick role
- E. Researchers have not fully evaluated the effects of these particular approaches in hysterical disorders

VII. DISSOCIATIVE DISORDERS

- A. The key to one's identity—the sense of who we are and where we fit in our environment—is memory
- B. Our recall of the past helps us to react to present events and guides us in making decisions about the future
- C. People sometimes experience a major disruption of their memory, identity, or consciousness:
 1. They may not remember new information

2. They may not remember old information
- D. When such changes in memory lack a clear physical cause, they are called “dissociative” disorders
 1. In such disorders, one part of the person’s memory typically seems dissociated, or separated, from the rest
 2. These disorders often are memorably portrayed in books, movies, and television programming
 3. DSM-IV also lists depersonalization disorder as a dissociative disorder
- E. Keep in mind that dissociative symptoms often are found in cases of acute and posttraumatic stress disorders
 1. When such symptoms occur as part of a stress disorder, they do not necessarily indicate a dissociative disorder—a pattern in which dissociative symptoms dominate
 - a. On the other hand, research suggests that people with one of these disorders also develop the other as well
- F. There are several kinds of dissociative disorders, including dissociative amnesia, dissociative fugue, and dissociative identity disorder (multiple personality disorder)
 1. Dissociative amnesia
 - a. People with dissociative amnesia are unable to recall important information, usually of an upsetting nature, about their lives
 - b. The loss of memory is much more extensive than normal forgetting and is not caused by organic factors
 - c. Often an episode of amnesia is directly triggered by a specific upsetting event
 - d. Dissociative amnesia may be:
 - (a) Localized (circumscribed)—most common type; loss of all memory of events occurring within a limited period of time
 - (b) Selective—loss of memory for some, but not all, events occurring within a period of time
 - (c) Generalized—loss of memory, beginning with an event, but extending back in time; may lose sense of identity; may fail to recognize family and friends
 - (d) Continuous—forgetting both old and *new* information and events; quite rare in cases of dissociative amnesia
 - e. All forms of the disorder are similar in that the amnesia interferes with memory of episodic memory—one’s autobiographical memory of personal material
 - (a) Semantic memory—memory for abstract or encyclopedic information—usually remains intact
 - f. Clinicians do not know how common dissociative amnesia is, but many cases seem to begin during serious threat to health and safety
 2. Dissociative fugue
 - a. People with dissociative fugue not only forget their personal identities and details of their past lives, but also flee to an entirely different location
 - (a) For some, the fugue is brief: a matter of hours or days—and end suddenly
 - (b) For others, the fugue is more severe: people may travel far from home, take a new name and establish new relationships, and even a new line of work; some display new personality characteristics
 - b. Approximately 0.2 percent of the population experience dissociative fugue
 - c. It usually follows a severely stressful event
 - (a) Fugues tend to end abruptly
 - (b) When people are found before their fugue has ended, therapists may find it necessary to continually remind them of their own identity
 - d. The majority of people regain most or all of their memories and never have a recurrence
 3. Dissociative identity disorder/multiple personality disorder
 - a. A personality with dissociative identity disorder (DID; formerly multiple personality disorder) develops two or more distinct personalities—subpersonalities—each with a unique set of memories, behaviors, thoughts, and emotions

- b. At any given time, one of the subpersonalities dominates the person's functioning
 - (a) Usually one of these subpersonalities, called the primary, or host, personality, appears more often than the others
 - (b) The transition from one subpersonality to the next ("switching") is usually sudden and may be dramatic
- c. Cases of this disorder were first reported almost three centuries ago
- d. Many clinicians consider the disorder to be rare, but some reports suggest that it may be more common than once thought
- e. Most cases are first diagnosed in late adolescence or early adulthood
 - (a) Symptoms generally begin in childhood after episodes of abuse
 - (b) Typical onset is prior to age five
 - (c) Women receive the diagnosis three times as often as men
- f. How do subpersonalities interact?
 - (a) The relationship between or among subpersonalities varies from case to case
 - (b) Generally there are three kinds of relationships:
 - (i) Mutually amnesic relationships—subpersonalities have no awareness of one another
 - (ii) Mutually cognizant patterns—each subpersonality is well aware of the rest
 - (iii) One-way amnesic relationships—most common pattern—some personalities are aware of others, but the awareness is not mutual
 - 1. Those who are aware ("co-conscious subpersonalities") are "quiet observers"
 - (c) Investigators used to believe that most cases of the disorder involved two or three subpersonalities
 - (i) Studies now suggest that the average number per patient is much higher—15 for women, 8 for men
 - (ii) There have been cases with over 100
- g. How do subpersonalities differ?
 - (a) Subpersonalities often exhibit dramatically different characteristics, including
 - (i) Vital statistics
 - 1. Subpersonalities may differ in features as basic as age, sex, race, and family history
 - (ii) Abilities and preferences
 - 1. Although encyclopedic knowledge is not usually affected by dissociative amnesia or fugue, in DID it is often disturbed
 - 2. It is not uncommon for different subpersonalities to have different abilities, including being able to drive, speak a foreign language, or play an instrument
 - (iii) Physiological responses
 - 1. Researchers have discovered that subpersonalities may have physiological differences, such as differences in autonomic nervous system activity, blood pressure levels, and allergies
- h. How common is dissociative identity disorder?
 - (a) Traditionally, DID was believed to be rare
 - (b) Some researchers even argue that many or all cases are *iatrogenic*, that is, unintentionally produced by practitioners
 - (i) These arguments are supported by the fact that many cases of DID first come to attention only after a person is already in treatment
 - 1. This is not true of all cases
 - (c) The number of people diagnosed with the disorder has been increasing
 - (d) Although the disorder still is uncommon, thousands of cases have been documented in the United States and Canada alone

- (i) Two factors may account for this increase:
 1. A growing number of clinicians believe that the disorder does exist and are willing to diagnose it
 2. Diagnostic procedures have become more accurate
 - (e) Despite changes, many clinicians continue to question the legitimacy of the category
 - i. How do theorists explain dissociative disorders?
 - (a) A variety of theories have been proposed to explain dissociative disorders
 - (i) Older explanations have not received much investigation
 - (ii) Newer viewpoints, which combine cognitive, behavioral, and biological principles, have captured the interest of clinical scientists
 - (b) The psychodynamic view
 - (i) Psychodynamic theorists believe that dissociative disorders are caused by *repression*, the most basic ego defense mechanism
 - (ii) People fight off anxiety by unconsciously preventing painful memories, thoughts, or impulses from reaching awareness
 - (iii) In this view, dissociative amnesia and fugue are single episodes of massive repression
 - (iv) DID is thought to result from a lifetime of excessive repression, motivated by very traumatic childhood events
 - (v) Most of the support for this model is drawn from case histories, which report brutal childhood experiences
 1. Yet, some individuals with DID do not seem to have experiences of abuse
 2. Why might only a small fraction of abused children develop this disorder?
 - (c) The behavioral view
 - (i) Behaviorists believe that dissociation grows from normal memory processes and is a response learned through operant conditioning
 - (ii) Momentary forgetting of trauma leads to a drop in anxiety, which increases the likelihood of future forgetting
 - (iii) Like psychodynamic theorists, behaviorists see dissociation as escape behavior
 - (iv) Also, like psychodynamic theorists, much of the support for this model comes from case histories
 - (v) While the data support this model, they also are consistent with other explanations
 - (d) State-dependent learning
 - (i) If people learn something when they are in a particular state of mind, they are likely to remember it best when they are in the same condition
 - (ii) This link between state and recall is called state-dependent learning
 - (iii) This model has been demonstrated with substances and mood and may be linked to arousal levels
 - (iv) It has been theorized that people who are prone to develop dissociative disorders have state-to-memory links that are unusually rigid and narrow—each thought, memory, and skill is tied exclusively to a particular state of arousal, so that they recall a given event only when they experience an arousal state almost identical to the state in which the memory was first acquired
 - (e) Self-hypnosis
 - (i) While hypnosis can help people remember events that occurred and were forgotten years ago, it also can help people forget facts, events, and their personal identity

- (ii) Called “hypnotic amnesia,” this phenomenon has been demonstrated in research studies with word lists
 - (iii) The parallels between hypnotic amnesia and dissociative disorders are striking and have led researchers to conclude that dissociative disorders may be a form of self-hypnosis
- j. How are dissociative disorders treated?
- (a) People with dissociative amnesia and fugue often recover on their own
 - (i) Only sometimes do their memory problems linger and require treatment
 - (b) In contrast, people with DID usually require treatment to regain their lost memories and develop an integrated personality
 - (c) Treatment for dissociative amnesia and fugue tends to be more successful than those for DID
 - (d) How do therapists help people with dissociative amnesia and fugue?
 - (i) The leading treatments for these disorders are psychodynamic therapy, hypnotic therapy, and drug therapy
 - 1. Psychodynamic therapists guide patients to their unconscious and bring forgotten experiences into consciousness
 - 2. In hypnotic therapy, patients are hypnotized and guided to recall forgotten events
 - 3. Sometimes intravenous injections of barbiturates are used to help patients regain lost memories
 - a. Often called “truth serums,” the key to the drugs’ success is their ability to sedate people and free their inhibitions
 - (e) How do therapists help individuals with DID?
 - (i) Unlike victims of dissociative amnesia or fugue, people with DID do not typically recover without treatment
 - (ii) Treatment for this pattern, like the disorder itself, is complex and difficult
 - (iii) Therapists usually try to help the client by:
 - 1. Recognizing the disorder
 - a. Therapists typically try to bond with the primary personality and with each of the subpersonalities
 - b. As bonds are forged, therapists try to educate the patients and help them recognize the nature of the disorder
 - c. Some use hypnosis or video as a means of presenting other subpersonalities
 - d. Many therapists recommend group therapy
 - 2. Recovering memories
 - a. To help patients recover missing memories, therapists use many of the approaches applied in other dissociative disorders, including psychodynamic therapy, hypnotherapy, and drug treatment
 - b. These techniques tend to work slowly in cases of DID
 - 3. Integrating the subpersonalities
 - a. The final goal of therapy is to merge the different subpersonalities into a single, integrated entity
 - b. Integration is a continuous process with fusion as the final merging
 - c. Many patients distrust this final treatment goal, and many subpersonalities see integration as a form of death
 - d. Once the subpersonalities are integrated, further therapy is typically needed to maintain the complete personality and to teach social and coping skills to prevent later dissociations

VIII. DEPERSONALIZATION DISORDER

- A. DSM-IV-TR categorizes depersonalization disorder as a dissociative disorder, even though it is different from the other dissociative patterns
- B. The central symptom is persistent and recurrent episodes of depersonalization—a change in one’s experience of the self in which one’s mental functioning or body feels unreal or foreign
- C. People with depersonalization disorder feel as though they have become separated from their body and are observing themselves from outside
 1. This sense of unreality can extend to other sensory experiences and behavior
 2. Depersonalization often is accompanied by derealization—the feeling that the external world, too, is unreal and strange
- D. Depersonalization experiences by themselves do not indicate a depersonalization disorder
 1. Transient depersonalization reactions are fairly common
 2. The symptoms of a depersonalization, in contrast, are persistent or recurrent, and cause considerable distress, interfere with social relationships and job performance
- E. The disorder occurs most frequently in adolescents and young adults, hardly ever in people over 40
- F. The disorder comes on suddenly and tends to be long lasting
- G. Few theories have been offered to explain depersonalization disorder and little research has been conducted on the problem

LEARNING OBJECTIVES

1. Define somatoform disorders, including conversion disorders, somatization disorders, and pain disorders.
2. Explain how physicians distinguish between hysterical somatoform disorders and true medical problems.
3. Describe the criteria for diagnosing factitious disorder; include in this discussion Munchausen syndrome and Munchausen syndrome by proxy.
4. Compare and contrast hypochondriasis and body dysmorphic disorders.
5. Compare and contrast the psychodynamic, cognitive, and behavioral views of somatoform disorders.
6. Describe the general characteristics of the dissociative disorders: dissociative amnesia, dissociative fugue, and dissociative identity disorder.
7. Discuss the explanations of dissociative disorder to include psychodynamic explanations, behavioral explanations, state-dependent learning, and self-hypnosis.
8. Discuss treatment for the dissociative disorders.
9. Describe depersonalization disorder.

KEY TERMS

alternate personalities
 amnestic episode
 body dysmorphic disorder
 Briquet’s syndrome

continuous amnesia
 conversion disorder
 depersonalization disorder
 dissociative amnesia

dissociative disorders
 dissociative fugue
 dissociative identity disorder

dysmorphophobia
 Electra complex
 episodic memory
 exposure and response
 prevention
 factitious disorder
 fusion
 generalized amnesia
 glove anesthesia
 host personality
 hypnotic therapy
 hypochondriasis
 hysterical somatoform
 disorders
 iatrogenic disorder
 identity

localized amnesia
 malingering
 memory
 multiple personality disorder
 Munchausen syndrome
 Munchausen syndrome by
 proxy
 mutually amnestic
 relationships
 mutually cognizant patterns
 one-way amnestic
 relationships
 operant conditioning
 pain disorder associated with
 psychological factors
 phallic stage

placebo
 placebo effect
 preoccupation somatoform
 disorders
 primary gain
 repression
 secondary gain
 selective amnesia
 self-hypnosis
 semantic memory
 somatization disorder
 somatoform disorder
 state-dependent learning
 subpersonalities
 switching

MEDIA RESOURCES

Abnormal Psychology Student Tool Kit

Produced and edited by Ronald J. Comer, Princeton University and Gregory Comer, Princeton Academic Resources. Tied directly to the CyberStudy sections in the text, this Student Tool Kit offers 57 intriguing Video Cases running three to seven minutes each. The Video Cases focus on persons affected by disorders discussed in the text. Students first view the video and then answer a series of thought-provoking questions. Additionally, the Student Tool Kit contains multiple-choice practice test questions with built-in instructional feedback for every option.

Video Cases and Discussions:

- When do somatoform symptoms impair functioning and endanger sufferers?
- Why is it important to distinguish somatoform symptoms from factitious or true medical symptoms?
- Observe an individual with multiple personality disorder, and see “switches” from subpersonality to subpersonality.

Practical, Research, and Decision-Making Exercises:

- Observing and measuring the power of suggestion.
- Manufacturing memories.

PowerPoint Slides

Available at the Instructor’s site on the companion Web site are comprehensive PowerPoint slide presentations and supplemental student handouts for Chapter 7. The slide files reflect the main points of the chapter in significant detail. Student handouts were created using the instructor slides as a base, with key points replaced as “fill-in” items. Answer keys and suggestions for use also are provided.

DSM-IV-TR Masters

- B-20, DSM-IV-TR Diagnostic Criteria for Somatization Disorder
- B-21, DSM-IV-TR Diagnostic Criteria for Conversion Disorder
- B-22, DSM-IV-TR Diagnostic Criteria for Pain Disorder
- B-22, DSM-IV-TR Diagnostic Criteria for Hypochondriasis
- B-23, DSM-IV-TR Diagnostic Criteria for Body Dysmorphic Disorder
- B-23, DSM-IV-TR Diagnostic Criteria for Factitious Disorder
- B-24, DSM-IV-TR Diagnostic Criteria for Dissociative Amnesia
- B-24, DSM-IV-TR Diagnostic Criteria for Dissociative Fugue
- B-25, DSM-IV-TR Diagnostic Criteria for Dissociative Identity Disorder
- B-25, DSM-IV-TR Diagnostic Criteria for Depersonalization Disorder

Internet Sites

Please see Appendix A for full and comprehensive references.

Sites relevant to Chapter 7 material are:

<http://www.isst-d.org>

This Web site is the International Society for the Study of Trauma and Dissociation and supplies copyrighted Guidelines for Treating Dissociative Identity Disorder in Adults, with links to each section of the guidelines. There are also links specified for general information, assisting professionals, and finding a therapist.

<http://www.sparknotes.com/>

Sparknotes.com is a Web site designed to provide simplistic formats in generally studied subject matters. This page contains an introduction and summary to both dissociative and somatoform disorders, a description and/or definition of common terms, and the etiology and treatment for both.

<http://www.mbpexpert.com>

This site contains information on factitious disorder by proxy and Munchausen syndrome by proxy.

<http://www.cdc.gov/cfs>

A comprehensive page from the CDC that discusses the many factors associated with chronic fatigue syndrome.

<http://allpsych.com/disorders/somatoform/>

This site includes characteristics, etiology, symptoms, and treatment of somatoform disorders.

Mainstream Films

Films relevant to Chapter 7 material are listed and summarized below.

Key to Film Listings:

P = psychopathology focus

T = treatment focus

E = ethical issues raised

Please note that some of the films suggested may have graphic sexual or violent content due to the nature of certain subject matters.

Agnes of God

This 1985 film stars Jane Fonda as Dr. Livingston, a psychiatrist who is called in as part of the investigation when a dead infant is found at a convent. The child is found to belong to solemn, naive Sister Agnes (Meg Tilly), who offers little in the information about who the father is or why she committed the crime. **P, T, E, serious film**

The Butterfly Effect

Starring Ashton Kutcher, this suspense film follows a boy who blocks out painful memories of his life, only to recall them in an unusual way. **P, commercial/suspense film**

Hannah and Her Sisters

From 1986, this film chronicles the changing relationships among three sisters living in New York City. The film stars Woody Allen as a television writer who is divorced from Hannah and suffers from hypochondriasis. **P, T, comedy**

Identity

Released in 2003, this film seems to follow strangers from all different walks of life: a limo driver escorting a movie star, parents with a young son, a cop transporting a convict, a prostitute, a young couple, and a motel manager who are then brought together in a rainstorm. As they are killed off one by one, the connections between them become clearer. **P, T, commercial/suspense film**

Mulholland Drive

This Oscar-nominated David Lynch film is about a woman with amnesia lost in Los Angeles who is helped by an ingenue also new to the city. Everything is not, however, as it seems. **P, commercial/suspense film**

The Piano

This Oscar-winning film from 1993 stars Holly Hunter as Ada, a mute-by-choice 19th-century woman sent to New Zealand in an arranged marriage with a patriarchal landowner (Sam Neill). **P, serious film**

Primal Fear

From 1996, this film stars Edward Norton as an accused killer claiming dissociative identity disorder (multiple personality disorder) and Richard Gere as his attorney. The film is full of plot twists and turns. **P, T, E, serious/commercial film**

Psycho

This 1960 classic Hitchcock film (remade in 1998) follows Norman Bates, a lonely hotel clerk with a dissociative disorder. **P, horror/commercial film**

Send Me No Flowers

From 1964, this film stars Rock Hudson as a sweet and hopeless man with hypochondriasis. **P, comedy**

The Sixth Sense

While not a major point of this film about a young boy who "sees dead people," a child victim of Munchausen syndrome by proxy is briefly profiled. **P, commercial/suspense/paranormal film**

Spellbound

From 1945, this Hitchcock film (with scenery by Salvador Dali) stars Ingrid Bergman as a psychiatrist and Gregory Peck as an amnesic patient involved in a manhunt. **P, T, E, commercial thriller/romance film**

Sybil

From 1976, Sally Field gives an award-winning performance as Sybil, a disturbed young woman who suffers from dissociative identity behavior. **P, serious film**

The Three Faces of Eve

This 1957 film is the true story of a Georgia housewife (played by Joanne Woodward in an award-winning performance) with three personalities. **P, T, serious film**

Vanilla Sky

This 2001 Cameron Crowe film stars Tom Cruise as a successful publisher who finds his life taking a turn for the surreal after a car accident. **P, commercial/suspense film**

Other Films:

Apocalypse Now (1979) dissociative disorder. **P, serious film**

Arsenic and Old Lace (1944) dissociative disorder. **P, comedy**

The Boston Strangler (1968) multiple personality disorder. **P, serious film**

Captain Newman, MD (1963) dissociative disorder. **P, T, serious film**

Fight Club (1999) dissociative disorder. **P, serious film**

Hollywood Ending (2002) somatoform disorder (hysterical blindness). **P, comedy/commercial film**

The King of Comedy (1983) dissociative disorder. **P, serious/comedy film**

Nurse Betty (2000) dissociative disorder. **P, serious/comedy film**

Play It Again Sam (1972) hypochondriacs. **P, comedy**

Raising Cain (1992) multiple personality disorder. **P, commercial/suspense film**

Sunset Boulevard (1950) dissociative disorder. **P, serious film**

Tommy (1975) somatoform disorder. **P, T, rock musical**

Comer Video Segments

Available as a supplement, this revised set of videotapes contains short clips depicting various topics related to abnormal psychology. Please see the accompanying Video Guide for specific clips linked to Chapter 7.

Recommendations for Purchase or Rental

The Comer Video Segments include excerpts from many superb clinical documentaries. While the segments alone are ideal for use in lectures, it often is useful to assign the entire documentary for special class screenings or library use by students. The following videos and other media are available for purchase or rental and appropriate for use in class or for assignment outside of class.

Living with Amnesia

Films for the Humanities and Sciences

P.O. Box 2053

Princeton, NJ 08543-2053

Phone: 800-257-5126

CLASS DEMONSTRATIONS AND ACTIVITIES**Case Study**

Present a case study to the class.

Panel Discussion

Have students volunteer (or assign them) to portray mental health “workers” from different theoretical perspectives in a panel discussion. Each student should present the main explanation and treatment for the anxiety disorders from his or her theoretical background. Students in the audience can ask questions of the panelists. Additionally, other students can role-play patients suffering from particular somatoform or disso-

ciative disorders. [NOTE: A brief reminder about sensitivity and professionalism is worthwhile here.] Have the panelists or audience members attempt to make a diagnosis.

“It’s Debatable I: Dissociative Identity Disorder is ‘real’” (see Preface instructions for conducting this activity)

Have students volunteer (or assign them) in teams to opposite sides of the debate topic. Have students present their cases in class following standard debate guidelines.

“It’s Debatable II: Repressed Childhood Memories or False Memory Syndrome? (see Preface instructions for conducting this activity and A Closer Look (p. 223 in the text) for more information on the topic)

Have students volunteer (or assign them) in teams to opposite sides of the debate topic. Have students present their cases in class following standard debate guidelines.

The Anonymous Five-Minute Essay: “I can’t go to school today”

An amusing exercise is to have students write down their most creative excuse for not attending school (related to faking illness). It should be an episode “in which they probably could have qualified for some acting award, and of which, to this day, they are proud.” Inform students that you may select their example for reading to the class.

Group Work: Dissociative Identity Disorder

Tell the class that you have been called as an expert witness at a trial of a person who is claiming, as his defense, that he has multiple personality disorder. You will be questioned as to the validity of the diagnostic category (which is still being debated among psychologists). Divide students into groups and assign them either the position that multiple personality disorder is or is not a valid disorder. Have groups present their arguments.

Distinguishing Disorders

The differences among factitious disorder, conversion disorder, somatization disorder, pain disorder, hypochondriasis, and body dysmorphic disorder can be difficult to understand. Pointing out the important distinction (such as the voluntary nature of symptoms in factitious disorder) is very helpful. Displaying the DSM criteria for these disorders simultaneously while leading a discussion of the differences also can be helpful.

SUGGESTED TOPICS FOR DISCUSSION

Munchausen Syndrome versus Munchausen Syndrome by Proxy

Lead a discussion of these disorders. Munchausen syndrome is an extreme and long-term form of factitious disorder in which a person feigns symptoms to gain admission to a hospital and receive treatment. Munchausen syndrome by proxy is a factitious disorder in which parents feign or produce physical illnesses in their children. In both instances, the motivation appears to be attention from doctors (either because one is sick or because one’s child is sick). See a Closer Look on p. 209 of the text for more information.

Open Discussion: Too Healthy?

Ask students whether there should be a DSM category for people who are overly concerned with good

health. They can be people who are overly concerned about eating habits or exercise. Should these types of behaviors be considered abnormal?

Development of Dissociative Disorders

Lead a discussion of why some people who are sexually abused as children develop dissociative identity disorder while most don’t. Research indicates that individuals who develop dissociative disorders are much more susceptible to self-hypnosis and hypnotic suggestion than the average person. Additionally, why is this disorder more common among females than males? Are there regions of the country where this disorder is more prevalent?

ASSIGNMENTS/EXTRA CREDIT SUGGESTIONS

“Write a Pamphlet”

With the use of a software program like Microsoft Publisher or simply paper and markers, students can

create a pamphlet on one or all of the somatoform and/or dissociative disorders. Students also could create a pamphlet on “How to Detect Malingering.” Stu-

dents should be encouraged to be as accurate and up-to-date as possible and also to present all sides of the disorder (e.g., alternate treatment approaches or theories).

Keep a Journal

In addition to helping students synthesize material, this activity also is helpful in developing writing skills. Have students keep a journal of their thoughts on course material through the semester. This can be done in the first or last five minutes of class or as an out-of-class assignment. Faculty generally should have students submit their journals for review on an on-going basis as students can have the tendency to delay writing until the end of the semester. Some suggestions for journal topics include: reactions to the case examples; strengths and weaknesses of prevailing theoretical explanations; hypothetical conversations with sufferers of specific disorders, etc.

Presume You Are an Expert . . . (The Development of Dissociative Disorders)

Tell the students that you received a phone call from your senator last night. He or she recognizes that you are doing a fine job instructing students on the issue of childhood abuse. Your senator wants you and several students to come to Washington, D.C., to testify before a Senate subcommittee about the effects of the abuse on children. Ask students to prepare a five-minute presentation outlining a position on why some people who are sexually abused as children develop dissociative identity disorder while most don't. One position might be: "It is actually normal for dissociative disorder to develop following severe abuse." A second position is: "Only in unusual cases or examples does dissociative disorder develop as a result of childhood sexual abuse." Have groups present their discussions and positions.

Abnormal Psychology Student Tool Kit Video Questions

As a homework assignment, have students watch a video clip and answer the accompanying questions. Students can answer the questions directly into the on-line assessment feature. The results of these quizzes report to the site's built-in grade book.

Web Site Quiz

For homework or extra credit, have students complete the quizzes for Chapter 7 located on the companion Web site. Students can complete an on-line test of the key chapter material (using questions NOT from the test bank) and have their scores e-mailed directly to the course instructor.

Essay Topics

For homework or extra credit, have students write an essay addressing one (or more) of the following topics:

- (1) Discuss your thoughts about the impact of socio-cultural factors on (a) body image and (b) Body Dysmorphic Disorder (BDD). Eye on Culture (p. 212 in the text) details perceptions of beauty in other cultures. What beauty aesthetics in Western culture would outsiders see as bizarre? To what extent do these perceptions impact the rates and types of cosmetic surgery seen in the world today (see p. 210 in the text)?
- (2) A Closer Look on p. 209 in the text discusses Munchausen syndrome by proxy, a disorder many find both bizarre and disturbing. What do you think is the explanation behind such a disorder? Do you think Munchausen syndrome by proxy should be considered a psychological disorder or a crime?
- (3) Compare and contrast factitious disorders, malingering, and somatoform disorders. What are your reactions to each type of disorder? Do you think they are "legitimate" psychological disorders?

Research Topics

For homework or extra credit, have students write a research report addressing one (or more) of the following topics:

- (1) Conduct a "Psych Info" search and write an annotated bibliography on treatments for factitious disorders and somatoform disorders. What theoretical model is being evaluated?
- (2) Conduct a "Psych Info" search and write an annotated bibliography on the dissociative disorders, including depersonalization disorder. What research is being conducted on these disorders? Are they being researched in the same ways? Does the classification of depersonalization as a dissociative disorder make sense diagnostically?
- (3) Research the beauty standard in non-Western countries (as discussed on p. 212 in the text). Why are practices in other cultures considered "wrong" while analogous acts in one's own culture are "right?" Can you think of other examples from Western culture that support this argument?
- (4) Conduct a Psych Info search on Repression and False Memory Syndrome and write a review (see A Closer Look, p. 223 in the text). Which side of the argument is most compelling to you?
- (5) Research some of the "Peculiarities of Memory" discussed in A Closer Look on p. 228 in the text.

Should any of these be included as disorders in the DSM?

Film Review

To earn extra credit, have students watch one (or more) of the mainstream films listed earlier in this chapter and write a brief (3–5) page report. Students should summarize the plot of the film in sufficient detail to demonstrate familiarity, but should focus their papers on the depiction of psychological abnormality. What errors or liberties did the filmmaker take? What is the message (implicit or explicit) concerning the mentally ill?

Case Study Evaluations

To complement the Comer and Gorenstein supplemental case study text, case study evaluations have

been created. Students can be assigned the appropriate case study and evaluation as homework or for class discussion. While case study evaluation questions are listed in their entirety on the companion Web site at www.worthpublishers.com/comer, the relevant case studies are referenced next.

Case Study 6: Hypochondriasis

Crossword Puzzles

As a homework assignment or for extra credit, have students complete and submit Crossword Puzzle #7.

Word Searches

As a homework assignment or for extra credit, have students complete and submit Word Search #7.