Anxiety, Dissociative, and Somatoform Disorders

Diagnostic Criteria for Anxiety Disorders

Diagnostic Criteria for Panic Disorder

A. Both 1 and 2:
1. Recurrent unexpected Panic Attacks
2. At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
   a. Persistent concern about having additional attacks
   b. Worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, “going crazy”)
   c. A significant change in behavior related to the attacks

B. The presence of Agoraphobia (for 300.21 Panic Disorder With Agoraphobia) OR
   The absence of Agoraphobia (for 300.01 Panic Disorder Without Agoraphobia)

C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive–Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Diagnostic Criteria for Obsessive–Compulsive Disorder

A. Either obsessions or compulsions:
   Obsessions as defined by 1, 2, 3, and 4:
   1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
   2. The thoughts, impulses, or images are not simply excessive worries about real-life problems
   3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
   4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by 1 and 2:
   1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
   2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day); or significantly interfere with the person’s normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:
   With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

Diagnostic Criteria for Anxiety Disorders

Diagnostic Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both the following were present:
   1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. The person’s response involved intense fear, helplessness, or horror.
   Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
   Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2. Recurrent distressing dreams of the event.
   Note: In children, there may be frightening dreams without recognizable content.
   3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
   Note: In young children, trauma-specific reenactment may occur.
   4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

continued
Disability, all sufferers at times demonstrate behavior different from their usual behavior. Dissociative disorders are often precipitated by a traumatic event, such as a disaster, rape, or war (Simeon, Guralnik, Knutelska, & Schmeidler, 2002).

**Dissociative Amnesia** Dissociative amnesia, memory loss not caused by an organic problem, is usually related to an acute, precipitating, traumatic event. The most common type is localized amnesia, in which memory loss occurs for a specific time related to the trauma. Selective amnesia is localized for a specific time, with partial memory of events during that time. The least common types of psychogenic amnesia are generalized amnesia, a complete loss of memory of one’s past, and continuous amnesia, in which memory loss begins at a particular point in time and continues to the present.

Yuki’s firstborn child died of sudden infant death syndrome 3 months ago. Although she remembers arriving in the emergency department with her baby, she continues to have no memory of finding him in his crib, calling the paramedics, or hearing the doctor telling her that her baby was dead.

**Dissociative Fugue** Dissociative fugue is a rare dissociative disorder in which people, while either maintaining their identity or adopting a new identity, wander or take unexpected trips. The disorder is often precipitated by subacute, chronic stress. The episode may last several hours or several days. During the fugue state, these people may appear either normal or disoriented and confused; they usually behave in ways inconsistent with their usual personality and values. The fugue state often ends abruptly, and there is either partial or complete amnesia for that period. Dissociative amnesia and dissociative fugue both are most commonly seen during war and in the aftermath of disasters.

**Depersonalization Disorder** Depersonalization disorder is characterized by persistent or recurrent feelings of being detached from one’s body or thoughts. People describe feeling like robots, being an outside observer of their bodies or thoughts, or feeling like they are living in a dream. They remain oriented to reality in that they know they are not really robots or living in a dream. It is thought to result from emotional abuse in childhood; the more severe the abuse, the more severe the symptoms. Depersonalization disorder usually begins in adolescence and is often not responsive to therapy or medication (Michal et al., 2005).

**Dissociative Identity Disorder** Dissociative identity disorder (DID), formerly multiple-personality disorder, is the most severe form of dissociative disorders. This diagnosis is given when at least two personalities exist in the same person. Each personality, or alter, is integrated and complex; that is, each has its own memory, value structure, behavioral pattern, and primary affective expression. The host personality, which is the original personality, has at best only a partial awareness of the alters. People with DID suffer from an alteration in conscious awareness of their total being.

Efrain has been working for several years with Judith in outpatient therapy. Over a period of time he has been introduced to the following personalities within her “family” system:

**Judith**—35 years old, married, one son; very traditional, good housekeeper, attends church regularly, dresses in a careful and...