CHAPTER OUTLINE

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- Treatment of Dissociative Disorders

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**Summing Up 241–242**
We Share a Single Body

Elaina is a licensed clinical therapist. Connie is a nurse. Sydney is a delightful little girl who likes to collect bugs in an old mayonnaise jar. Lynn is shy and has trouble saying her l’s, and Heather—Heather is a teenager trying hard to be grown-up. We are many different people, but we have one very important thing in common: We share a single body. . . .

We have dozens of different people living inside us, each with our own memories, talents, dreams, and fears. Some of us “come out” to work or play or cook or sleep. Some of us only watch from inside. Some of us are still lost in the past, a tortured past full of incest and abuse. And there are many who were so damaged by this past and who have fled so deep inside, we fear we may never reach them. . . .

Many of our Alter personalities were born of abuse. Some came because they were needed, others came to protect.

Leah came whenever she heard our father say, “Come lay awhile with me.” If she came, none of our other Alters would have to do those things he wanted. She could do them for us, and protect us from that part of our childhood.

Source: From “Quiet Storm,” a pseudonym used by a woman who claims to have several personalities residing within herself.
In early versions of the DSM, dissociative and somatoform disorders were classified with the anxiety disorders under the general category of “neurosis.” This grouping was based on the psychodynamic model, which holds that dissociative and somatoform disorders, as well as the anxiety disorders discussed in Chapter 6, involve maladaptive ways of managing anxiety. In the anxiety disorders, the appearance of disturbing levels of anxiety is expressed directly in behavior, such as in a phobic reaction to an object or situation. In contrast, the role of anxiety in the dissociative and somatoform disorders is inferred rather than expressed overtly in behavior. Persons with dissociative disorders manifest psychological problems, such as loss of memory or changes in identity, that, according to the psychodynamic model, keep the underlying sources of anxiety out of awareness, such as conflicts over sexual or aggressive impulses. Likewise, people with some somatoform disorders often show a strange indifference to physical problems, such as loss of vision, that would greatly concern most of us. Here, too, it was theorized that the “symptoms” mask unconscious sources of anxiety. Some theorists interpret indifference to symptoms to mean that those symptoms have an underlying benefit; that is, they help prevent anxiety from intruding into consciousness.

The DSM now separates the anxiety disorders from the other categories of neuroses—the dissociative and somatoform disorders—with which they were historically linked. Yet many practitioners continue to use the broad conceptualization of neuroses as a useful framework for classifying the anxiety, dissociative, and somatoform disorders.

**Dissociative Disorders**

The major dissociative disorders include dissociative identity disorder, dissociative amnesia, dissociative fugue, and depersonalization disorder. In each case, there is a disruption or dissociation (“splitting off”) of the functions of identity, memory, or consciousness that normally make us whole. Table 7.1 presents an overview of the dissociative disorders discussed in the text.

**Dissociative Identity Disorder**

The Ohio State campus dwelled in terror as four college women were seized, coerced to cash checks or get money from automatic teller machines, then raped. A cryptic phone call led to the capture of Billy Milligan, a 23-year-old drifter who had been dishonorably discharged from the Navy.

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**Not the Boy Next Door**

Billy wasn’t quite the boy next door. He tried twice to commit suicide while he was awaiting trial, so his lawyers requested a psychiatric evaluation. The psychologists and psychiatrists who examined Billy deduced that ten personalities dwelled inside of him. Eight were male and two were female. Billy’s personality had been fractured by a brutal childhood. The personalities displayed diverse facial expressions, memories, and vocal patterns. They performed in dissimilar ways on personality and intelligence tests.

Arthur, a sensible but phlegmatic personality, conversed with a British accent. Danny, 14, was a painter of still lifes. Christopher, 13, was normal enough, but somewhat anxious. A 3-year-old English girl went by the name of Christine. Tommy, a 16-year-old, was an antisocial personality and escape artist. It was Tommy who had enlisted in the Navy. Allen was an 18-year-old con artist. Allen also smoked. Adeleena was a 19-year-old introverted lesbian. It was she who had committed the rapes. It was probably David who had made the mysterious phone call. David was an anxious 9-year-old who wore the anguish of early childhood...
trauma on his sleeve. After his second suicide attempt, Billy had been placed in a straitjacket. When the guards checked his cell, however, he was sleeping with the straitjacket as a pillow. Tommy later explained that he was responsible for Billy’s escape.

The defense argued that Billy was afflicted with multiple personality disorder. Several alternate personalities resided within him. The alternate personalities knew about Billy, but Billy was unaware of them. Billy, the core or dominant personality, had learned as a child that he could sleep as a way of avoiding the sexual and physical abuse of his father. A psychiatrist claimed that Billy had likewise been “asleep”—in a sort of “psychological coma”—when the crimes were committed. Therefore, Billy should be judged innocent by reason of insanity.

Billy was decreed not guilty by reason of insanity. He was committed to a mental institution. In the institution, 14 additional personalities emerged. Thirteen were rebellious and labeled “undesirables” by Arthur. The fourteenth was the “Teacher,” who was competent and supposedly represented the integration of all the other personalities. Billy was released six years later.

—Adapted from Keyes, 1982

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**Table 7.1 Overview of Dissociative Disorders**

<table>
<thead>
<tr>
<th>TYPE OF DISORDER</th>
<th>Lifetime Prevalence in Population (approx.)</th>
<th>Description</th>
<th>Associated Features</th>
</tr>
</thead>
</table>
| Dissociative Identity Disorder | Unknown                                     | Emergence of two or more distinct personalities                            | • Alternates may vie for control  
• May represent a psychological defense against severe childhood abuse or trauma      |
| Dissociative Amnesia    | Unknown                                     | Inability to recall important personal material that cannot be accounted for by medical causes | • Information lost to memory is usually of traumatic or stressful experiences  
• Subtypes include localized amnesia, selective amnesia, and generalized amnesia     |
| Dissociative Fugue      | 0.2% (2 people in 1,000)                    | Amnesia “on the run”; the person travels to a new location and is unable to remember personal information or reports a past filled with false information not recognized as false | • Person may be confused about his or her personal identity or assumes a new identity  
• Person may start a new family or business                                          |
| Depersonalization Disorder | Unknown                                     | Episodes of feeling detached from one’s self or one’s body or having a sense of unreality about one’s surroundings (derealization) | • Person may feel as if he or she were living in a dream or acting like a robot  
• Episodes of depersonalization are persistent or recurrent and cause significant distress |

*Source: APA, 2000.*
**dissociative identity disorder**

A dissociative disorder in which a person has two or more distinct, or alter, personalities.

The term *split personality* refers to schizophrenia.

**FALSE.** The term *split personality* refers to multiple personality, not schizophrenia.

Billy was diagnosed with multiple personality disorder, which is now called **dissociative identity disorder.** In dissociative identity disorder, two or more personalities—each with well-defined traits and memories—“occupy” one person. They may or may not be aware of one another. In some isolated cases, alternate personalities (also called *alter personalities*) may even show different EEG records, allergic reactions, responses to medication, and even different eyeglass prescriptions (Birnbaum, Martin, & Thomann, 1996; S. D. Miller et al., 1991; S. D. Miller & Triggiano, 1991). Or one personality may be color blind, whereas others are not (Braun, 1986). These findings are based on isolated case reports; if they stand up to further scientific scrutiny, they would offer a remarkable illustration of the diversity of physiological patterns that are possible within the same person.

Dissociative identity disorder, which is often called “multiple personality” or “split personality” by laypeople, should not be confused with schizophrenia. Schizophrenia (which comes from roots that mean “split brain”) occurs much more commonly than multiple personality and involves the “splitting” of cognition, affect, and behavior. In a person with schizophrenia, there may be little agreement between thoughts and emotions, or between perceptions of reality and what is truly happening. The person with schizophrenia may become giddy when told of disturbing events or may experience hallucinations or delusions (see Chapter 12). In people with multiple personality, the personality apparently divides into two or more personalities, but each of them usually shows more integrated functioning on cognitive, affective, and behavioral levels than is true of people with schizophrenia.

Celebrated cases of multiple personality have been depicted in the popular media. One became the subject of the 1950s film *The Three Faces of Eve.* In the film, Eve White is a timid housewife who harbors two other personalities: Eve Black, a sexually provocative, antisocial personality, and Jane, a balanced, developing personality who could balance her sexual needs with the demands of social acceptability. The three faces eventually merged into one—Jane, providing a “happy ending.” The real-life Eve, whose name was Chris Sizemore, failed to maintain this integrated personality. Her personality reportedly split into 22 subsequent personalities. A second well-known case is that of Sybil. Sybil was played by Sally Field in the film of the same name and reportedly had 16 personalities.

**The Three Faces of Eve.** In the classic film *The Three Faces of Eve,* a timid housewife, Eve White (left) harbors two alter personalities: Eve Black (middle), a libidinous and antisocial personality, and Jane (right), an integrated personality who can accept her sexual and aggressive urges but still engage in socially appropriate behavior. In the film, the three personalities are successfully integrated. In real life, however, the person depicted in the film reportedly split into 22 personalities later on.
Features In some cases, the host (main) personality is unaware of the existence of the other identities, whereas the other identities are aware of the existence of the host (Dorahy, 2001). In other cases, the different personalities are completely unaware of one another. Sometimes two personalities vie for control of the person. Sometimes there is one dominant or core personality and several subordinate personalities. Some of the more common alter personalities include children of various ages, adolescents of the opposite gender, prostitutes, and gay males and lesbians. Some of the personalities may show psychotic symptoms—a break with reality expressed in the form of hallucinations and delusional thinking.

All in all, the clusters of alter personalities serve as a microcosm of conflicting urges and cultural themes. Themes of sexual ambivalence (sexual openness vs. restrictiveness) and shifting sexual orientations are particularly common. It is as if conflicting internal impulses cannot coexist or achieve dominance. As a result, each is expressed as the cardinal or steering trait of an alternate personality. The clinician can sometimes elicit alternate personalities by inviting them to make themselves known, as in asking, “Is there another part of you that wants to say something to me?” The following case illustrates the emergence of an alternate personality.

Harriet Emerges: A Case of Dissociative Identity Disorder

[Margaret explained that] she often “heard a voice telling her to say things and do things.” It was, she said, “a terrible voice” that sometimes threatened to “take over completely.” When it was finally suggested to [Margaret] that she let the voice “take over,” she closed her eyes, clenched her fists, and grimaced for a few moments during which she was out of contact with those around her. Suddenly she opened her eyes and one was in the presence of another person. Her name, she said, was “Harriet.” Whereas Margaret had been paralyzed, and complained of fatigue, headache and backache, Harriet felt well, and she at once proceeded to walk unaided around the interviewing room. She spoke scornfully of Margaret’s religiousness, her invalidism, and her puritanical life, professing that she herself liked to drink and “go partying” but that Margaret was always going to church and reading the Bible. “But,” she said impishly and proudly, “I make her miserable—I make her say and do things she doesn’t want to.” At length, at the interviewer’s suggestion, Harriet reluctantly agreed to “bring Margaret back,” and after more grimacing and fist clenching, Margaret reappeared, paralyzed, complaining of her headache and backache, and completely amnesiac for the brief period of Harriet’s release from prison.

—From Nemiah, 1978, pp. 179–180

Like Billy Milligan, Chris Sizemore, and Margaret, the dominant personality is often unaware of the existence of the alter personalities. The alter personalities may also lack any memory of the events experienced by other alters (Huntjens et al., 2005). It thus seems that unconscious processes control the underlying mechanism that results in dissociation, or splitting off of awareness. There may even be “interpersonality rivalry” in which one personality aspires to do away with another, usually in ignorance of the fact that murdering an alternate would result in the death of all.

Although women constitute the majority of cases of multiple personality, the proportion of males diagnosed with the disorder has been on the rise (Goff & Summs, 1993). Women with the disorder tend to have more alternate identities, averaging 15 or more, than do men, who average about 8 alter identities (APA, 2000). The reasons for this difference remain unknown.

The diagnostic features of dissociative identity disorder are listed in Table 7.2.

Controversies Although multiple personality is generally considered rare, the very existence of the disorder continues to arouse debate. Many professionals express profound doubts about the diagnosis (Pope et al., 1999).
Only a handful of cases worldwide were reported from 1920 to 1970, but since then the number of reported cases has skyrocketed into the thousands (Spanos, 1994). This may indicate that multiple personality is more common than was earlier believed. However, it is also possible that the disorder has been overdiagnosed in highly suggestible people who might simply be following suggestions that they might have the disorder (APA, 2000). Increased public attention paid to the disorder in recent years may also account for the perception that its prevalence is greater than was commonly believed.

The disorder does appear to be culture-bound and largely restricted to North America (Spanos, 1994). Relatively few cases have been reported elsewhere, even in such Western countries as Great Britain and France. A recent survey in Japan failed to find even one case, and in Switzerland, 90% of the psychiatrists polled had never seen a case of the disorder (Modestin, 1992; Spanos, 1994). Even in North America, few psychologists and psychiatrists have ever encountered a case of multiple personality. Most cases are reported by a relatively small number of investigators and clinicians who strongly believe in the existence of the disorder. Critics wonder if they may be helping to manufacture that which they are seeking.

Some leading authorities, such as the late psychologist Nicholas Spanos, believe so. Spanos and others have challenged the existence of dissociative identity disorder (Reisner, 1994; Spanos, 1994). To Spanos, dissociative identity is not a distinct disorder, but a form of role-playing in which individuals first come to construe themselves as having multiple selves and then begin to act in ways that are consistent with their conception of the disorder. Eventually their role-playing becomes so ingrained that it becomes a reality to them. Perhaps their therapists or counselors unintentionally planted the idea in their minds that their confusing welter of emotions and behaviors may represent different personalities at work. Impressionable people may have learned how to enact the role of persons with the disorder by watching others on television and in the movies. Films such as *The Three Faces of Eve* and *Sybil* have given detailed examples of the behaviors that characterize multiple personalities. Or perhaps therapists provided cues about the features of multiple personality.

Once the role is established, it may be maintained through social reinforcement, such as attention from others and avoidance of accountability for unacceptable behavior. This is not to suggest that people with multiple personalities are “faking,” any more than you are faking when you perform different daily roles as student, spouse, or worker. You may enact the role of a student (e.g., sitting attentively in class, raising your hand when you wish to talk) because you have learned to organize your behavior according to the nature of the role and because you have been rewarded for doing so. People with multiple personalities may have come to identify so closely with the role that it becomes real for them.

### Table 7.2

**Features of Dissociative Identity Disorder (Formerly Multiple Personality Disorder)**

<table>
<thead>
<tr>
<th>Feature</th>
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<tbody>
<tr>
<td>1. At least two distinct personalities exist within the person, with each having a relatively enduring and distinct pattern of perceiving, thinking about, and relating to the environment and the self.</td>
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<tr>
<td>2. Two or more of these personalities repeatedly take complete control of the individual’s behavior.</td>
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<tr>
<td>3. There is a failure to recall important personal information too substantial to be accounted for by ordinary forgetfulness.</td>
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<tr>
<td>4. The disorder cannot be accounted for by the effects of a psychoactive substance or a general medical condition.</td>
</tr>
</tbody>
</table>

*Source: Adapted from the *DSM-IV-TR* (APA, 2000).*
Relatively few cases of multiple personality involve criminal behavior, so the incentives for enacting a multiple personality role do not often relieve individuals of criminal responsibility for their behavior. But there still may be benefits to enacting the role of a multiple personality, such as a therapist’s expression of interest and excitement at discovering a multiple personality. People with multiple personalities were often highly imaginative during childhood. Accustomed to playing games of “make believe,” they may readily adopt alternate identities, especially if they learn how to enact the multiple personality role and there are external sources of validation, such as a clinician’s interest and concern.

The social reinforcement model may help to explain why some clinicians seem to “discover” many more cases of multiple personality than others. These clinicians may unknowingly cue clients to enact the multiple personality role and then reinforce the performance with extra attention and concern. With the right set of cues, certain clients may adopt the role of a multiple personality to please their clinicians. Some authorities have challenged the role-playing model (e.g., Gleaves, 1996), and it remains to be seen how many cases of the disorder in clinical practice the model can explain.

Whether dissociative identity disorder is a real phenomenon or a form of role-playing, there is no question that people who display this behavior have serious emotional and behavioral difficulties. Moreover, the diagnosis may not be all that unusual among some subgroups in the population, such as psychiatric inpatients. In one study of 484 adult psychiatric inpatients, at least 5% showed evidence of multiple personality (Ross et al., 1991). We have noted a tendency for claims of multiple personality to spread on inpatient units. In one case, Susan, a prostitute admitted for depression and suicidal thoughts, claimed that she could only exchange sex for money when “another person” inside her emerged and took control. Upon hearing this, another woman, Ginny—a child abuser who had been admitted for depression after her daughter had been removed from her home by social services—claimed that she only abused her daughter when another person inside of her assumed control of her personality. Susan’s chart recommended that she be evaluated further for multiple personality disorder (the term used at the time to refer to the disorder), but Ginny was diagnosed with a depressive disorder and a personality disorder, not with multiple personality disorder.

Suicidal behavior is common among people with multiple personalities. Seventy-two percent of the cases in a Canadian study (Ross et al., 1989) had attempted suicide, and about 2% had succeeded.

**Dissociative Amnesia**

Dissociative amnesia is believed to be the most common type of dissociative disorder (Maldonado, Butler, & Spiegel, 1998). *Amnesia* derives from the Greek roots *a-*, meaning “not,” and *mnasthai*, meaning “to remember.” In **dissociative amnesia** (formerly called *psychogenic amnesia*), the person becomes unable to recall important personal information, usually involving traumatic or stressful experiences, in a way that cannot be accounted for by simple forgetfulness. Nor can the memory loss be attributed to a particular organic cause, such as a blow to the head or a particular medical condition, or to the direct effects of drugs or alcohol. Unlike some progressive forms of memory impairment (such as dementia associated with Alzheimer’s disease; see Chapter 15), the memory loss in dissociative amnesia is reversible, although it may last for days, weeks, or even years. Recall of dissociated memories may happen gradually but often occurs suddenly and spontaneously, as when the soldier who has no recall of a battle for several days afterward suddenly remembers being transported to a hospital away from the battlefield.

Memories of childhood sexual abuse are sometimes recovered during the course of psychotherapy or hypnosis. The sudden emergence of such memories has become a source of major controversy within the field and the general community, as we explore in the *Controversies in Abnormal Psychology* feature.
Amnesia is not ordinary forgetfulness, such as forgetting someone’s name or where you left your car keys. Memory loss in amnesia is more profound or wide ranging. Dissociative amnesia is divided into five distinct types of memory problems.

1. **Localized amnesia.** Most cases take the form of localized amnesia in which events occurring during a specific time period are lost to memory. For example, the person cannot recall events for a number of hours or days after a stressful or traumatic incident, such as a battle or car accident.

2. **Selective amnesia.** In selective amnesia, people forget only the disturbing particulars that take place during a certain period of time. A person may recall the period of life during which he conducted an extramarital affair, but not the guilt-arousing affair itself. A soldier may recall most of the battle, but not the death of his buddy.

3. **Generalized amnesia.** In generalized amnesia, people forget their entire lives—who they are, what they do, where they live, whom they live with. This form of amnesia is very rare, although you wouldn’t think so if you watch daytime soap operas. Persons with generalized amnesia cannot recall personal information, but they tend to retain their habits, tastes, and skills. If you had generalized amnesia, you would still know how to read, although you would not recall your elementary school teachers. You would still prefer French fries to baked potatoes—or vice versa.

4. **Continuous amnesia.** In this form of amnesia, the person forgets everything that occurred from a particular point in time up to and including the present.

5. **Systematized amnesia.** Finally, in systematized amnesia, the memory loss is specific to a particular category of information, such as memory about one’s family or particular people in one’s life.

People with dissociative amnesia usually forget events or periods of life that were traumatic—that generated strong negative emotions, such as horror or guilt. Consider the case of Rutger.

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**Rutger: A Case of Dissociative Amnesia**

He was brought to the emergency room of a hospital by a stranger. He was dazed and claimed not to know who he was or where he lived, and the stranger had found him wandering in the streets. Despite his confusion, it did not appear that he had been drinking or abusing drugs or that his amnesia could be attributed to physical trauma. After staying in the hospital for a few days, he awoke in distress. His memory had returned. His name was Rutger and he had urgent business to attend to. He wanted to know why he had been hospitalized and demanded to leave. At the time of admission, Rutger appeared to be suffering from generalized amnesia: He could not recall his identity or the personal events of his life. But now that he was requesting discharge, Rutger showed localized amnesia for the period between entering the emergency room and the morning he regained his memory for prior events.

Rutger provided information about the events prior to his hospitalization that was confirmed by the police. On the day when his amnesia began, Rutger had killed a pedestrian with his automobile. There had been witnesses, and the police had voiced the opinion that Rutger—although emotionally devastated—was blameless in the incident. Rutger was instructed, however, to fill out an accident report and to appear at the inquest. Still nonplussed, Rutger filled out the form at a friend’s home. He accidentally left his wallet and his identification there. After placing the form in a mailbox, Rutger became dazed and lost his memory.

Although Rutger was not responsible for the accident, he felt awful about the pedestrian’s death. His amnesia was probably connected with feelings of guilt, the stress of the accident, and concerns about the inquest.

—Adapted from Cameron, 1963, pp. 355–356
CONTROVERSIES IN ABNORMAL PSYCHOLOGY

Are Recovered Memories Credible?

A high-level business executive’s comfortable life fell apart one day when his 19-year-old daughter accused him of having repeatedly molested her throughout her childhood. The executive lost his marriage as well as his $400,000-a-year job. But he fought back against the allegations, which he insisted were untrue. He sued his daughter’s therapists, who had helped her recover these memories. A jury sided with the businessman, awarding him $500,000 in damages from the two therapists.

This case is but one of many involving adults who claim to have only recently become aware of memories of childhood sexual abuse. Hundreds of people throughout the country have been brought to trial on the basis of recovered memories of childhood abuse, with many of these cases resulting in convictions and long jail sentences, even in the absence of corroborating evidence. Such recovered memories often occur following suggestive probing by a therapist or hypnotist (Loftus, 1993). The issue of recovered memories continues to be hotly debated in psychology and the broader community. At the heart of the debate is the question, “Are recovered memories believable?” No one doubts that childhood sexual abuse is a major problem confronting our society. But should recovered memories be taken at face value?

Several lines of evidence lead us to question the validity of recovered memories. Experimental evidence shows that false memories can be created, especially under the influence of leading or suggestive questioning (Begley, 2001b; Gleaves et al., 2004; Kihlstrom, 2004; Loftus, 1997; Zoellner et al., 2000). Memory for events that never happened may be created; they may seem just as genuine as memories of real events (Zola, 1999). Moreover, although people who have experienced actual abuse in childhood may be somewhat sketchy on the details, total amnesia concerning the trauma is rare (Wakefield & Underwager, 1996). A leading memory expert, psychologist Elizabeth Loftus (1996, p. 356), writes of the dangers of taking recovered memories at face value:

After developing false memories, innumerable “patients” have torn their families apart, and more than a few innocent people have been sent to prison. This is not to say that people cannot forget horrible things that have happened to them; most certainly they can. But there is virtually no support for the idea that clients presenting for therapy routinely have extensive histories of abuse of which they are completely unaware, and that they can be helped only if the alleged abuse is resurrected from their unconscious.

Should we conclude, then, that recovered memories are bogus? Not necessarily. Both false memories and recovered true memories may exist (Gleaves et al., 2004). It is possible for adults to suddenly recover memories of long-forgotten childhood experiences (Melchert, 1996), including memories of abuse (Chu et al., 1999). All in all, some recovered memories may be true; others may not be (Brown, 1997; Rubin, 1996).

In sum, we shouldn’t think of the brain as a kind of mental camera that stores snapshots of events as they actually happened in the form of memories. Memory is more of a reconstructive process in which bits of information are pieced together in ways that can sometimes lead to a distorted recollection of events, although the person may be convinced the memory is accurate. Unfortunately we don’t have the tools to distinguish the true memory from the false one (Clóitre, 2004; Loftus, 1993).

Critical Thinking

• Why should we not accept claims of recovered memories at face value?
• How does human memory work differently than a camera in recording events and experiences?

People sometimes claim they cannot recall certain events of their lives, such as criminal acts, promises made to others, and so forth. Falsely claiming amnesia as a way of escaping responsibility is called malingering, which refers to faking symptoms or making false claims for personal gain. We don’t have any guaranteed methods for distinguishing people with dissociative amnesia from malingers. But experienced clinicians can make reasonably well-educated guesses.

Dissociative Fugue

Fugue derives from the Latin fugere, meaning “flight.” The word fugitive has the same origin. Fugue is like amnesia “on the run.” In dissociative fugue (formerly called psychogenic fugue), the person travels suddenly and unexpectedly from his or her home or place of work, is unable to recall past personal information, and either becomes confused about his or her identity or assumes a new identity (either partially or completely) (APA, 2000). Despite these odd behaviors, the person may appear “normal” and show no other signs of mental disturbance (Maldonado et al., 1998). The person may not think about the past, or may report a past filled with false memories without recognizing them as false.

Whereas people with amnesia appear to wander aimlessly, people in a fugue state act more purposefully. Some stick close to home. They spend the afternoon in the park or in a theater, or they spend the night at a hotel under another name, usually avoiding contact with others. But the new identity is incomplete and fleeting, and the individual’s former sense of self returns in a matter of hours or a few days. Less common is a pattern in which the fugue state lasts for months or years and involves travel to distant places — sometimes far away, sometimes nearby. An individual framed for a crime he or she did not commit may suddenly disappear and turn up months later, perhaps even thousands of miles away. The fugue state continues until the individual’s memory of the trauma returns.

dissociative fugue A dissociative disorder in which one suddenly flees from one’s life situation, travels to a new location, assumes a new identity, and has amnesia for personal material.
places and assumption of a new identity. These individuals may assume an identity that is more spontaneous and sociable than their former selves, which were typically “quiet” and “ordinary.” They may establish new families and successful businesses. Although these events sound rather bizarre, the fugue state is not considered psychotic because people with the disorder can think and behave quite normally—in their new lives, that is. Then one day, quite suddenly, awareness of their past identity returns to them, and they are flooded with old memories. Now they typically do not recall the events that occurred during the fugue state. The new identity, the new life—including all its involvements and responsibilities—vanish from memory.

Fugue, like amnesia, is relatively rare and is believed to affect only about 2 people in 1,000 within the general population (APA, 2000). It is most likely to occur in wartime or in the wake of another kind of disaster or extremely stressful event. The underlying notion is that dissociation in the fugue state protects one from traumatic memories or other sources of emotionally painful experiences or conflict (Maldonado et al., 1998).

Fugue can also be difficult to distinguish from malingering. That is, persons who were dissatisfied with their former lives could claim to have amnesia when they are discovered in their new locations and new identities. Let us consider a case that could lead to varying interpretations (Spitzer et al., 1989).

Burt or Gene? A Case of Dissociative Fugue?

The man told the police that his name was Burt Tate. “Burt,” a 42-year-old white male, had gotten into a fight at the diner where he worked. When the police arrived, they found that he carried no identification. He told them he had drifted into town a few weeks earlier, but could not recall where he had lived or worked before arriving in town. Although no charges were pressed against him, the police prevailed upon him to come to the emergency room for evaluation. “Burt” knew the town he was in and the current date and recognized that it was somewhat unusual that he couldn’t remember his past, but he didn’t seem concerned about it. There was no evidence of any physical injuries, head trauma, or drug or alcohol abuse. The police made some inquiries and discovered that “Burt” fit the profile of a missing person, Gene Saunders, who had disappeared a month earlier from a city some 2,000 miles away. Mrs. Saunders was called in and confirmed that “Burt” was indeed her husband. She reported that her husband, who had worked in middle-level management in a manufacturing company, had been having difficulty at work before his disappearance. He was passed over for promotion and his supervisor was highly critical of his work. The job stress apparently affected his behavior at home. Once easygoing and sociable, he withdrew into himself and began to criticize his wife and children. Then, just before his disappearance, he had a violent argument with his 18-year-old son. His son called him a “failure” and stormed out the door. Two days later, the man disappeared. When he came face to face with his wife again, he claimed he didn’t recognize her, but appeared visibly nervous.

—Adapted from Spitzer et al., 1994, pp. 254–255
Although the presenting evidence supported a diagnosis of dissociative fugue, clinicians can find it difficult to distinguish true amnesia from amnesia that is faked to allow a person to start a new life.

**Depersonalization Disorder**

**Depersonalization** is a temporary loss or change in the usual sense of our own reality. In a state of depersonalization, people feel detached from themselves and their surroundings. They may feel as if they are dreaming or acting like a robot (Guralnik, Schmeidler, & Simeon, 2000; Sierra et al., 2006).

**Derealization**—a sense of unreality about the external world involving odd changes in the perception of one’s surroundings or in the passage of time—may also be present. People and objects may seem to change in size or shape and sounds may seem different. All these feelings can be associated with feelings of anxiety, including dizziness and fears of going insane, or with depression.

Although these sensations are strange, people with depersonalization maintain contact with reality. They can distinguish reality from unreality, even during the depersonalization episode. In contrast to generalized amnesia and fugue, they know who they are. Their memories are intact and they know where they are—even if they do not like their present state. Feelings of depersonalization usually come on suddenly and fade gradually.

Note that we have thus far described only normal feelings of depersonalization. Healthy people frequently experience transient episodes of depersonalization and derealization (Hunter et al., 2003). According to the DSM, about half of all adults experience single brief episodes of depersonalization, usually during times of extreme stress (APA, 2000). About 80% to 90% of people in the general population have dissociative experiences at one time or another (Gershuny & Thayer, 1999).

Given the commonness of occasional dissociative symptoms, Richie’s experience is not atypical.

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**Depersonalization at Disney World**

We went to Orlando with the children after school let out. I had also been driving myself hard, and it was time to let go. We spent three days “doing” Disney World, and it got to the point where we were all wearing shirts with mice and ducks on them and singing Disney songs. On the third day I began to feel unreal and ill at ease while we were watching these middle-American Ivory-soap teenagers singing and dancing in front of Cinderella’s Castle. The day was finally cooling down, but I broke into a sweat. I became shaky and dizzy and sat down on the cement next to the 4-year-old’s stroller without giving [my wife] an explanation. There were strollers and kids and [adults'] legs all around me, and for some strange reason I became fixated on the pieces of popcorn strewn on the ground. All of a sudden it was like the people around me were all silly mechanical creatures, like the dolls in the “It’s a Small World” [exhibit] or the animals on the “Jungle Cruise.” Things sort of seemed to slow down, the way they do when you’ve smoked marijuana, and there was this invisible wall of cotton between me and everyone else.

Then the concert was over and my wife was like “What’s the matter?” and did I want to stay for the Electrical Parade and the fireworks or was I sick? Now I was beginning to wonder if I was going crazy and I said I was sick, that my wife would have to take me by the hand and drive us back to the Sonesta Village [motel]. Somehow we got back to the monorail and turned in the strollers. I waited in the herd [of people] at the station like a dead person, my eyes glazed over, looking out over kids with Mickey Mouse ears and Mickey Mouse balloons. The mechanical voice on the monorail almost did me in and I got really shaky.

I refused to go back to the Magic Kingdom. I went with the family to Sea World, and on another day I dropped [my wife] and the kids off at the Magic Kingdom and picked them up that night. My wife thought I was goldbricking or something, and we had a helluva fight about it, but we had a life to get back to and my sanity had to come first.

—From the Author’s Files

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**Depersonalization** Episodes of depersonalization are characterized by feelings of detachment from oneself. During an episode, it may feel as if one were walking through a dream or observing the environment or oneself from outside one’s body.

**Derealization** A sense of unreality about the outside world.
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Richie’s depersonalization experience was limited to the one episode and would not qualify for a diagnosis of depersonalization disorder. Depersonalization disorder is diagnosed only when such experiences are persistent or recurrent and cause marked distress. The DSM diagnoses depersonalization disorder according to the criteria shown in Table 7.3. Note the following case example.

**TABLE 7.3**

<table>
<thead>
<tr>
<th>Diagnostic Features of Depersonalization Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recurrent or persistent experiences of depersonalization, which are characterized by feelings of detachment from one’s mental processes or body, as if one were an outside observer of oneself. The experience may have a dreamlike quality.</td>
</tr>
<tr>
<td>2. The individual is able to maintain reality testing (i.e., distinguish reality from unreality) during the depersonalization state.</td>
</tr>
<tr>
<td>3. The depersonalization experiences cause significant personal distress or impairment in one or more important areas of functioning, such as social or occupational functioning.</td>
</tr>
<tr>
<td>4. Depersonalization experiences cannot be attributed to other disorders or to the direct effects of drugs, alcohol, or medical conditions.</td>
</tr>
</tbody>
</table>

Source: Adapted from the *DSM-IV-TR* (APA, 2000).

**depersonalization disorder** A disorder characterized by persistent or recurrent episodes of depersonalization.

Richie’s depersonalization experience was limited to the one episode and would not qualify for a diagnosis of depersonalization disorder. Depersonalization disorder is diagnosed only when such experiences are persistent or recurrent and cause marked distress. The DSM diagnoses depersonalization disorder according to the criteria shown in Table 7.3. Note the following case example.

**A Case of Depersonalization Disorder**

A 20-year-old college student feared that he was going insane. For two years, he had increasingly frequent experiences of feeling “outside” himself. During these episodes, he experienced a sense of “deadness” in his body, and felt wobbly, frequently bumping into furniture. He was more apt to lose his balance during episodes that occurred when he was out in public, especially when he was feeling anxious. During these episodes, his thoughts seemed “foggy,” reminding him of his state of mind when he was given shots of a pain-killing drug for an appendectomy five years earlier. He tried to fight off these episodes when they occurred, by saying “stop” to himself and by shaking his head. This would temporarily clear his head, but the feeling of being outside himself and the sense of deadness would shortly return. The disturbing feelings would gradually fade away over a period of hours. By the time he sought treatment, he was experiencing these episodes about twice a week, each one lasting from three to four hours. His grades remained unimpaired, and had even improved in the past several months, because he was spending more time studying. However, his girlfriend, in whom he had confided his problem, felt that he had become totally absorbed in himself and threatened to break off their relationship if he didn’t change. She had also begun to date other men.

—Adapted from Spitzer et al., 1994, pp. 270–271

In terms of observable behavior and associated features, depersonalization may be more closely related to anxiety disorders such as phobias and panic disorder than to dissociative disorders. Unlike other forms of dissociative disorders that seem to protect the self from anxiety, depersonalization can lead to anxiety and in turn to avoidance behavior, as we saw in the case of Richie.

Cultural influences have an important bearing on the development and expression of abnormal behavior patterns, including dissociative syndromes such as depersonalization disorder. For example, evidence suggests that depersonalization experiences may be more common in individualistic cultures that emphasize
individualism or self-identity, such as the United States, than in collectivistic cultures, which emphasize group identity and responsibility to one’s social roles and obligations (Sierra et al., 2006). As we explore next, dissociative disorders may also take very different forms in different cultures.

Culture-Bound Dissociative Syndromes

Similarities exist between the Western concept of dissociative disorder and certain culture-bound syndromes found in other parts of the world. For example, amok is a culture-bound syndrome occurring primarily in southeast Asian and Pacific Island cultures that describes a trancelike state in which a person suddenly becomes highly excited and violently attacks other people or destroys objects (see Chapter 3). People who “run amuck” may later claim to have no memory of the episode or recall feeling as if they were acting like a robot. Another example is zar, a term used in countries in North Africa and the Middle East to describe spirit possession in people who experience dissociative states. During these states, individuals engage in unusual behavior, ranging from shouting to banging their heads against the wall.

Theoretical Perspectives

The dissociative disorders are fascinating and perplexing phenomena. How can one’s sense of personal identity become so distorted that one develops multiple personalities, blots out large chunks of personal memory, or develops a new identity? Although these disorders remain in many ways mysterious, some clues provide insights into their origins.
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Games of make-believe. It is normal for children to play games of make-believe and even to have imaginary playmates. In the case of multiple personalities, however, games of make-believe and the invention of imaginary playmates may be used as psychological defenses against abuse. Research suggests that most people who develop multiple personalities where abused as children.

Psychodynamic Views To psychodynamic theorists, dissociative disorders involve the massive use of repression, resulting in the “splitting off” from consciousness of unacceptable impulses and painful memories. Dissociative amnesia may serve an adaptive function of disconnecting or dissociating one’s conscious self from awareness of traumatic experiences or other sources of psychological pain or conflict (Dorahy, 2001). In dissociative amnesia and fugue, the ego protects itself from anxiety by blotting out disturbing memories or by dissociating threatening impulses of a sexual or aggressive nature. In dissociative identity disorder, people may express these unacceptable impulses through the development of alternate personalities. In depersonalization, people stand outside themselves—safely distanced from the emotional turmoil within.

Social-Cognitive Theory From the standpoint of social-cognitive theory, we can conceptualize dissociation in the form of dissociative amnesia or dissociative fugue as a learned response involving the behavior of psychologically distancing oneself from disturbing memories or emotions. The habit of psychologically distancing oneself from these matters, such as by splitting them off from consciousness, is negatively reinforced by relief from anxiety or removal of or of feelings of guilt or shame. As for example, shielding oneself from memories or emotions associated with past physical or sexual abuse by disconnecting (dissociating) them off from ordinary consciousness avoids anxiety or misplaced guilt these experiences may engender.

Some social-cognitive theorists, such as the late Nicholas Spanos, believe that dissociative identity disorder is a form of role-playing acquired through observational learning and reinforcement. This is not quite the same as pretending or malingered; people can honestly come to organize their behavior patterns according to particular roles they have observed. They might also become so absorbed in role-playing that they “forget” they are enacting a role.

Brain Dysfunction Might dissociative behavior be connected with underlying brain dysfunction? Research along these lines is still in its infancy, but preliminary evidence shows structural differences in brain areas involved in memory and emotion between patients with dissociative identity disorder (DID) and healthy controls (Vermetten et al., 2006). Although intriguing, the significance of these differences in explaining DID remains to be determined. Another study showed differences in brain metabolic activity between people with depersonalization disorder and healthy subjects (Simeon et al., 2000). These findings, which point to a possible dysfunction in parts of the brain involved in body perception, may help account for the feeling of being disconnected from one’s body that is associated with depersonalization.

Diathesis–Stress Model Despite widespread evidence of severe physical or sexual abuse in childhood in the great majority of cases of dissociative identity disorder (Foote et al., 2005; Spiegel, 2006), very few severely abused children develop multiple personalities. Consistent with the diathesis–stress model, certain personality traits, such as proneness to fantasize, high ability to be hypnotized, and openness to altered states of consciousness, may predispose individuals to develop dissociative experiences in the face of extreme stress, such as traumatic abuse in childhood. (See the Tying it Together section on page 226). These personality traits in themselves do not lead to dissociative disorders (Rauschenberger & Lynn, 1995). They are actually quite common in the population. However, they may increase the risk that people who experience severe trauma will develop dissociative phenomena as a survival mechanism (Butler et al., 1996). People who are low in fantasy proneness or hypnotizability may experience the kinds of anxious, intrusive thoughts characteristic of posttraumatic stress disorder (PTSD) in the aftermath of traumatic stress, rather than dissociative experiences (Kirmayer, Robbins, & Paris, 1994).

Perhaps most of us can divide our consciousness so that we become unaware of—at least temporarily—those events we normally focus on. Perhaps most of us can thrust
the unpleasant from our minds and enact various roles—parent, child, lover, businessperson, and soldier—that help us meet the requirements of our situations. Perhaps the marvel is not that attention can be splintered, but that human consciousness is normally integrated into a meaningful whole.

**Treatment of Dissociative Disorders**

Dissociative amnesia and fugue are usually fleeting experiences that end abruptly. Episodes of depersonalization can be recurrent and persistent, and they are most likely to occur when people are undergoing periods of mild anxiety or depression. In such cases, clinicians usually focus on managing the anxiety or depression. Much of the attention in the research literature has focused on dissociative identity disorder and specifically on integrating the alter personalities into a cohesive personality structure (Burton & Lane, 2001).

Psychoanalysts seek to help people with dissociative identity disorder uncover and learn to cope with early childhood traumas. They often recommend establishing direct contact with alter personalities (Burton & Lane, 2001). The therapist may ask the client to close his or her eyes and wait for the alter personalities to emerge (Krakauer, 2001). Wilbur (1986) points out that the analyst can work with whatever personality dominates the therapy session. The therapist asks any and all personalities that come out to talk about their memories and dreams and assures them that the therapist will help them make sense of their anxieties, safely “relive” traumatic experiences, and make them conscious. The disclosure of abuse is considered essential to the therapeutic process (Krakauer, 2001). Wilbur notes that anxiety experienced during a therapy session may lead to a switch in personalities, because alter personalities were presumably developed as a means to cope with intense anxiety. But if therapy is successful, the self will be able to work through the traumatic memories and will no longer need to escape into alternate “selves” to avoid the anxiety associated with the trauma. Thus, reintegration of the personality becomes possible.

Through the process of integration, the disparate elements or “alters” are woven into a cohesive self. Here a patient speaks about this process of “making mine” those parts of the self that had been splintered off.

"Everybody's Still Here"

. . . Integration made me feel alive for the first time. When I feel things now, I know I feel them. I’m slowly learning it’s okay to feel all feelings, even unpleasant ones. The bonus is, I get to feel pleasurable feelings as well. I also don’t worry about my sanity anymore.

It’s difficult to explain even to people who try to understand what integration means to someone who has been “in parts” for a lifetime. I still talk in a “we” way sometimes. Some of my “before integration” friends assume I can now just get back to being “me”—whatever that is. They don’t realize integration is like being three all over again. I don’t know how to act in certain situations because “I” never did it before. Or I only know how to respond in fragmented ways. What does “sadness” mean to someone who doesn’t feel it continually? I don’t know sometimes when I feel sad if I really should. It’s confusing and scary being responsible for me all by myself now.

The most comforting aspect of integration for me, and what I especially want other multiples to know is: Nobody died. Everybody’s still here inside me, in their correct place without controlling my body independently. There was not a scene where everybody left except one. I am a remarkably different “brand new” person. I’ve spent months learning how to access my alters’ skills and emotions—and they are mine now. I have balance and perspective that never existed before. I’m happy and content. This isn’t about dying. It’s about celebrating living to the fullest extent possible.

—From Olson, 1997
Although we have different conceptualizations of dissociative phenomena, evidence points to a history of childhood abuse in a great many cases. The most widely held view of dissociative identity disorder is that it represents a means of coping with and surviving severe, repetitive childhood abuse, generally beginning before the age of 5 (Burton & Lane, 2001; Foote, 2005). The severely abused child may retreat into alter personalities as a psychological defense against unbearable abuse. The construction of these alter personalities allows these children to psychologically escape or distance themselves from their suffering. In the “T” case example in the opening of the chapter, one alter personality, Leah, bore the worst of the abuse for all the others. Dissociation may offer a means of escape when no other is available. In the face of continued abuse, these alter personalities may become stabilized, making it difficult for the person to maintain a unified personality. In adulthood, people with multiple personalities may use their alter personalities to block out traumatic childhood memories and their emotional reactions to them, thus wiping the slate clean and beginning life anew in the guise of alter personalities. The alter identities or personalities may also help the person cope with stressful situations or express deep-seated resentments that the individual is unable to integrate within his or her primary personality.

Compelling evidence indicates that exposure to childhood trauma, usually by a relative or caretaker, is involved in the development of dissociative disorders, especially dissociative identity disorder. The great majority of people with dissociative identity disorder report being physically or sexually abused as children (Lewis et al., 1997; Weaver & Clum, 1995). In some samples, rates of reported childhood physical or sexual abuse have ranged from 76% to 95% (Ross et al., 1990; Scroppo et al., 1998). Evidence of cross-cultural similarity comes from a study in Turkey, which showed that the great majority of dissociative identity disorder patients in one research sample reported sexual or physical abuse in childhood (Sar et al., 1996). Childhood trauma or abuse is also reported more often in cases of dissociative amnesia and depersonalization disorder than in control groups (e.g., Simeon et al., 1997, 2001).

Childhood abuse is not the only source of trauma linked to dissociative disorders. Exposure to the trauma of warfare among both civilians and soldiers plays a part in some cases of dissociative fugue and dissociative amnesia. In fugue, the stress of combat and the secondary gain of leaving the battlefield seem to be important contributors (Loewenstein, 1991). The stress of coping with severe financial problems and the wish to avoid punishment for socially unacceptable behavior are other possible antecedents to episodes of fugue (Riether & Stoudemire, 1988). High levels of stress may also be linked to depersonalization disorder (Kluft, 1988).

The Concept Map for Abnormal Psychology at the end of the chapter depicts the causal factors in dissociative disorders and approaches to treating these intriguing yet puzzling disorders. Here, in Figure 7.1, you will find an illustration of a conceptual model of dissociative identity disorder based on the diathesis–stress framework.

**FIGURE 7.1 Diathesis–stress model of dissociative identity disorder.**

In this model, exposure to severe, recurrent trauma (stress), together with certain predisposing factors (diathesis), leads in some few cases to the development of alter personalities, which over time become stabilized and strengthened by social reinforcement and blocking out of disturbing memories.
Does therapy work? Coons (1986) followed 20 “multiples” aged from 14 to 47 at time of intake for an average of 3-1/4 years. Only 5 of the subjects showed a complete reintegration of their personalities. Other therapists report significant improvement in measures of dissociative symptoms and depressive symptoms in treated patients, even in those who failed to achieve integration. However, greater symptom improvement was reported for those who achieved integration (Ellason & Ross, 1997).

Reports of the effectiveness of psychoanalytic and other forms of therapy, such as behavior therapy, rely on uncontrolled case studies. Controlled studies of treatments of dissociative identity disorder or other forms of dissociative disorder are yet to be reported (Maldonado et al., 1998). The relative infrequency of the disorder has hampered efforts to conduct controlled experiments that compare different forms of treatment with each other and with control groups. Nor do we have evidence showing psychiatric drugs or other biological approaches to be effective in bringing about an integration of various alternate personalities. Psychiatric drugs, such as the antidepressant Prozac, have also failed to produce therapeutic benefits in treating depersonalization disorder beyond those effects associated with placebos (Simeon et al., 2004). This lack of responsiveness is suggestive that depersonalization disorder is not secondary to depression.

SOMATOFORM DISORDERS

The word *somatoform* derives from the Greek *soma*, meaning “body.” In the **somatoform disorders**, people have physical (“somatic”) symptoms without an identifiable physical cause (De Gucht & Maes, 2006; Stotland, 2004). The symptoms significantly interfere with the person’s life and often lead the person to go doctor shopping in the hope of finding a medical practitioner who could explain and treat their ailments (Rief & Sharpe, 2004). Or they may hold the belief that they are gravely ill, despite reassurances from their doctors to the contrary.

The concept of somatoform disorder presumes that the physical symptoms reflect psychological factors or conflicts. For example, some people complain of problems in breathing or swallowing, or of a “lump in the throat.” Problems such as these can

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**The “Children” Should Not Feel Ashamed**

A 45-year-old woman had suffered from dissociative identity disorder throughout her life. Her dominant personality was timid and self-conscious, rather reticent about herself. But soon after she entered treatment, a group of “little ones” emerged, who cried profusely. The therapist asked to speak with someone in the personality system who could clarify the personalities that were present. It turned out that they included several children, all of whom were under 9 years of age and had suffered severe, painful sexual abuse at the hands of an uncle, a great-aunt, and a grandmother. The great-aunt was a lesbian with several voyeuristic lesbian friends. They would watch the sexual abuse, generating fear, pain, rage, humiliation, and shame.

It was essential in therapy for the “children” to come to understand that they should not feel ashamed because they had been helpless to resist the abuse.

—Adapted from Wilbur, 1986, pp. 138–139

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**somatoform disorders** A disorder characterized by complaints of physical problems or symptoms that cannot be explained by physical causes.
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malingering  Faking illness in order to avoid work or duty.

reflect overactivity of the sympathetic branch of the autonomic nervous system, which might result from anxiety. All in all, at least 20% of doctor visits involve complaints that cannot be explained medically (Rief & Sharpe, 2004).

There are several distinct types of somatoform disorders. In conversion disorder, a person may experience “paralysis” of a hand or leg that cannot be explained medically or that is inconsistent with the workings of the nervous system. In hypochondriasis, people misinterpret their physical symptoms, believing them to be signs of a serious illness, despite the fact that thorough medical evaluations fail to support their concerns. In body dysmorphic disorder, the person either has an imagined defect in appearance or exaggerates a minor physical flaw. In pain disorder, the person experiences pain in which psychological factors are held to play a prominent role. In somatization disorder, people present with many recurring physical complaints that cannot be fully explained by any known medical condition. Table 7.4 provides an overview of the somatoform disorders discussed in the text.

Somatoform disorders are not the same as malingering, or purposeful fabrication of symptoms for obvious gain (such as avoiding work). Feigning physical illness to avoid work or to qualify for disability benefits may be deceitful or even dishonest, but

Table 7.4  Overview of Somatoform Disorders

<table>
<thead>
<tr>
<th>TYPE OF DISORDER</th>
<th>Lifetime Prevalence in Population (approx.)</th>
<th>Description</th>
<th>Associated Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion Disorder</td>
<td>Reported rates vary, from 1.1 in 10,000 people to 1 in 200 people</td>
<td>Change or loss of a physical function without medical cause</td>
<td>• Emerges in context of conflicts or stressful experiences, which lends credence to its psychological origins</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• May be associated with la belle indifférence (indifference to symptoms)</td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>1% to 5%</td>
<td>Preoccupation with the belief that one is seriously ill</td>
<td>• Fear persists despite medical reassurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Tendency to interpret physical sensations or minor aches and pains as signs of serious illness</td>
</tr>
<tr>
<td>Somatization Disorder</td>
<td>0.2%–2% in women, less than 0.2% in men</td>
<td>Recurrent, multiple complaints about physical symptoms that have no clear organic basis</td>
<td>• Recurrent, multiple complaints about physical symptoms that have no clear organic basis</td>
</tr>
<tr>
<td>Body Dysmorphic Disorder</td>
<td>Unknown</td>
<td>Preoccupation with an imagined or exaggerated physical defect</td>
<td>• Person may believe that others think less of them as a person because of the perceived defect.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Person may engage in compulsive behaviors, such as excessive grooming, that aim to correct the perceived defect</td>
</tr>
<tr>
<td>Pain Disorder</td>
<td>Unknown</td>
<td>Persistent physical pain believed to be associated with psychological factors</td>
<td>• Pain severe and persistent enough to interfere with daily functioning; medical conditions and psychological factors may play important roles in accounting for the pain</td>
</tr>
</tbody>
</table>

factitious disorder A disorder characterized by intentional fabrication of psychological or physical symptoms for no apparent gain.

Münchausen syndrome A type of factitious disorder characterized by the fabrication of medical symptoms.

Is this patient really sick? Münchausen syndrome is characterized by the fabrication of medical complaints for no other apparent purpose than to gain admission to hospitals. Some Münchausen patients may produce life-threatening symptoms in their attempts to deceive doctors.
or the more puzzling forms of abnormal behavior. 

ences and continue to enact the role to escape stressors in their adult lives from repeated sexual abuse or other traumatic experiences since childhood to escape from repeated sexual abuse or other traumatic experiences since childhood. Perhaps they learned to enact a sick role in the protected hospital environment provides a sense of security that was lacking in childhood. Perhaps the hospital becomes a stage on which they can act out resentments against doctors and parents that have turned nasty and stick to their guns. They are also skillful enough actors to convince others that their complaints are genuine.

Why do patients with Münchausen syndrome fake illness or put themselves at risk by making themselves to be sick or injured? Some inject themselves with enough blood thinner and you, too, can take stage center in an emergency room.

Confronted, she denied all charges. The stuff was not hers; someone was trying to frame her; if nobody believed her, she would check out of the place and find doctors who really cared. And off she went. Later, it was learned that she had recently been in two other hospitals: The same story, same symptom and same sequence of events.

Diagnosis: Münchausen syndrome.

Münchausen patients may go to great lengths to seek a confirmatory diagnosis, such as agreeing to exploratory surgery, even though they know there is nothing wrong with them. Some inject themselves with drugs to produce symptoms such as skin rashes. When confronted with evidence of their deception, they may turn nasty and stick to their guns. They are also skillful enough actors to convince others that their complaints are genuine.

Why do patients with Münchausen syndrome fake illness or put themselves at risk by making themselves to be sick or injured? Perhaps enacting the sick role in the protected hospital environment provides a sense of security that was lacking in childhood. Perhaps the hospital becomes a stage on which they can act out resentments against doctors and parents that have been brewing since childhood.

When and Why of Normal Memory Loss.

“A woman staggered into the emergency room of a New York City hospital bleeding from the mouth, clutching her stomach and wailing with pain. Even in that setting, forever serving bleeders and clutters and wailers, there was something about her, some terrible star quality that held center stage. Her pain was larger than life.

“Tell a harrowing story: A man had seduced her, then tied her up, beaten her, forced her to surrender money and jewelry on threat of death. She had severe pain in her lower left side, and an unbearable headache.

She was admitted, and exhaustively tested. Nothing could be found; no reason for the bleeding or the pain; the specialists were left scratching their heads.

Then, one day, a hospital aide came upon these items in her bedside table: a needle, syringe, and a blood thinner called heparin. Eureka. Inject yourself with enough blood thinner and you, too, can take stage center in an emergency room.

Confronted, she denied all charges. The stuff was not hers; someone was trying to frame her; if nobody believed her, she would check out of the place and find doctors who really cared. And off she went. Later, it was learned that she had recently been in two other hospitals: The same story, same symptom and same sequence of events.

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Why do patients with Münchausen syndrome fake illness or put themselves at risk by making themselves to be sick or injured? Perhaps enacting the sick role in the protected hospital environment provides a sense of security that was lacking in childhood. Perhaps the hospital becomes a stage on which they can act out resentments against doctors and parents that have been brewing since childhood. Perhaps they are trying to identify with a parent who was often sick. Or perhaps they learned to enact a sick role in the protected hospital environment provides a sense of security that was lacking in childhood. Perhaps the hospital becomes a stage on which they can act out resentments against doctors and parents that have been brewing since childhood.

TRUTH OR FICTION

Some people show up repeatedly at hospital emergency rooms, feigning illness and seeking treatment for no apparent reason.

TRUE. People with Münchausen syndrome may show up repeatedly at emergency rooms, feigning illness and demanding treatment. Their motives remain a mystery.

MÜNCHAESEN SYNDROME BY PROXY

In her memoir entitled Sickened, Julie Gregory recounts how she was subjected to numerous X-rays and operations as a child, not because there was anything wrong with her, but to find the cause of an illness that existed only in her mother’s mind (Gregory, 2003). At age 13, Gregory underwent an invasive medical procedure, a heart catheterization, which her mother insisted upon to “get to the bottom of this thing.” When the cardiologist informed Julie’s mother that the test results were within normal limits, her mother argued for an even more invasive test involving open-heart surgery. When the doctor refused, Julie’s mother confronted him in Julie’s presence.

“Sickened

“I can’t believe it? I cannot believe this! You’re not going to dig into this and do the open-heart? I thought we had agreed to follow this through to the end, Michael. I thought you said you were committed to me on this.”

“I’m committed to finding Julie’s illness, Ms. Gregory, but Julie doesn’t need heart surgery. Usually parents are thrilled to—”

“Oh, that’s just it? That’s all you’re going to do? Just drop me like a hot potato? I mean, for crying out loud, why can’t I just have a normal kid like other mothers? I mean I’m a good mom . . .”

I’m standing behind my mother’s left leg, my eyes glued to the doctor, boring an SOS into his eyes: “Don’t make me go, don’t let her take me.”

“Ms. Gregory, I didn’t say you weren’t a good mother. But I can’t do anything else here. You need to drop the heart procedures. Period.” And with that he turned on his heels.

“Well, you’re the one who’s going to be sorry,” Mom screeches, “When this kid dies on you. That’s what. ‘Cause you’re going to get sued out the ying-yang for being such an incompetent idiot. Can’t even find out what’s wrong with a thirteen-year-old girl! You are insane! This kid is sick, you hear me? She’s sick!”


Julie’s case highlights a most pernicious form of child maltreatment called Münchausen syndrome by proxy (Rosenberg, 2003; Stutts, Hickey, & Kasdan, 2003), in which people intentionally falsely or induce physical or emotional illness or injury in a child or dependent person (Feldman, 2003).

Parents or caregivers who induce illness in their children may be trying to gain sympathy or experience the sense of control made possible by attending to a sick child. The disorder is controversial and remains under study by the psychiatric community. The controversy arises in large part because it appears to put a diagnostic label on abusive behavior. What is clear is that the disorder is linked to heinous crimes against children (Mart, 2003). In one sample case, a mother was suspected of purposely causing her 3-year-old’s repeated bouts of diarrhea (Schreier & Ricci, 2002). Sadly, the child died before authorities could intervene. In another case, a foster mother is alleged to have brought about the deaths of three children by giving them overdoses of medicines containing potassium and sodium. The chemicals induced suffocation or heart attacks.

A review of 451 cases of Münchausen syndrome by proxy reported in the scientific literature showed that 6% of the victims died (Sheridan, 2003). Typical victims were 4 years of age or under. Mothers were perpetrators in three of four cases. Cases of Münchausen syndrome by proxy often involve mysterious high fevers in children, seizures of unknown origin, and similar symptoms. Doctors typically find the illnesses to be unusual, prolonged, and unexplained. They require some medical sophistication on the part of the perpetrator.

Table 7.5

Diagnostic Features of Conversion Disorder

<table>
<thead>
<tr>
<th>Feature</th>
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<tr>
<td>1. At least one symptom or deficit involving voluntary motor or sensory functions that suggests the presence of a physical disorder.</td>
</tr>
<tr>
<td>2. Psychological factors are judged to be associated with the disorder because the onset or exacerbation of the physical symptom is linked to the occurrence of psychosocial stressors or conflict situations.</td>
</tr>
<tr>
<td>3. The person does not purposefully produce or fake the physical symptom.</td>
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<tr>
<td>4. The symptom cannot be explained as a cultural ritual or response pattern, nor can it be explained by any known physical disorder on the basis of appropriate testing.</td>
</tr>
<tr>
<td>5. The symptom causes significant emotional distress, impairment in one or more important areas of functioning, such as social or occupational functioning, or is sufficient to warrant medical attention.</td>
</tr>
<tr>
<td>6. The symptom is not restricted to complaints of pain or problems in sexual functioning, nor can it be accounted for by another mental disorder.</td>
</tr>
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</table>

Source: Adapted from the *DSM-IV-TR* (APA, 2000).

Let us now proceed to discuss several major types of somatoform disorder: conversion disorder, hypochondriasis, body dysmorphic disorder, pain disorder, and somatization disorder.

### Conversion Disorder

**Conversion disorder** is characterized by a major change in or loss of physical functioning, although no medical findings are found to account for the physical symptoms or deficits (see Table 7.5). The symptoms are not intentionally produced. The person is not malingering. The physical symptoms usually come on suddenly in stressful situations. A soldier’s hand may become “paralyzed” during intense combat, for example. The fact that conversion symptoms first appear in the context of, or are aggravated by, conflicts or stressors suggest a psychological connection (APA, 2000). Reported rates of the disorder in the general population range from as few as 1.1 in 10,000 people to perhaps as many as 1 in 200 people (APA, 2000). Like dissociative identity disorder, conversion disorder has been linked to childhood traumatization. A recent study found a higher frequency of childhood physical and sexual abuse among conversion disorder patients than among comparison patients diagnosed with mood disorders (Roelofs et al., 2002).

Conversion disorder is so named because of the psychodynamic belief that it represents the channeling, or conversion, of repressed sexual or aggressive energies into physical symptoms. Conversion disorder was formerly called *hysteria* or *hysterical neurosis*, and it played an important role in Freud’s development of psychoanalysis (see Chapter 1). Hysterical or conversion disorders seem to have been more common in Freud’s day than they are today.

According to the *DSM*, conversion symptoms mimic neurological or general medical conditions involving problems with voluntary motor (movement) or sensory functions. Some classic symptom patterns take the form of paralysis, epilepsy, problems in coordination, blindness and tunnel vision, loss of the sense of hearing or of smell, or loss of feeling in a limb (anesthesia). The bodily symptoms found in conversion disorders often do not match the medical conditions they suggest. For example, conversion epileptics, unlike true epileptic patients, may maintain control over their bladders during an attack. People whose vision is supposedly impaired may walk through the physician’s office without bumping into the furniture. People who become “incapable” of standing or walking may nevertheless perform other leg movements normally. Nonetheless, hysteria and conversion symptoms are sometimes incorrectly diagnosed in people who turn out to have underlying medical conditions (Stone et al., 2005).
Table 7.6

**Diagnostic Features of Hypochondriasis**

1. The person is preoccupied with a fear of having a serious illness or with the belief that one has a serious illness. The person interprets bodily sensations or physical signs as evidence of physical illness.
2. Fears of physical illness, or beliefs of having a physical illness, persist despite medical reassurances.
3. The preoccupations are not of a delusional intensity (the person recognizes the possibility that these fears and beliefs may be exaggerated or unfounded) and are not restricted to concerns about appearance.
4. The preoccupations cause significant emotional distress or interfere with one or more important areas of functioning, such as social or occupational functioning.
5. The disturbance has persisted for 6 months or longer.
6. The preoccupations do not occur exclusively within the context of another mental disorder.

*Source: Adapted from the DSM-IV-TR (APA, 2000).*

If you suddenly lost your vision, or if you could no longer move your legs, you would probably show understandable concern. But some people with conversion disorders, like those with dissociative amnesia, show a remarkable indifference to their symptoms, a phenomenon termed *la belle indifférence* (“beautiful indifference”) (Stone et al., 2006). The DSM advises against relying on indifference to symptoms as a factor in making the diagnosis, however, because many people cope with real physical disorders by denying or minimizing their pain or concerns, which relieves anxieties—at least temporarily.

**Hypochondriasis**

The core feature of hypochondriasis is a preoccupation or fear that one’s physical symptoms are due to a serious, underlying illness, such as cancer or heart disease. The fear persists despite medical reassurances that it is groundless (see Table 7.6). Hypochondriasis is believed to affect about 1% to 5% of the general population and about 5% of patients seeking medical care (APA, 2000; Barksy & Ahern, 2004).

People with hypochondriasis do not consciously fake their physical symptoms. They generally experience physical discomfort, often involving the digestive system or an assortment of aches and pains. Unlike conversion disorder, hypochondriasis does not involve the loss or distortion of physical function. Unlike people with conversion disorder, who are often indifferent toward their symptoms, people with hypochondriasis are very concerned, indeed unduly concerned, about their symptoms and what they fear they may mean. The disorder appears to be about equally common in men and women. It most often begins between the ages of 20 and 30, although it can begin at any age.

People with hypochondriasis may be overly sensitive to benign changes in physical sensations, such as slight changes in heartbeat and minor aches and pains (Barsky et al., 2001). Anxiety about physical symptoms can produce its own physical sensations, however—for example, heavy sweating and dizziness, even fainting. Thus, a vicious cycle may ensue. People with hypochondriasis may become resentful when their doctors tell them that their own fears may be causing their physical symptoms. They frequently go “doctor shopping” in the hope that a competent and sympathetic physician will heed them before it is too late. Physicians, too, can develop hypochondriasis, as we see in the following case example.
Dissociative and Somatoform Disorders

**Body Dysmorphic Disorder**

People with body dysmorphic disorder (BDD) are preoccupied with an imagined or exaggerated physical defect in their appearance. They may spend hours examining themselves in the mirror and go to extreme measures to correct the perceived defect, even undergoing invasive or unpleasant medical procedures, including unnecessary plastic surgery (Crerand et al., 2005). Others remove all mirrors from their homes so as not to be reminded of the glaring flaw in their appearance. People with BDD may believe that others view them as ugly or deformed and that their unattractive physical appearance leads others to think negatively of them.

Although BDD is believed to be relatively common, we don’t have specific data on the rates of the disorder because many people with the disorder fail to seek help. The condition is more likely to be diagnosed in women than in men (Leckman, 2001). Most people who meet diagnostic criteria for hypochondriasis continue to show evidence of the disorder when reinterviewed 5 years later (Barsky et al., 1998). Most also have other psychological disorders, especially major depression and anxiety disorders (Barsky, Wyshak, & Klerman, 1992; Noyes et al., 1993).

**The Doctor Feels Sick: A Case of Hypochondriasis**

Robert, a 38-year-old radiologist, has just returned from a 10-day stay at a famous diagnostic center where he has undergone extensive testing of his entire gastrointestinal tract. The evaluation proved negative for any significant physical illness, but rather than feel relieved, the radiologist appeared resentful and disappointed with the findings. The radiologist has been bothered for several months with various physical symptoms, which he describes as symptoms of mild abdominal pain, feelings of “fullness,” “bowel rumblings,” and a feeling of a “firm abdominal mass.” He has become convinced that his symptoms are due to colon cancer and has become accustomed to testing his stool for blood on a weekly basis and carefully palpating his abdomen for “masses” while lying in bed every several days. He has also secretly performed X-ray studies on himself. There is a history of a heart murmur that was detected when he was 13, and his younger brother died of congenital heart disease in early childhood. When the evaluation of his murmur proved it to be benign, he nonetheless began to worry that something might have been overlooked. He developed a fear that something was actually wrong with his heart, and while the fear eventually subsided, it has never entirely left him. In medical school he worried about the diseases that he learned about in pathology. Since graduating, he has repeatedly experienced concerns about his health that follow a typical pattern: noticing certain symptoms, becoming preoccupied with what the symptoms might mean, and undergoing physical evaluations that proved negative. His decision to seek a psychiatric consultation was prompted by an incident with his 9-year-old son. His son accidentally walked in on him while he was palpating his abdomen and asked, “What do you think it is this time, Dad?” He becomes tearful as he relates this incident, describing his feelings of shame and anger—mostly at himself.

—Adapted from Spitzer et al., 1994, pp. 88–90

**Hypochondriasis**

People who develop hypochondriasis have more health worries, have more psychiatric symptoms, and perceive their health to be worse than do other people (Noyes et al., 1993). They are also more likely than other psychiatric patients to report having been sick as children, having missed school because of health reasons, and having experienced childhood trauma, such as sexual abuse or physical violence (Barsky et al., 1994). Most people who meet diagnostic criteria for hypochondriasis continue to show evidence of the disorder when reinterviewed 5 years later (Barsky et al., 1998). Most also have other psychological disorders, especially major depression and anxiety disorders (Barsky, Wyshak, & Klerman, 1992; Noyes et al., 1993).

**What to take?** Hypochondriasis is a persistent concern or fear that one is seriously ill, although no organic basis can be found to account for one’s physical complaints. People with this disorder frequently medicate themselves with over-the-counter medications and find little if any reassurance in doctors’ assertions that their health is not in jeopardy.
Claudia checked her hair in the mirror innumerable times during the day. She would spend two hours every morning doing her hair and still wouldn’t be satisfied. Her constant pruning and checking had become a compulsive ritual. As she told her therapist, “I want to stop pulling and checking it, but I just can’t help myself.”

“Can’t you see it?” A person with body dysmorphic disorder may spend hours in front of a mirror obsessing about an imagined or exaggerated physical defect in appearance.

“Having a ‘bad hair day’ for Claudia meant that she would not go out with her friends and would spend every second examining herself in the mirror and fixing her hair. Occasionally she would cut pieces of her hair herself in an attempt to correct the mistakes of her last haircut. But cutting it herself inevitably made it even worse, in her view. Claudia was forever searching for the perfect haircut that would correct defects only she could perceive. Several years earlier she had what she described as a perfect haircut. “It was just right. I was on top of the world. But it began to look crooked when it grew in.”

Claudia related that she was taught to equate physical beauty with happiness: “I was told that to be successful you had to be beautiful. How can I be happy if I look this way?”

Pain Disorder

The major feature of somatoform pain disorder is pain associated with psychological factors, such as stressful life events. The psychological factors may contribute to the development, severity, or maintenance of the pain. The pain is severe enough and
persistent enough to interfere with the person’s daily functioning. For example, the pain may make it difficult for the person to attend school or go to work. The pain can become the major focus of the person’s life and lead to disruption of normal family life. Pain disorder appears to be relatively common, although precise estimates of its prevalence are lacking (APA, 2000).

The DSM system does not exclude the possibility that medical conditions may help explain somatoform pain disorder; both medical conditions and psychological factors can play important roles in the disorder. But when psychological factors play little if any role in the development of pain, the condition is not classified as somatoform pain disorder.

However, the distinction between medical pain and psychiatric pain presents a problem for clinicians (Sharpe & Williams, 2002). The underlying medical cause of pain is often difficult to ascertain. Because they cannot find a physical cause, clinicians may assume that psychological factors play a prominent role. On the other hand, separating “medical pain” from “psychiatric pain” may discount the important role of psychological factors, such as coping responses, in cases of pain that involve obvious medical disease. In sum, the problem of chronic pain is widespread and involves both psychological and medical factors. However, there remains a debate in the field with respect to whether somatoform pain disorder should stand on its own as a diagnosable psychological disorder (Sullivan, 2000).

**Somatization Disorder**

Somatization disorder, formerly known as Briquet’s syndrome, is characterized by multiple and recurrent somatic complaints that begin prior to the age of 30 (but usually during the teen years). These complaints persist for at least several years, and result either in the seeking of medical attention or in significant impairment in fulfilling social or occupational roles.

Somatization disorder frustrates patients, their families, and their physicians (Holder-Perkins & Wise, 2002). Complaints usually involve different organ systems. Patients’ complaints cannot be explained by physical causes or exceed what would be expected from a known physical problem. Complaints seem vague or exaggerated, and the person frequently receives medical care from a number of physicians, sometimes at the same time. Seldom does a year pass without some physical complaint that prompts a trip to the doctor, or generally, to many doctors. A study that tracked medical-care utilization of somatizing patients found them to be heavy users of medical services (Barsky, Orav, & Bates, 2005).

The essential feature of hypochondriasis is fear of disease, of what bodily symptoms may portend. Persons with somatization disorder, by contrast, are pestered by the symptoms themselves. Both diagnoses may be given to the same individual if the diagnostic criteria for both disorders are met.

Reported rates of somatization disorder vary from 0.2% to 2% in women to less than 0.2% in men (APA, 2000). The disorder is also four times more likely to occur among African Americans than other ethnic or racial groups (Swartz et al., 1991). Yet, like pain disorder, somatization disorder is controversial. Many patients, especially female patients, are misdiagnosed with psychological disorders, including somatization disorder, because modern medicine fails to identify the underlying medical basis of their physical complaints (Klonoff & Landrine, 1997).

Somatization disorder usually begins in adolescence or young adulthood and appears to be a chronic or even lifelong disorder. Although not much is known about the childhood backgrounds of people with somatization disorder, a recent study characterized the family environments in which many somatization disorder patients were raised as emotionally cold, distant, and unsupportive and wracked by a pattern of chronic emotional and physical abuse (Brown, Schrag, & Trimble, 2005).
koro syndrome A culture-bound somatoform disorder, found primarily in China, in which people fear that their genitals are shrinking.

In China in the 1980s, more than 2,000 people fell prey to the belief that their genitals were shrinking and retracting into their bodies. This condition, called koro, is classified by the DSM system as a culture-bound syndrome.

✓ TRUE. An epidemic was reported in China in which some 2,000 people fell prey to the belief that their genitals were shrinking and retracting into their bodies. This condition, called koro, is classified by the DSM system as a culture-bound syndrome.

dhat syndrome A culture-bound somatoform disorder, found primarily among Asian Indian males, characterized by excessive fears over the loss of seminal fluid.

Koro and Dhat Syndromes: Far Eastern Somatoform Disorders?

In the United States, it is common for people who develop hypochondriasis to be troubled by the idea that they have serious illnesses, such as cancer. The koro and dhat syndromes of the Far East share some clinical features with hypochondriasis. Although these syndromes may seem foreign to North American readers, each is connected with the folklore of its own culture.

Koro syndrome is a culture-bound syndrome found primarily in China and some other Far Eastern countries (Sheung-Tak, 1996). People with koro syndrome fear that their genitals are shrinking and retracting into their body, which they believe will result in death (Fabian, 1991; Goetz & Price, 1994; Tseng et al., 1992). Koro is considered a culture-bound syndrome, although some cases have been reported outside China and the Far East (e.g., Chowdhury, 1996). The syndrome has been identified mainly in young men, although some cases have also been reported in women (Tseng et al., 1992). Koro syndrome tends to be short-lived and to involve episodes of acute anxiety that one’s genitals are retracting. Physiological signs of anxiety that approach panic are common, including profuse sweating, breathlessness, and heart palpitations. Men who suffer from koro have been known to use mechanical devices, such as chopsticks, to try to prevent the penis from retracting into the body (Devan, 1987).

Koro syndrome has been traced within Chinese culture as far back as 3000 B.C.E. Epidemics involving hundreds or thousands of people have been reported in China, Singapore, Thailand, and India (Tseng et al., 1992). In Guangdong Province in China, an epidemic of koro involving more than 2,000 persons occurred during the 1980s (Tseng et al., 1992). Guangdong residents who developed koro tended to be more superstitious, lower in intelligence, and more accepting of koro-related folk beliefs (such as the belief that shrinkage of the penis will be lethal) than those who did not fall victim to the epidemic (Tseng et al., 1992). Medical reassurance that such fears are unfounded often quells koro episodes (Devan, 1987). Koro episodes among those who do not receive corrective information tend to pass with time but may recur. A number of investigators would like to see the koro syndrome incorporated into the DSM as a somatoform disorder (Bernstein & Gaw, 1990; Fishbain, 1991).

Dhat syndrome, found among young Asian Indian males, involves excessive fears over the loss of seminal fluid during nocturnal emissions (Akhtar, 1988). Some men with this syndrome also believe (incorrectly) that semen mixes with urine and is excreted through urination. Men with dhat syndrome may roam from physician to physician seeking help to prevent nocturnal emissions or the (imagined) loss of semen mixed with excreted urine. There is a widespread belief within Indian culture (and other Near and Far Eastern cultures) that the loss of semen is harmful because it depletes the body of physical and mental energy (Chadda & Ahuja, 1990). Like other culture-bound syndromes, dhat must be understood within its cultural context:

In India, attitudes toward semen and its loss constitute an organized, deep-seated belief system that can be traced back to the scriptures of the land...[even as far back as the classic Indian sex manual, the Kama Sutra, which was believed to be written by the sage Vatsayana between the third and fifth centuries A.D.]....Semen is considered to be the elixir of life, in both a physical and mystical sense. Its preservation is supposed to guarantee health and longevity.

—From Akhtar, 1988, p. 71

It is a commonly held Hindu belief that it takes “forty meals to form one drop of blood; forty drops of blood to fuse and form one drop of bone marrow, and forty drops of this to produce one drop of semen” (Akhtar, 1988, p. 71). Based on the
The term *hysteria* derives from the Greek word for testicle.

**FALSE.** The term is derived from *hystera*, the Greek word for uterus.

Dhat syndrome. Found principally in India, dhat syndrome describes men with an intense fear or anxiety over the loss of semen.

The cultural belief in the life-preserving nature of semen, it is not surprising that some Indian males experience extreme anxiety over the involuntary loss of the fluid through nocturnal emissions (Akhtar, 1988). Dhat syndrome has also been associated with difficulty in achieving or maintaining erection, apparently due to excessive concern about loss of seminal fluid through ejaculation (Singh, 1985).

**Theoretical Perspectives**

Conversion disorder, or “hysteria,” was known to the great physician of ancient Greece, Hippocrates, who attributed the strange bodily symptoms to a wandering uterus (*hystera* in Greek) creating internal chaos. Hippocrates noticed that these complaints were less common among married than unmarried women. He prescribed marriage as a “cure” on the basis of these observations and also on the theoretical assumption that pregnancy would satisfy uterine needs and fix the organ in place. Pregnancy fosters hormonal and structural changes that are of benefit to some women with menstrual complaints, but Hippocrates’s mistaken belief in the “wandering uterus” has contributed throughout the centuries to degrading interpretations of complaints by women of physical problems. Despite Hippocrates’s belief that hysteria is exclusively a female concern, it also occurs in men.

Not much is known about the biological underpinnings of somatoform disorders. However, a genetic link to somatization disorder is suggested by evidence that the disorder tends to run in families, primarily among female members (Guze, 1993). However, we cannot rule out the possibility that social influences play a part in explaining this familial association.

Brain-imaging studies of patients with hysterical paralysis (a limb the person claims to be unable to move, despite healthy muscles and nerve) points to possible disruptions occurring in brain circuitry responsible for controlling movement and emotional responses (Kinetz, 2006). These imaging studies suggest that normal control
Chapter 7

of movement may be inhibited by activation of brain circuits involved in processing emotions. We should caution that we are only at the beginning stages of understanding the biological bases of conversion disorder and much remains unknown. Like the dissociative disorders, the scientific study of conversion disorder and other forms of somatoform disorder has been largely approached from the psychological perspective, which is our focus here.

Psychodynamic Theory Hysterical disorders provided an arena for some of the debate between the psychological and biological theories of the 19th century. The alleviation—albeit often temporarily—of hysterical symptoms through hypnosis by Charcot, Breuer, and Freud contributed to the belief that hysteria was rooted in psychological rather than physical causes and led Freud to the development of a theory of the unconscious mind (see Chapter 1). Freud held that the ego manages to control unacceptable or threatening sexual and aggressive impulses arising from the id through defense mechanisms such as repression. Such control prevents the anxiety that would occur if the person were to become aware of these impulses. In some cases, the leftover emotion that is “strangulated,” or cut off, from the threatening impulses, becomes converted into a physical symptom, such as hysterical paralysis or blindness. Although the early psychodynamic formulation of hysteria is still widely held, empirical evidence has been lacking. One problem with the Freudian view is that it does not explain how energies left over from unconscious conflicts become transformed into physical symptoms (E. Miller, 1987).

According to psychodynamic theory, hysterical symptoms are functional: They allow the person to achieve primary gains and secondary gains. The primary gain of the symptoms is to allow the individual to keep internal conflicts repressed. The person is aware of the physical symptom but not of the conflict it represents. In such cases, the “symptom” is symbolic of, and provides the person with a “partial solution” for, the underlying conflict. For example, the hysterical paralysis of an arm might symbolize and also prevent the individual from acting out on repressed unacceptable sexual (e.g., masturbatory) or aggressive (e.g., murderous) impulses. Repression occurs unconsciously, so the individual remains unaware of the underlying conflicts. La belle indifférence, first noted by Charcot, is believed to occur because the physical symptoms help relieve rather than cause anxiety. From the psychodynamic perspective, conversion disorders, like dissociative disorders, serve a purpose.

Secondary gains from the symptoms are those that allow the individual to avoid burdensome responsibilities and to gain the support—rather than condemnation—of those around them. For example, soldiers sometimes experience sudden “paralysis” of their hands, which prevents them from firing their guns in battle. They may then be sent to recuperate at a hospital rather than face enemy fire. The symptoms in such cases are not considered contrived, as would be the case in malingering. A number of bomber pilots during World War II suffered hysterical “night blindness” that prevented them from carrying out dangerous nighttime missions. In the psychodynamic view, their “blindness” may have achieved a primary gain of shielding them from guilt associated with dropping bombs on civilian areas. It may also have achieved a secondary purpose of helping them avoid dangerous missions.

Learning Theory Theoretical formulations including both psychodynamic theory and learning theory, focus on the role of anxiety in explaining conversion disorders. Psychodynamic theorists, however, seek the causes of anxiety in unconscious conflicts. Learning theorists focus on the more direct reinforcing properties of the symptom and its secondary role in helping the individual avoid or escape anxiety-evoking situations.
From the learning perspective, the symptoms in conversion and other somatoform disorders may also carry the benefits, or reinforcing properties, of the “sick role.” Persons with conversion disorders may be relieved of chores and responsibilities such as going to work or performing household tasks (Miller, 1987). Being sick also usually earns sympathy and support. See Tying it Together on page 226 for a schematic representation of the psychodynamic and learning theory conceptualizations of conversion disorder.

Differences in learning experiences may explain why conversion disorders were historically more often reported among women than men. It may be that women in Western culture are more likely than men to be socialized to cope with stress by enacting a sick role (Miller, 1987). We are not suggesting that people with conversion disorders are fakers. We are merely pointing out that people may learn to adopt roles that lead to reinforcing consequences, regardless of whether they deliberately seek to enact these roles.

Some learning theorists link hypochondriasis and body dysmorphic disorder to obsessive–compulsive disorder (OCD; see Chapter 6) (e.g., Barsky et al., 1992; Buhlmann et al., 2002; Cororve & Gleaves, 2001). In hypochondriasis, people are bothered by obsessive, anxiety-inducing thoughts about their health. Running from doctor to doctor may be a form of compulsive behavior that is reinforced by the temporary relief from anxiety that patients experience when doctors assure them that their fears are unwarranted. Yet the troublesome thoughts eventually return, prompting repeated consultations. The cycle then repeats. Similarly, with body dysmorphic disorder, the constant grooming and pruning in the attempt to “fix” the perceived physical defect may offer partial relief from anxiety, but the “fix” is never quite good enough to completely erase the underlying concerns.

Cognitive Theory Cognitive theorists have speculated that some cases of hypochondriasis may represent a type of self-handicapping strategy, a way of blaming poor performance on failing health (Smith, Snyder, & Perkins, 1983). In other cases, diverting attention to physical complaints can serve as a means of avoiding thinking about other life problems.

Another cognitive explanation focuses on the role of distorted thinking. People who develop hypochondriasis have a tendency to exaggerate the significance of minor physical complaints (Barsky et al., 2001). They misinterpret benign symptoms as signs of a serious illness, which creates anxiety, which leads them to chase down one doctor after another in an attempt to uncover the dreaded disease they fear they have. The anxiety itself may lead to unpleasant physical symptoms, which are likewise exaggerated in importance, leading to more worrisome cognitions.

Cognitive theorists speculate that hypochondriasis and panic disorder, which often occur together, may share a common cause: a distorted way of thinking that leads the person to misinterpret minor changes in bodily sensations as signs of pending catastrophe (Salkovskis & Clark, 1993). Differences between the two disorders may hinge on whether the misinterpretation of bodily cues carries a perception of an imminent threat that leads to a rapid spiraling of anxiety (panic disorder) or of a longer-range threat that leads to a fear of an underlying disease process (hypochondriasis).

Given the role of anxiety in hypochondriasis and somatization disorder, investigators question whether these disorders should continue to be classified as distinct forms of somatoform disorders (Creed & Barsky, 2004). Evidence shows a high rate of co-occurrence (comorbidity) of hypochondriasis and somatization disorder with both anxiety and depressive disorders (Creed & Barsky, 2004; de Waal et al., 2004; Holder-Perkins & Wise, 2002). As the DSM-V is taking shape, some investigators are calling for a reconsideration of how the somatoform disorders are classified (e.g., De Gucht & Maes, 2006; Mayou et al., 2005).
Figure 7.2 provides a visual representation of the two leading concept models of conversion disorder (psychodynamic theory and learning theory).

Treatment of Somatoform Disorders

The treatment approach that Freud pioneered, psychoanalysis, began with the treatment of hysteria, which is now termed conversion disorder. Psychoanalysis seeks to uncover and bring unconscious conflicts that originated in childhood into conscious awareness. Once the conflict is aired and worked through, the symptom is no longer needed and should disappear. The psychoanalytic method is supported by case studies, some reported by Freud and others by his followers. However, the infrequent occurrence of conversion disorders in contemporary times has made it difficult to mount controlled studies of the psychoanalytic technique.

The behavioral approach to treating conversion disorders and other somatoform disorders focuses on removing sources of secondary reinforcement (or secondary gain) that may become connected with physical complaints. Family members and others, for example, often perceive individuals with somatization disorder as sickly and incapable of carrying normal responsibilities. This reinforces dependent and complaining behaviors. The behavior therapist may teach family members to reward attempts to assume responsibility and to ignore nagging and complaining. The behavior therapist may also work directly with patients, helping them learn more adaptive ways of handling stress or anxiety (through relaxation and cognitive restructuring, for example).

Cognitive-behavioral therapy has achieved good results in treating several types of somatoform disorders, including hypochondriasis and body dysmorphic disorder.
Dissociative and Somatoform Disorders

SUMMING UP

**Dissociative Disorders**

What are dissociative disorders? Dissociative disorders involve changes or disturbances in identity, memory, or consciousness that affect the ability to maintain an integrated sense of self. Thus, the symptoms are theorized to reflect psychological rather than organic factors.

What is dissociative identity disorder? In dissociative identity disorder, two or more distinct personalities, each possessing well-defined traits and memories, exist within the person and repeatedly take control of the person’s behavior.

What is dissociative amnesia? In dissociative amnesia, the person experiences a loss of memory for personal information that cannot be accounted for by organic causes.

What is dissociative fugue? In dissociative fugue, the person suddenly travels away from home or place of work, shows a loss of memory for his or her personal past, and experiences identity confusion or takes on a new identity.

What is depersonalization disorder? In depersonalization disorder, the person experiences persistent or recurrent episodes of depersonalization of sufficient severity to cause significant distress or impairment in functioning.

How do theorists explain the development of dissociative disorders? Psychodynamic theorists view dissociative disorders as a form of psychological defense by which the ego defends itself against troubling memories and unacceptable impulses by blotting them out of consciousness. There is increasing documentation of a link between dissociative disorders and early
childhood trauma, which lends support to the view that dissociation may serve to protect the self from troubling memories. To learning and cognitive theorists, dissociative experiences involve ways of learning not to think about certain troubling behaviors or thoughts that might lead to feelings of guilt or shame. Relief from anxiety negatively reinforces this pattern of dissociation. Some social-cognitive theorists suggest that multiple personality may represent a form of role-playing behavior.

**How is dissociative identity disorder treated?** The major form of treatment is psychotherapy aimed at achieving a reintegration of the personality by focusing on helping persons with dissociative identity disorder uncover and integrate dissociated painful experiences from childhood.

**Somatoform Disorders**

**What are somatoform disorders?** In somatoform disorders, there are physical complaints that cannot be accounted for by organic causes. Thus, the symptoms are theorized to reflect psychological rather than organic factors. Three major types of somatoform disorders are conversion disorder, hypochondriasis, and somatization disorder.

**What is Münchausen syndrome?** Münchausen syndrome, a type of factitious disorder, is characterized by the deliberate fabrication of physical symptoms for no apparent reason, other than to assume a patient role.

**What is conversion disorder?** In conversion disorder, symptoms or deficits in voluntary motor or sensory functions occur that suggest an underlying physical disorder, but no apparent medical basis for the condition can be found to account for the condition.

**What is hypochondriasis?** Hypochondriasis is a preoccupation with the fear of having, or the belief that one has, a serious medical illness, although no medical basis for the complaints can be found, and fears of illness persist despite medical reassurances.

**What is pain disorder?** Pain disorder is a type of somatoform disorder in which psychological factors are presumed to play important roles in explaining symptoms of pain.

**What is body dysmorphic disorder?** In body dysmorphic disorder, people are preoccupied with an imagined or exaggerated defect in their physical appearance.

**What is somatization disorder?** People with somatization disorder have multiple and recurrent complaints of physical symptoms that have persisted for many years and that cannot be accounted for by organic causes.

**How are somatoform disorders conceptualized within the major theoretical perspectives?** The psychodynamic view holds that conversion disorders represent the conversion into physical symptoms of the leftover emotion or energy cut off from unacceptable or threatening impulses that the ego has prevented from reaching awareness. The symptom is functional, allowing the person to achieve both primary gains and secondary gains. Learning theorists focus on reinforcements that are associated with conversion disorders, such as the reinforcing effects of adopting a “sick role.” One learning-theory model likens hypochondriasis to obsessive–compulsive behavior. Cognitive factors in hypochondriasis include possible self-handicapping strategies and cognitive distortions.

**What are the major approaches to treating somatoform disorders?** Psychodynamic therapists attempt to uncover and bring to the level of awareness the unconscious conflicts, originating in childhood, believed to be at the root of the problem. Once the conflict is uncovered and worked through, the symptoms should disappear because they are no longer needed as a partial solution to the underlying conflict. Behavioral approaches focus on removing underlying sources of reinforcement that may be maintaining the abnormal behavior pattern. More generally, behavior therapists assist people with somatoform disorders to learn to handle stressful or anxiety-arousing situations more effectively. In addition, a combination of cognitive-behavioral techniques, such as exposure with response prevention and cognitive restructuring, may be used in treating hypochondriasis and body dysmorphic disorder. Antidepressant medication may prove to be helpful in treating some forms of somatoform disorders.

**KEY TERMS**

- dissociative disorder (p. 212)
- dissociative identity disorder (p. 214)
- dissociative amnesia (p. 217)
- dissociative fugue (p. 219)
- depersonalization (p. 221)
- derealization (p. 221)
- depersonalization disorder (p. 222)
- somatoform disorders (p. 227)
- malingering (p. 228)
- factitious disorder (p. 229)
- Münchausen syndrome (p. 229)
- conversion disorder (p. 231)
- hypochondriasis (p. 232)
- body dysmorphic disorder (BDD) (p. 233)
- pain disorder (p. 234)
- somatization disorder (p. 235)
- koro syndrome (p. 236)
- dhat syndrome (p. 236)
MEDIA TOOLS

A variety of digital and online learning tools are available to enrich your learning experience and help you succeed in the course. These resources include:

- **MyPsychLab**, an online learning system for your course in abnormal psychology that allows you to test your mastery of concepts in the book by using chapter-by-chapter diagnostic tests. Results from the diagnostic tests help you build a customized study plan. To access MyPsychLab, visit www.prenhall.com/mypychlab and follow the instructions on the site.

- **“Speaking Out” Patient Interviews**, a set of video case examples of actual patients you can access on the companion CD-ROM included with the text. Icons in the margins of the chapter highlight the video case examples included on the CD-ROM.

- **Companion Web site**, an online study center that offers computer-scored quizzes you can use to test your knowledge, along with other study tools and links to related sites to enhance your learning of abnormal psychology. To access the companion web site, visit www.prenhall.com/nevid and use the various tabs and links on the site to access these learning resources.
**Dissociative Disorders**

- Disruption or dissociation of identity, memory, or consciousness

**Causes and Treatment**

- Psychotherapy aimed at reintegration of the personality in cases of dissociative identity disorder. However, studies of treatment effectiveness have been limited to isolated case examples.

- Social-environmental factors, such as severe childhood sexual or physical abuse (in dissociative identity disorder) or exposure to traumatic experiences (in dissociative amnesia and dissociative fugue).

- Social-cognitive factors, such as positive reinforcement (attention) for enacting the role of a multiple personality and negative reinforcement in the form of anxiety relief from splitting off disturbing memories (in dissociative amnesia and dissociative fugue).

- Possible biological factors, such as abnormalities in parts of the brain involved in regulating memory and emotion.

**Types**

- Dissociative Identity Disorder
- Dissociative Amnesia
- Dissociative Fugue
- Depersonalization Disorder
Somatoform Disorders

- Physical complaints not accounted for by organic causes or exaggerated concerns about physical complaints or perceived physical defects

and may be explained by causal factors including:
- Conversion Disorder
- Hypochondriasis
- Body Dysmorphic Disorder
- Pain Disorder
- Somatization Disorder

and include such types as:

- Cognitive-behavioral techniques to promote more adaptive ways of handling stress and anxiety and correct distorted beliefs about health or appearance
- Psychodynamic therapy to gain insight into underlying unconscious conflicts
- Limited uses of drug therapy in treating some types of somatoform disorder

Possible genetic factors (somatization disorder)
- Social-environmental factors, such as socialization into dependent (sick) roles
- Learning factors, such as positive reinforcement (for enacting sick role) and negative reinforcement (relief from anxiety by avoiding or escaping anxiety-evoking or burdensome situations)
- Cognitive factors, such as misinterpretations of physical symptoms
- In Freudian theory, conversion of psychic energy into physical symptoms (conversion disorder)
- Interactions among multiple factors