E Resource Anxiety Disorders Second
F44 Dissociative (Conversion) Disorders

F44 Dissociative (conversion) disorders
F44.0 Dissociative amnesia
F44.1 Dissociative fugue
F44.2 Dissociative stupor
F44.3 Trance and possession disorders
F44.4 Dissociative motor disorders
F44.5 Dissociative convulsions
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F44.9 Dissociative (conversion) disorder, unspecified

Dissociative (Conversion) Disorders

- The common theme shared by dissociative disorders is a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. There is normally a considerable degree of conscious control over the memories and sensations that can be selected for immediate attention, and the movements that are to be carried out.
- The term "conversion hysteria" should be avoided, because it is confusing and stigmatizing.
- The prevalence is not exactly known (up to 10%).
- Sudden onset and termination of dissociative states.
- There are several forms of dissociative syndromes.

Manifestations of Hysteria

A. Physical (conversion) Symptoms

(a) ***Motor*** e.g. Paralysis, paresis, tremors, rigidity, abnormal gait, ataxia, fits.

(b) ***Sensory General :*** Anaesthesia, paraesthesia, Hyperalgesia, Pain.
Sensory Special: Visual difficulties, blindness, deafness, loss of taste, loss of smell.

(c) ***Visceral*** e.g. Hiccough, vomiting, retention of urine, constipation.

B. Mental (Dissociative) Symptoms

(a) ***Amnesia***
(b) ***Fugues***
(c) ***Hysterical seizures:*** They usually lack a number of features of true

epileptic seizures e.g. lack of unconsciousness, an unusual pattern of physical consequences of seizure (tongue bite, incontinence), do not occur in sleep, lack post seizure sequelae (confusion, headache, bodyache, vomiting, paralysis) and lack of EEG abnormality.

(d) ***Multiple Personalities.***

(e) ***Hysterical Pseudodementia. Hysterical Psychosis:*** Represents the patient's idea of madness.

(g) ***Trance/Twilight states:*** Dream like states.

Dissociative Amnesia

- The main feature is loss of memory, usually of important recent event, which is not due to organic mental disorder and is too extensive to be explained by ordinary forgetfulness or fatigue.
- The amnesia is usually centered on traumatic events, such as accidents, combat experiences, or unexpected bereavements, and used to be partial and selective.
- The amnesia typically develops suddenly and can last from minutes to days.
- Differential diagnosis: complicated; it is necessary to rule out all organic brain disorders as well as various intoxications. The most difficult differentiation is from conscious simulation - malingering.

Dissociative Stupor

- The individual suffers from diminution or absence of voluntary movement and normal responsiveness to external stimuli such as light, noise, and touch.
- The person lies or sits largely motionless for long periods of time.
- Speech and spontaneous and purposeful movement are completely absent.
- Muscle tone, posture, breathing, and sometimes eye-opening and coordinated eye movements are such that it is clear that the individual is neither asleep nor unconscious.

Positive evidence of psychogenic causation in the form of either recent stressful events or prominent interpersonal or social problems

Trance and Possession Disorders

There is a temporary loss of both the sense of personal identity and full awareness of the surroundings. The individual can act as if taken over by another personality, spirit, deity, or "force". Repeated sets of extraordinary movements, postures, and utterances can be observe

Dissociative Disorders of Movement and Sensation

- There is a loss of or interference with movements or loss of sensations (usually cutaneous). Mild and transient varieties of these disorders are often seen in adolescence, particularly in girls, but the chronic varieties are usually found in young adults.
- Dissociative motor disorders
- Dissociative convulsions
- Dissociative anaesthesia
- Ganser's syndrome – „approximate" or grossly incorrect answers

Multiple personality disorder means the apparent existence of two or more distinct personalities within an individual, with only one of them being evident at a time (Mr. Jekyl and Mr. Hyde). Each personality is complete, with its own memories, behaviours, and preferences, but neither has access to the memories of the other and the two are almost always unaware of each other's existence. Change from one personality to another is in the first instance usually sudden and closely associated with traumatic events

Clinical Management

- Psychotherapy is a method of choice of treatment of dissociative disorders (e.g. psychodynamic programs, hypnosis).
- Medications have no proven value with exception of sodium amobarbital interview.

Differential Diagnosis of Conversion Hysteria

	Conversion hysteria	***Malingering***
Nature of Symptom	Nonanatomic	Anatomic or non-anatomic
Emotional Response to Symptoms	Relative indifference	Exaggerated concern
Onset	Sudden in response to conflict	Gradual planned
Etiology	Non-volitional	Volitional
Presumed Motivation	Resolution of psychological or situational conflict	Compensation or prosecution
Preexisting Physical Pathology	Absent/Present	Absent
Suggestibility	High	Low
Cognitive State	Dissociation memory and attention disturbance	Intact
Response to Treatment	Sudden, dramatic for short term	None

Hyst. Fit vs GME

	Hysterical Fit	**GME (Grand Mal Epilepsy)**
Pattern	Not fixed	Stereotyped
Place	Infront of others	Anywhere
Aura	Unusual	Usual
Moaning	Faint	Epileptic cry
Progression	Not	Jacksonian
Consciousness	Altered but pain response	lost but no response to pain
Injury	Self protection	Frequent
Incontinence	Rare	Common
Type	Limp,jerky	Tonic-clonic
Time	10-15min	2-3 min
Postictal confusion	Rare	Confusion/paralysis
Amnesia	Partial	Total
Speech	Verbalization	No
Head turning	Side to side	To one side
Eye gaze	Avoidant	Staring
Prolactin	Normal	Increased
Creatinine kinase	Normal	Raised
pH	Normal	Changed
Reflexes	Normal	Babinski
EEG	Normal	Abnormal
Precipitant	Emotional	May or not
During sleep	Never	May be

F43 Reaction to Severe Stress, and Adjustment Disorders

- F43 Reaction to severe stress, and adjustment disorders
- F43.0 Acute stress reaction
- F43.1 Post-traumatic stress disorder
- F43.2 Adjustment disorders
- F43.8 Other reactions to severe stress
- F43.9 Reaction to severe stress, unspecified

Reaction to Severe Stress, and Adjustment Disorders

This category differs from others in that it includes disorders identifiable not only on grounds of symptomatology and course but also on the basis of one or other of two

Causative influences:

An exceptionally stressful life event (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime) producing an acute stress reaction. These significant life change leading to continued unpleasant circumstances that result in an adjustment disorder.

Stressful event is thought to be the primary and overriding causal factor, and the disorder would not have occurred without its impact

Acute Stress Reaction

Transient disorder of significant severity, which develops in an individual without any previous mental disorder in response to exceptional physical and/or psychological stress.

Not all people exposed to the same stressful event develop the disorder.

- The symptoms: an initial state of „daze", with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli, and disorientation. This state may be followed either by further withdrawal from the surrounding situation (extreme variant - dissociative stupor), or by agitation and overactivity.
- Autonomic signs - tachycardia, sweating or flushing, as well as other anxiety or depressive symptoms.

- The symptoms usually appear within minutes of the impact of the stressful event, and disappear within several hours, maximally 2—3 days.

Post-traumatic Stress Disorder (PTSD)

- PTSD is a delayed and/or protracted response to a stressful event of an exceptionally threatening or catastrophic nature.
- The three major elements of PTSD include
    1) reexperiencing the trauma through dreams or recurrent and intrusive thoughts ("flashbacks")
    2) showing emotional numbing such as feeling detached from others
    3) having symptoms of autonomic hyperarousal such as irritability and exaggerated startle response, insomnia
- Commonly there is fear and avoidance of cues that remind the sufferer of the original trauma. Anxiety and depression are commonly associated with the above symptoms. Excessive use of alcohol and drugs may be a complicating factor.
- The onset follows the trauma with a latency period, which may range from several weeks to months, but rarely more than half a year.
- The lifetime prevalence is estimated at about 0.5% in men and 1.2% in women.

Post-traumatic Stress Disorder (PTSD)

Clinical Management

- Pharmacological approach:
    - antidepressant medication
    - short-term benzodiazepines trials
    - mood stabilizers (carbamazepine, valproate)
    - antipsychotics
- Psychotherapy is also of importance - CBT using education and exposure techniques

Group therapy, family therapy and self-help groups are widely recommended

Adjustment Disorders

- Adjustment disorder comprises states of subjective distress and emotional disturbance arising in the period of adaptation to a significant life change or to the consequences of a stressful life event, such as serious physical illness, bereavement or separation, migration or refugee status.
- The clinical picture: depressed mood, anxiety, worry, a feeling of inability to cope, plan ahead, or continue in the present situation, and some degress of disability in the performance of daily routine.
- Onset - within 1 month; duration - below 6 months.
- More frequently women, unmarried and young persons.
- Psychotherapy is the first line treatment of this disorder. Symptomatic treatment may comprise short trial of hypnotics or benzodiazepines.

F45 Somatoform Disorders

F45 Somatoform disorders
F45.0 Somatization disorder
F45.1 Undifferentiated somatoform disorder
F45.2 Hypochondriacal disorder
F45.3 Somatoform autonomic dysfunction
F45.4 Persistent somatoform pain disorder
F45.8 Other somatoform disorders
F45.9 Somatoform disorder, unspecified

F45 Somatoform Disorders

- Somatoform disorders - multiple, recurrent and frequent somatic complaints requiring medical attention without association with any physical disorder are prominent.
- The medical history of multiple contacts with primary care and specialized health services is typical before the patient is referred to psychiatric care.
- Characteristics of somatoform disorders:
    1. somatic complains of many medical maladies without association with serious demonstrable peripheral organ disorder

psychological problems and conflicts that are important in initiating, exacerbating and maintaining the disturbance

F45.0 Somatization Disorder
Diagnostic Guidelines

A definite diagnosis requires the presence of all of the following:

a) at least 2 years of multiple and variable physical symptoms for which no adequate physical explanation has been found,
b) persistent refusal to accept the advice or reassurance of several doctors that there is no physical explanation for the symptoms,
c) some degree of impairment of social and family functioning attributable to the nature of symptoms and resulting behavior.

F45.0 Somatization Disorder
Differential Diagnosis

- Medical conditions may be confused with somatoform disorder especially early in their course (multiple sclerosis, brain tumor, hyperparathyroidism, hyperthyroidism, lupus erythematosus).
- Further investigation or consultation should be considered in long-term somatization disorder if there is a shift in the emphasis or stability of the physical complaints. This change in symptoms suggests possible development of physical disease.
- Affective (depressive) and anxiety disorders accompany somatization disorders but need not be specified separately unless they are sufficiently marked and persistent.

F45.0 Somatization Disorder
Therapy and Prognosis

- Chronic relapsing condition starting in adolescence or even as late as the third decade of life.
- New symptoms during the emotional distress.
- Typical episodes last 6 to 9 months; quiescent time of 9 to 12 months.
- Management strategies:
    1. the trusting relationship between the patient and one (if possible) primary care physician
    2. set up regularly scheduled visits every 4 or 6 weeks
    3. keep outpatient visits brief-perform at least a partial physical examination during each visit directed at the organ system of complaint
    4. understand symptoms as emotional message rather than a sing of new disease, look for signs of disease rather than focus on symptom
    5. avoid diagnostic tests, laboratory evaluations and operative procedures unless clearly indicated
    6. set a goal to get selected somatization patients referral- ready for mental health care

Group therapy (time limited, behavior oriented and structured group).

F45.1 Undifferentiated Somatoform Disorder

- The diagnosis should be considered if the complete and typical clinical picture of somatization disorders has not been fulfilled.
- No physical basis of the symptoms presented remains the basis for the diagnosis.
- Differential diagnosis:
    - frequently occur in major depression and schizophrenia.
    - chronic history of multiple somatic complaints
    - begin before the age of 30
    - adjustment disorder with unexplained somatic complaints should last by definition less than 6 moths
- Therapy and prognosis:
    - chronic and relapsing but some cases experience only one episode
    - treatment approaches – as in somatization disorder

F45.2 Hypochondriacal Disorder

- The disorder is characterized by a persistent preoccupation and a fear of developing or having one or more serious and progressive physical disorders.
- Patients persistently complain of physical problems or are persistently preoccupied with their physical appearance.
- The fear is based on the misinterpretation of physical signs and sensations.

Physician physical examination does not reveal any physical disorder, but the fear and convictions persist despite the reassurance

F45.2 Hypochondriacal Disorder
Diagnostic Guidelines

- Presence of both of the following criteria:
    1. persistent belief in the presence of at least one serious physical illness underlying the presenting symptom or symptoms, even thought repeated investigations and examinations have not identified any adequate physical explanation, or a persistent preoccupation with presumed deformity or disfigurement
    2. persistent refusal to accept the advice and reassurance of several different doctors that there is no physical illness or abnormity underlying the symptoms

Includes: Body dysmorphic disorder, Dysmorphophobia (non delusional), Hypochondriacal neurosis, Hypochondriasis, Nosophobia

F45.2 Hypochondriacal Disorder Differential Diagnosis

- Basic - ruling out underlying organic disease.
- The main somatoform disorder that need to be differentiated from hypochondriasis is somatization disorder.
- Hypochondriasis needs to be distinguished from factitious disorder with predominantly physical signs and from malingering.

F45.2 Hypochondriacal Disorder
Therapy and Prognosis

- The illness is usually long-standing, with episodes lasting months or years. Recurrences occur frequently after psychosocial distress.
- Higher socio-economic status, presence of other treatable condition, anxiety and depression, an acute onset, absence of personality disorder or comorbid organic disease predict better outcome.
- No evidence-based treatment has been described.
- Patients strongly refuse the mental health care professionals and remain in primary health care.
- Similar management and group therapy strategy as in somatization disorder may be useful.

F45.3 Somatoform Autonomic Dysfunction

- The symptoms are presented as physical disorder of system or organ largely or completely under controlled by autonomic innervation, i.e. the cardiovascular, gastrointestinal, or respiratory system and some aspects of genitourinary system.
- The symptoms are usually of two types:
    1. complaints based on objective signs of autonomic arousal (palpitation, sweating, flushing, tremor)
    2. idiosyncratic, subjective, non-specific (fleeting aches and pains, burning, heaviness, tightness, sensation of being bloated or distended)
- These symptoms patients refer to a specific organ or system.
- In many cases there is evidence of psychological stress or current problems related to the disorder.

F45.3 Somatoform Autonomic Dysfunction

Diagnostic Guidelines

a) Symptoms of autonomic arousal such as palpitations, sweating, tremor, flushing which are troublesome and persistent
b) Additional subjective symptoms referred to specific organ or system
c) Preoccupation with the symptoms and possibility of serious (often non specified disorder). It does not respond to repeated explanations and reassurance of physicians
d) No evidence of a significant disturbance of structure or function of the system or organ

F45.3 Somatoform Autonomic Dysfunction

Differential Diagnosis

- In comparison with generalized anxiety there is predominance of psychological component of autonomic arousal. In somatization disorders autonomic symptoms when they are present they are nor prominent nor persistent and symptoms are not so persistently attributed to one organ or system.
- Excludes: psychological and behavioural factors associated with disorders or diseases classified elsewhere (F54).
- The individual disorder may be classified by fifth character indicating the organ or system affected

F45.3 Somatoform Autonomic Dysfunction Therapy and Prognosis

- Similar chronic relapsing condition as the somatization disorder.
- Patients report worse health than do those with chronic medical condition and their report of specific symptoms if they meet the severity criteria is sufficient and need not to be considered legitimate by the clinician.

Treatment strategies will be similar stressing the importance of the interdisciplinary collaboration

F45.4 Persistent Somatoform Pain Disorder

- The predominant symptom is a persistent severe and distressing pain that cannot be explained fully by a physiological process of physical illness.
- Pain occurs in association with emotional conflicts or psychosocial problems.
- The expression of chronic pain may vary with different personalities and cultures.
- The patient is not malingering and the complaints about the intensity of the pain are to be believed.

F45.4 Persistent Somatoform Pain Diagnostic Guidelines

- The clinical examination should focus on
    a) the extend the patient is disabled by the pain
    b) the degree of complicating emotional factors and comorbid psychiatric conditions
- Includes: psychalgia, psychogenic backache or headache, somatoform pain disorder.

F45.4 Persistent Somatoform Pain

Differential Diagnosis

- Not included:
  - pain presumed to be of psychological origin occurring during the course of depression or schizophrenia
  - pain due to known or inferred physiological mechanism such as muscle tension pain or migraine but still believed to have psychological cause are coded as P54
  - the somatoform pain disorder has to be differentiated from histrionic behaviour in reaction to organic pain
- Excluded backache NOS (M54.9), pain NOS (acute, chronic) (R52.-), tension type headache (G44.2).

F45.4 Persistent Somatoform Pain

Therapy and prognosis

- Once diagnosis is completed the outpatient treatment on regular basis by one interested physician has to be carried out.
- Patients have to be reassured that the treatment continues if there is some improvement.
- Those with pain-prone reaction to distress are described to have poor or transient improvement.
- Patients with comorbid depression may improve with antidepressant medication.
- Treatment with any type of the pain disorder subtypes needs to be multidisciplinary and multidimensional from the onset.

F45.8 Other Somatoform Disorders

- In these disorders the presented complaints are not mediated through the autonomic nervous, and are limited to specific system of body part.
- Any other disorders of sensation not due to physical disorders which are closely associated in time with stressful event or problem and which results in significant increase of attention for the patient, personal or medical care should also be classified here.
- Swelling, movement on the skin and paraesthesias (tingling or/and numbness) are common.
- Disorders included in this category:
  a) “globus hystericus
  b) psychogenic torticollis and other disorders of spasmodic movement (excluding Tourette’s syndrome)
  c) psychogenic pruritus but excluding specific skin lesions such as alopecia, dermatitis eczema, or urticaria of psychogenic origin

F45.9 Somatoform Disorder, Unspecified

Includes unspecified physiological or psychosomatic disorder in patients whose symptoms and associated disability do not fit the full criteria for other somatoform disorders. The treatment and the outcome however do not considerably differ

Other Neurotic Disorders

F48 Other neurotic disorders

F48.0 Neurasthenia

F48.1 Depersonalization–derealization syndrome

F48.8 Other specified neurotic disorders

F48.9 Neurotic disorder, unspecified