What Are Dissociative Disorders?

Sudden but temporary alteration in consciousness, identity, sensorimotor behavior, or memory
Relatively rare, but very dramatic

Dissociative Disorders

- A group of conditions involving disruptions in a person’s normally integrated functions of
  - Consciousness
  - Memory
  - Identity
  - Perception
Dissociative Disorders

Depersonalization: persistent or recurrent feelings of being detached from one’s mental processes or body accompanied by intact reality testing

Dissociative Disorders

- Dissociative Amnesia: Failure to recall previously stored personal information when that failure cannot be accounted for by ordinary forgetting. Not caused by head injury. Affects only certain types of memory. Often associated with a traumatic event. Memory may appear suddenly.
- Dissociative Fugue: Departs from home surroundings

Dissociative Disorders

- Dissociative Identity Disorder (DID): Person manifests two or more distinct identities or alters that alternate in some way in taking control of behavior
- Rare
- Usually starts in childhood
Dissociative Identity Disorder (DID)

- Formerly known as Multiple Personality Disorder
- The existence of two or more distinct alters within one individual
  - Each is dominant at different times
  - Often have different names and unique traits
  - Principal personality often cannot remember what happens when alternates are in control
    - "Lost time"
  - Stress or crisis brings on shifts

Controversies

- Is the disorder real or faked?
- If the disorder is not faked, how does it develop?
- Are recovered memories of abuse in the disorder real or false?
- If abuse has occurred, did it play a causal role?

Treatment and Outcomes in Dissociative Disorders

- No systematic controlled research has been conducted
- Possible treatments include
  - Hypnosis
  - Integration of Separate Alters
VI. What Is Schizophrenia?

Thought Disorder—NOT multiple personalities
Characterized by:
• Bizarre thinking
• Inappropriate emotional response
• Lack of reality testing
• Deterioration of social and intellectual functioning
• Symptoms must begin before age 45
• Must be present for at least 6 months
  – 1 month more or less continuously
• Impaired reality testing and disturbance in functioning makes schizophrenic disorder a type of psychosis

Schizophrenia

• Psychosis: Significant loss of contact with reality
• Symptoms:
  – Positive: Delusions and hallucinations
  – Negative: Inability to read others’ emotions

Symptoms of Schizophrenia

Positive symptoms: Delusions and hallucinations

Negative symptoms: Inability to read others’ emotions
Positive Symptoms in Schizophrenia

Reflect an excess or distortion in a normal repertoire of behavior and experience such as:
- Delusions
- Hallucinations
- Disorganized speech
- Disorganized behavior

Delusions

Thought Distortions: Disordered thinking
- Grandeur: Believe they are someone great (God, president)
- Persecution: People are out to get them.
- Reference: People are talking about them.
- Thought Broadcasting: People can read their minds.
- Thought Insertion: Others are putting bad thoughts into their minds.

Hallucinations

Perceptual Distortions
- Compelling perceptual experiences that occur without any physical stimulus
  - Auditory hallucinations (hearing voices) most common
  - Voices are perceived as coming from outside the person
  - Voices comment on or direct behavior
**Hallucinations**

– Visual: Seeing things (demons)
– Olfactory: Smelling things (smoke, decaying fish)
– Tactile: Sensation that something is crawling on or under the skin

**Disorganized Speech**

– Impaired language use: *Word salad*
– Memory deficits
  • Working and long-term memory
  • Attention problems

**Negative Symptoms in Schizophrenia**

• Reflect an absence or deficit of behaviors that are normally present
  – Flat or blunted emotional expressiveness
  – Alogia: Poverty of speech
  – Avolition: Lack of desire, motivation, persistence
Distortions in Emotional Reactions

Inappropriate affect
- Emotional responses that are not appropriate for the situation
- Sometimes there is absence of affect
  - Flat affect
- Sometimes a range of emotions are experienced very quickly
  - Ambivalent affect

Subtypes of Schizophrenia

Paranoid Type
Disorganized Type
Catatonic Type
Undifferentiated Type
Residual Type

Paranoid Schizophrenia

- Delusions of grandeur and / or persecution
- Possibly hallucinations
- Both organized around a theme
  - E.g., "Aliens are stealing my thoughts."
- Often little cognitive or other impairments
- Higher rates of recovery than other types
Disorganized Schizophrenia

- Severely disturbed thought processes, disorganized behavior, incoherent, inappropriate affect
- Disintegration of normal personality
- Total lack of reality testing

Catatonic Schizophrenia

- Impairments in motor activity.
  - **Excited** catatonic schizophrenia
    - Bursts of violent or excited motor activity
    - Excessive talking and shouting
  - **Withdrawn** catatonic schizophrenia
    - Little to no motor or verbal activity at all *(stupor)*
    - Muscular rigidity
    - Waxy flexibility: molded into different positions

Residual Schizophrenia

- In touch with reality despite schizophrenic symptoms
- At least one previous episode of another type
Undifferentiated Schizophrenia
- All the essential features of a schizophrenic disorder
- Symptoms do not fit easily into one of the other types

Causes of Schizophrenia

Biological Factors
- Concordance rates
  - Degree to which the disorder is shared by two or more individuals or groups
  - Higher for identical than fraternal twins
    - 86% versus 15%
- Neurotransmitters
  - Dopamine theory of schizophrenia
    » Symptoms caused by too much dopamine

Environmental Factors
- Prenatal malnutrition and infection, birth injuries
- Exposure to lead, poverty, city life
- Family factors
  - Loss of a parent in childhood
  - Childhood depression or bipolar disorder
Psychosocial and Cultural Aspects

- Many theories about bad families causing schizophrenia have not stood the test of time including
  - The idea of the “schizophrenic mother”
  - The double-bind hypothesis
- Instead, communication problems may be the result of having a schizophrenic in the family
- Patients with schizophrenia are more likely to relapse if their families are high in expressed emotion

Treatment

- Antipsychotic Drugs: Block Dopamine receptors
- Two types of antipsychotics
  - Conventional (neuroleptics)
  - Novel
- Patients taking novel antipsychotics
  - Have fewer extrapyramidal (motor abnormality) side effects
  - Tend to do better overall

Psychosocial Approaches

- Case Management
- Social-Skills Training
- Cognitive-Behavioral Therapy
- Other forms of individual treatment
- Family Therapy
Family Therapy

- Provides families with communication skills
- Reduces high levels of expressed emotion

VII. What Are Personality Disorders?

Inflexible and long-standing maladaptive behaviors that cause distress and social/occupational impairment
Chronic interpersonal difficulties
Those diagnosed tend to fall into stereotypical gender and ethnic categories
Problems with one's identity or sense of self

Difficulties Doing Research on Personality Disorders

- Controversial
- Can be difficult to diagnose
- Those diagnosed tend to fall into stereotypical gender and ethnic categories
Cluster A: Personality Disorders

- Paranoid
- Schizoid
- Schizotypal

Characteristics:
- Distrustful
- Suspicious
- Socially Detached

Personality Disorders: Cluster A

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>Suspiciousness, mistrust, tendency to see self as blameless; on guard for perceived attacks by others; odd eccentric.</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Impaired social relationships; inability and lack of desire to form attachments to others</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>Peculiar thought patterns; oddities of perception and speech that interfere with communication and social interaction</td>
</tr>
</tbody>
</table>

Cluster B: Personality Disorders

- Histrionic
- Narcissistic
- Antisocial
- Borderline Personality Disorders

Characteristics:
- Dramatic
- Emotional
- Erratic
### Personality Disorders: Cluster B

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histrionic</td>
<td>dramatic; overconcern with attractiveness; tendency of irritability and temper outbursts if attention seeking is frustrated; emotional</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>Grandiosity; preoccupation with receiving attention; self-promoting; lack of empathy</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Lack of moral or ethical development; inability to follow approved models of behavior; deceitfulness; shameless manipulation of others; history of conduct problems as a child</td>
</tr>
<tr>
<td>Borderline</td>
<td>Impulsiveness; inappropriate anger; drastic mood shifts; chronic feelings of boredom; attempts at self-mutilation or suicide</td>
</tr>
</tbody>
</table>

### Cluster C: Personality Disorders

- Avoidant
- Dependent
- Obsessive-Compulsive

**Characteristics**
- Anxious
- Fearful

### Personality Disorders: Cluster C

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Characteristics</th>
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<tbody>
<tr>
<td>Avoidant</td>
<td>Hypersensitivity to rejection or social derogation; shyness; insecurity in social interaction and initiating relationships</td>
</tr>
<tr>
<td>Dependent</td>
<td>Difficulty in separating in relationships; discomfort at being alone; subordination of needs in order to keep others involved in a relationship; indecisiveness</td>
</tr>
<tr>
<td>Obsessive-compulsive</td>
<td>Excessive concern with order, rules, and trivial details; perfectionism; lack of expressiveness and warmth; difficulty in relaxing and having fun</td>
</tr>
</tbody>
</table>
Provisional Categories

Passive-Aggressive
Depressive

Personality Disorders: Provisional Categories

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<th>Characteristics</th>
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<tr>
<td>Passive-aggressive</td>
<td>Negativistic attitudes and passive resistance to adequate performance expressed through indirect means such as complaining, being sullen and argumentative, expressing envy and resentment toward those who are more fortunate</td>
</tr>
<tr>
<td>Depressive</td>
<td>Pervasive depressive cognitions; persistent unhappiness or dejection; feeling of inadequacy, guilt, and self-criticism</td>
</tr>
</tbody>
</table>

Causal Factors in Antisocial Personality Disorder

- Genetic influences
- Learning of antisocial behavior
- Adverse environmental factors
General Sociocultural Causal Factors for Personality Disorders

- Is our emphasis on impulse gratification, instant solutions, and pain-free benefits leading more people to develop the self-centered lifestyles that we see in more extreme forms in personality disorders?

Treatments and Outcomes

- Very difficult to treat (especially Cluster A)
- Treatment of the Cluster C disorders seems most promising
- Dialectical Behavior Therapy (DBT) shows promise for treating Borderline Personality Disorder (Cluster B)

Treatments and Outcomes in Psychopathic and ASPD

- Treatment of psychopaths is difficult
- Cognitive-behavioral treatments offer some promise
VIII. Eating Disorders

- Psychological disorders that are characterized by severe disturbances in eating behavior
- Anorexia Nervosa:
  - self starvation, refusal to maintain normal body
  - weight, fear of being overweight, life threatening,
  - distorted body image

Eating Disorders

- The two most common forms of eating disorders are
  - Anorexia nervosa
  - Bulimia nervosa
- At the heart of both disorders is
  - An intense and pathological fear of becoming overweight and fat
  - A pursuit of thinness that is relentless and sometimes deadly

Anorexia Nervosa

Characterized by:
- Self starvation
- Refusal to maintain normal body
- Fear of being overweight
- Distorted body image
- Life threatening
Anorexia Nervosa

- The mortality rate for females with anorexia nervosa is more than twelve times higher than the mortality rate for females aged 15–24 in the general population

Bulimia Nervosa

Characterized by:
- Frequent episodes of binge eating & purging
- Lack of control over eating
- Recurrent inappropriate behavior to prevent weight gain
- Typically of normal weight

Age of Onset and Gender Differences

- Anorexia nervosa is most likely to develop in 15- to 19-year-olds
- Bulimia nervosa is most likely to develop in women aged 20-24
- There are 10 females for every male with an eating disorder
Medical Complications

- Anorexia can lead to
  - Death from heart arrhythmias
  - Kidney damage
  - Renal failure
  - Amenorrhea
- Bulimia can lead to
  - Electrolyte imbalances
  - Hypokalemia (low potassium)
  - Damage to hands, throat, and teeth from induced vomiting

Comorbidity

Associated with:
- Clinical Depression
- Obsessive-Compulsive Disorder
- Substance Abuse Disorders
- Various Personality Disorders

Prevalence

- The lifetime prevalence of anorexia nervosa is around 0.5%
- The lifetime prevalence of bulimia is around 1–3%
Culture
• Eating disorders are becoming a problem worldwide
• The attitudes that lead to eating disorders are more common in Whites and Asians than African Americans

Etiology
• Multi-determined
• Runs in families
• Genetic influence has yet to be determined
• Set-point theory (the idea that our bodies resist marked variation) may play a role
• Serotonin levels may play a role

Sociocultural Factors
• Fashion magazines idealize extreme thinness
• Women often internalize the thin ideal
Risk and Causal Factors in Eating Disorders

• Nearly all instances of eating disorders begin with normal dieting
• Perfectionism
• Childhood sexual abuse may play a role

Treatment for Anorexia Nervosa

• Emergency procedures to restore weight
• Cognitive-behavioral therapy
• Antidepressants or other medications
• Family therapy

Treatment for Bulimia Nervosa

• Antidepressants or other medications
• Cognitive-behavioral therapy
• Little is known