Other Disorders: Trauma-related Disorders and Misdiagnosis

Misdiagnosis and Differential Diagnosis

Posttraumatic Stress Disorder

Many differential (alternative) diagnoses exist, including Adjustment Disorders, and Acute Stress Disorder, which has a shorter duration (under a month), Anxiety disorders and Obsessive-compulsive disorder (OCD), Major depressive disorder, Dissociative Disorders and Personality Disorders. Interpersonal difficulties which begin or were greatly increased, after a traumatic event may indicate PTSD since a personality disorder would have these difficulties independently of whether any trauma occurred. Flashbacks in PTSD need to be distinguished from the illusions and hallucinations present in schizophrenia and other psychotic disorder. [2]

Acute Stress Disorder

Adjustment Disorders, Panic Disorder, Dissociative Disorders, Posttraumatic Stress Disorder, Obsessive-compulsive disorder (OCD), Psychotic Disorders and Traumatic Brain Injury are other diagnoses which could be considered.

Adjustment Disorders

Major Depressive Disorder (depression), Acute Stress Disorder or PTSD and Personality Disorders can be considered as alternative diagnoses, as well as normal stress reactions. [2]

Dissociative Identity Disorder

The most common misdiagnoses are Bipolar Disorder (formerly known as manic depression), Schizophrenia, and Borderline Personality Disorder (BPD).[5] All these disorders can co-exist with Dissociative Identity Disorder, since it is a Dissociative Disorder and so not in the same group of disorders as they others. Bipolar Disorder involves changes in mood that cycle between Depression and either mania (or the less severe hypomania), and sometimes "mixed episodes" which have features of both. In Dissociative Identity Disorder there are also frequent mood changes, these rapidly switching moods (within minutes or hours) are commonly caused by the presence of alters which have different moods, and the changes in moods can be puzzling to the person. The common misdiagnosis is Bipolar Disorder type 2, which involves hypomania rather than full mania, however mood changes in Bipolar Disorder do not switch back and forth as rapidly as those in Dissociative Identity Disorder.[2]:296

Schizophrenia includes a range of different possible symptoms and is a Psychotic Disorder, and a spectrum of Schizophrenia symptom disorders exist. All the Schizophrenia symptom disorders involve a break with reality. [2] In Dissociative Identity Disorder reality testing is described as being "in tact". Hearing voices, which are actually the communication of alter personalities is very common in DID, hearing voices may also present in Schizophrenia but in a slightly different way, and many of the symptoms historically used to diagnose symptoms of Schizophrenia are more common in Dissociative Identity Disorder - these are known as Schneiderian first-rank symptoms (FRS). See passive influence in Dissociative Identity Disorder for a description of these symptoms. Amnesia is a required symptom of DID but not a diagnostic symptom in Schizophrenia.[2]

Borderline Personality Disorder has many symptoms that overlap with the self-destructive behaviors common in Dissociative Identity Disorder, as well as symptoms that overlap with Complex PTSD (see below). The majority of people with Dissociative Identity Disorder also have Complex PTSD, and many have a diagnosis for Borderline Personality Disorder too (although these symptoms in DID many effect just the "host" identity or just specific alters).

Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a common misdiagnosis for Post-traumatic Stress Disorder and Dissociative Identity Disorder (DID). [2] While many people with BPD also have PTSD,[4] BPD may be diagnosed instead of, rather than in addition, to PTSD. Recent research has been shown clear differences between both PTSD and Complex PTSD and BPD.[3, 4] A key difference from Dissociative Identity Disorder is the presence of recurrent episodes of amnesia.[1, 2]
Comorbid Diagnoses

The majority of people with a Trauma or Dissociative Disorder also have other diagnoses at the same time, known as comorbid diagnosis. Dual diagnosis is a term commonly used when a substance abuse disorder also exists, for example alcoholism. Conversion Disorder is common in people with Dissociative Disorders.

Posttraumatic Stress Disorder

Around 80% of people with PTSD have another psychiatric disorder at the same time. Depression, bipolar, anxiety or substance use disorders are common. Both substance use and conduct disorders are more common in males than females. U.S. military and combat veterans have high rates of Traumatic Brain Injury occurring along with PTSD. In children, Oppositional Defiant Disorder and Separation Anxiety Disorder are the most common comorbid diagnoses.

Acute Stress Disorder

Extremely negative thoughts relating to the trauma are common, including excessive guilt for not preventing the trauma or not adapting successfully after trauma. Catastrophic thinking may occur, for example viewing flashbacks as a sign of reduced mental ability. Panic attacks, chaotic or impulsive behavior are common, for example reckless driving or making irrational decisions. Children may show separation anxiety. People who also have mild Traumatic Brain Injury commonly experience post-concussive symptoms, such as headaches, dizziness, sensitivity to light/sound, concentration problems and irritability, all of which are also common in Acute Stress Disorder.

Adjustment Disorders

These can occur along with almost any other mental disorder, provided the other disorder(s) do not fully explain the person's symptoms. Adjustment Disorders are particularly common in accompanying physical illness.

Dissociative Identity Disorder

Most people with DID develop PTSD at some point. Depression, anxiety, and substance use disorders are commonly diagnosed in people with DID. Self-injury, non-epileptic seizures and suicidal behavior are also common.

Dissociative Amnesia
Many people with dissociative amnesia have PTSD at some point in their life, especially when the traumatic events prior to the amnesia are recalled. Somatic symptom disorders and conversion disorder are also common. Many people with this disorder have a personality disorder, with the most common being dependent personality disorder, avoidant personality disorder and borderline personality disorder.[2] When amnesia reduces more symptoms often become apparent, which may lead to other diagnoses such as persistent depression (dysthymia) or another depressive disorder, or Adjustment Disorder. Common symptoms include dysphoria, grief, rage, shame, guilt, psychological conflict/turmoil, suicidal or homicidal ideas and impulses. [2]

**Depersonalization/Derealization Disorder**

Depression and anxiety disorders are common. Rates of PTSD are low. The most common co-occurring personality disorders are avoidant, borderline, and obsessive-compulsive personality disorder. [2]

**Somatic Symptom and related Disorders**

These disorders, previously referred to as somatoform disorders, include prominent somatic (bodily) symptoms which cause significant distress or impaired functioning. These are physical symptoms and commonly treated with physical, rather than psychiatric, care. Many symptoms are medically unexplained, meaning they do not have a known medical cause at this point, however the physical symptoms are real and there are high rates of co-occurring physical health conditions in people with Somatic symptom disorder in particular. [2] Early traumas, including abuse, and genetics/biological vulnerability are known to contribute to these illnesses. This group of disorders are varied, and include Illness Anxiety Disorder (health anxiety which is severe enough to cause physical symptoms) and controversially also includes Factitious Disorder.

Somatoform Dissociation Questionnaire (SDQ) The Dissociative Identity Disorder treatment guidelines suggest the SDQ, developed by trauma expert Ellert R.S. Nijenhuis, is helpful in aiding diagnosis of DID and Dissociative Disorder Not Otherwise Specified. [5]

Factitious Disorder DSM-5 code 300.19 (ICD-10 code F68.10) is a differential diagnosis for some disorders; this is intentionally and consciously falsifying either physical or psychological symptoms. It involves deception, and may involve intentionally inducing illness or injury or manipulating laboratory tests to indicate an abnormality where none exists. It is estimated to affect around 1% of people who are currently hospitalized, making it rarer than Dissociative Identity Disorder (for example), which affects 1-3% of the general population. [2], [5] Malingering is similar to Factitious Disorder but where external gain can be identified, for example time off work. No estimates of prevalence are available in the DSM-5. Factitious Disorder and Malingering both involve deception. [2]

**Conversion Disorder**

This is also known as Functional Neurological Symptom Disorder, and involves “altered voluntary motor or sensory function” without a recognized neurological or medical cause but significant enough to cause impaired functioning or significant distress. For example, loss of use of a limb. The ICD-10 psychiatric manual recognizes these as Dissociative [Conversion] Disorders, including weakness or paralysis, abnormal movement, speech or swallowing symptoms, sensory loss (including inability to feel pain). A psychological stressor may or may not be a known cause. Conversion Disorder includes psychogenic or non-epileptic seizures. Depersonalization, derealization, and dissociative amnesia are common. [2]

**References**
