1. Dissociative disorders

- What are dissociative disorders, and why are they controversial?
  • As noted in the textbook, dissociative disorders are bewildering.
  • A dissociative disorder is a disorder of consciousness.
  • In a dissociative disorder, a person is dissociated by a stressful situation from his or her normal life, perhaps by a fugue state:
    – A sudden loss of memory; or
    – A change in identity.
    - **Dissociative disorders:** controversial, rare disorders in which conscious awareness becomes separated (dissociated) from previous memories, thoughts and feelings.
      - The person's conscious awareness disassociated from painful memories, thoughts, and feelings. - they may be in a **fugue state:** a sudden loss of memory or change in identity often in response to an overwhelmingly stressful situation.
      - When we face trauma - dissociative detachment may protect us from being overwhelmed by emotion.
      - Ex. this man from the war disappear and when they found him in the homeless shelter - he had no idea about his identity or family.

1. Dissociative disorders: dissociation

• Dissociation itself is not unusual. Many people can easily experience this by standing up quickly from a squatting position. This produces a feeling of light-headedness, and the person may feel as if he or she is watching him- or herself from a distance. (Don't try this at home unless you have someone to catch you if you faint.)
• However, this transient feeling does not involve a loss of a large chunk of memory or of one's own identity.

1a. Dissociative identity disorder

• Dissociative identity disorder (DID) is characterised by a "massive dissociation of self from ordinary consciousness."
• Formerly called multiple personality disorder or split personality, DID is associated with a person exhibiting two or more distinct and alternating personalities who typically are not aware of each other's existence.
• The different personalities control the person's behaviour, and each speaks with its own voice, perhaps in a distinctive accent.
• In literature, the classic is the normal Dr. Jekyll and the miserable Mr. Hyde.- this guy used an alternative personaility who he used to murder someone and blame it on a guy he hated - he was a practiced liar who read about multiple personaility disorder - and they were able to meet his alternative murder personaility through hypnosis

- **Dissociative identity disorder:** a rare dissociative disorder in which a person exhibits 2 or more distinct and alternating personalities. (multiple personality disorder - before).
  - They dissociate himself from ordinary consciousness - and have 2+ distinct identities - and they control the person's behaviour at different times.
  - They are rarely violent

1a. Dissociative identity disorder (continued)

• As noted in the textbook, violence is not normally part of DID, but there have been cases of a hidden violent personality, as in the Hillside Strangler case in California. However, there is no objective evidence of DID in this case, which may simply be deviousness on Bianchi's part.

1b. Understanding dissociative identity disorder

• Is DID a true disorder?

• Hypnotised "normal" students were able to create a second personality.

- They told psychologist to pretend they were accused murderers and given a hypnotic treatment they spontaneously expressed this 2nd personality. → so is dissociative identity just a more extreme version of our capacity to vary the selves that we present. - like we lound with friends quite with grandparents.

• This bears some similarities to the different façades (or different personality "flavours") that we present to parents, friends, lovers, bosses, etc.

• Adding to the argument that DID is not a true disorder is the rapid rise in DID diagnoses and in the number of personalities per person. In other words, we may be experiencing a vogue (pop psy) among people doing the diagnosing.

• DID is typically not diagnosed in the UK or other cultures outside Canada and the US, although some cultures speak of "spirit possession".

- It could just be an extension of our normal capacity to do personality shifts

1b. Understanding DID (continued)

• Adding to the argument that DID is not a true disorder is the rapid rise in DID diagnoses and in the number of personalities per person. In other words, we may be experiencing a vogue among people doing the diagnosing.

– From 1930 to 1960, about 2 cases of DID were diagnosed every 10 years.

– In the 1980s, more than 20,000 cases were reported.

– Moreover, the mean number of "personalities" per patient increased from 3 to 12.

- Like psychologist could probe a person about another personality and thus they start to fantasize and experience another self - even though it is not really there.

1b. Understanding DID (continued)

• On the other hand (pardon the pun), there is some evidence that DID exists, including a change in handedness with a change in personality and changes in visual function.

• Both psychoanalytic and learning perspectives see DID as a defence against the anxiety associated with unacceptable impulses.

• An alternative view is that DID is a form of coping with post-traumatic stress, especially related to childhood abuse.

• A weakness in this area is that we cannot predict who will exhibit DID; rather, the studies are all retrospective.

- They say it is real because -there are shifts in body and brain states when associating with differing personalities
- Handedness (use of right or left hand) sometimes switches with personality
- Shifts in eye muscles have been seen as one switches personalities
- They have abnormal brain anatomy - shrinkage in areas that aid memory and detection of threat and heightened activity - in brain areas that control inhibition of traumatic memories.
- They say DID symptoms - are a way of coping with anxiety (ex through an eruption of unacceptable impulses) - the second personality - allows discharge of forbidden impulses
- The dissociative disorders are reinforced by anxiety reduction
- It may be a form of PTSD - it is a natural response to traumatic experiences during childhood. - like abuse as a child can trigger DID

So some think DID is a multiple personalities - people use to detach from horrific experiences

Skeptic think DID - is a condition constructed out of patient and therapist interaction - acted out by fantasy prone emotionally vulnerable people

Personality disorders have 3 clusters:

1. Avoidant personality disorder - anxiety/ fear of rejection
2. Schizotypal personality disorder - odd behaviours - like emotionless disengagement
3. dramatic or impulsive behaviours - like attention seeking **Borderline personality disorder** - and **antisocial personality disorder (**dangerous) **narcissistic personality disorder** (self inflating)

2. Personality disorders

- What are the three clusters of personality disorders? What behaviours and brain activity characterise the antisocial personality?

  • In some cases, behavioural patterns are so dysfunctional that they get in the way of social functioning, but do not include depression or delusions.

  • Personality disorders are disruptive, inflexible, and enduring behaviour patterns that impair one's social functioning. There are different clusters, including:

  – Avoidant personality disorder, where the person is withdrawn and has a fearful sensitivity to rejection, related to anxiety.

  – Schizotypal personality disorder, with emotionless disengagement and eccentric behaviour; and

  – Dramatic or impulsive behaviours, such as borderline personality disorder, narcissistic personality disorder, and the sometimes dangerous antisocial personality disorder.

  - **Personality disorders -** inflexible and enduring behaviour patterns that impair social functioning .
  - **Antisocial personality disorder:** a person (usually a man) exhibits lack of conscience for wrongdoing even towards family and friend members may be aggressive, ruthless or a clever con artist.

2a. Antisocial personality disorder

• Antisocial personality disorder is the most troubling and heavily researched personality disorder.

• Persons with this disorder used to be labelled sociopaths or psychopaths. Typically male, their lack of conscience is evident in the early teens through lying, stealing, fighting, and inappropriate sexual behaviour. They typically have lower emotional intelligence.

– About half become antisocial adults who cannot hold a job, have poor parenting and marital skills, and criminal behaviour.

– These people may become con artists, or worse.

– Absent a criminal leaning, they may become CEOs or politicians, for example.

• Aside from the case studies mentioned in the textbook check out The Stranger Beside Me, by true-crime author Ann Rule.

- Typically a male whose lack of conscience become plain before age 15 and he begins to lie steal fight or display unrestrained sexual behaviour.
- They show lower emotional intelligence (the ability to understand, manage and perceive emotions)
- Due to combination of intelligence and antisocial personality → may give a charming con artist or a fearless focussed soldier or CEO or politician.
- They sometimes have criminal behaviour and are remorseless - it is not an essential component of antisocial behaviour
- Many criminals don't actually have anti social behaviour - because many criminals show concern for friends and family.
- Antisocial people - behave impulsively and have little fear

- Sometimes their impulses can be violent - henry lee lucas - killed his first victim when he was 13 and felt no regret - he hurt 360 men and women - he killed 50 people

2b. Understanding antisocial personality disorder

• Biological relatives of people with antisocial and unemotional tendencies have an increased risk of antisocial behaviour.

• People with these tendencies show little autonomic arousal in the face of aversive events, and have lower levels of stress hormones.

• Young children who are impulsive, uninhibited, low in anxiety, and unconcerned with social rewards can become:

– aggressive or antisocial adolescents, or

– athletes or adventurers.

• Without a sense of social responsibility, their behaviour may become criminal.

- Can be genetic
- They are fearless - when awaiting shocks and loud noises they have little ANS activation
- Their level of stress hormone is lower than normal
- If you are slower to develop conditioned fears as a child then you are more likely to commit a crime
- If you have social responsibility and fearlessness - it can be adaptive - many maerican presidents have this trait
- But when your remove social responsibility and are just fearless - you can become a killer or con artist.

2b. Understanding antisocial personality disorder

• PET scans of murderers' brains show reduced frontal lobe activity (control activities) compared to matched "normals", especially among impulsive murderers.

• Violent repeat offenders have 11% less frontal lobe tissue than normal.

- This explains why people with antisocial personality disorder have deficiencies in planning, organizing and inhibiting.
- They also respond to others facial emotional distress and have no empathy - thus they have a low emotional intelligence.

• As shown in Figure 15.14 (p. 651), the combination of childhood poverty (social) and obstetrical complications at birth (biological) produces doubles the risk of committing crimes relative to either one of these factors.

• Childhood maltreatment and a gene altering neurotransmitter levels together predict antisocial behaviour.

- Genes that put you at risk for antisocial behaviour - also put you at risk for substance use disorder
- Biological risk factors (premature birth) or social factors (poverty) - can double your risk of committing crime.
- Childhood maltreatment and gene that altered neT balance - can predict antisocial problems
- Environment interacts with the biopsychosocial perspective to explain this phenomenon.
- They have a hyperactive dopamine reward system - that gives them and impulsive drive to do something regardless of the consequences.
- When antisocial people shown emotional photos of men holding a knife to a women - they have less activity in brain for emotional stimuli and slow HR and perspiration.

3. Eating disorders

• Physiologically, our bodies are disposed to maintain a normal weight, which includes “stores” for when food is not readily available.

• However, social and psychological factors can influence a person’s eating habits, overriding “pre-programmed” physiological factors.

• For example, how many students in this class suffer malnutrition? How many students brought food to class? Are there physiological reasons for eating during class, or is this behaviour a habit or a whim?

3a. Eating disorders: Anorexia nervosa

• Anorexia nervosa became well known with the death of drummer and singer Karen Carpenter at age 32 in 1983

• Anorexia nervosa is most common among adolescents, and about 90% of cases are seen in females.

• Anorexia typically begins by dieting to lose weight, but progresses until the achieved weight is below norms by 15% or more.

• Despite achieving a body weight that is below normal, people with anorexia may perceive themselves as overweight.

• We need food to stay alive, so it is necessary to eat. About half of people with anorexia enter a binge-purge-depression cycle.

- **Anorexia nervosa:** an eating disorder in which a person (teen female) maintains a starvation diet, despite being significantly underweight sometimes accompanied by excessive exercise.

3b. Eating disorders: Bulimia nervosa

• A person with bulimia will gorge on food as a break from a diet.

• Typically, a period of gorging is followed by purging (either by vomiting or using laxatives to speed the food through the body), or by excessive exercise or fasting.

• A period of depression may follow as part of the binge-purge cycle.

- **Bulimia nervosa:** an eating disorder in which a person alternates binge eating (usually if high cal foods) with purging (vomiting or laxative use) or fasting.
- This can also be triggered by a weight loss diet - which is broken by gorging on forbidden foods
- Overeating is compensated by purging, fasting or excessive exercise.
- They are preoccupied with food and are fearful of being overweight
- They have weight fluctuations within or above normal ranges - making it easy to hide condition

3c. Eating disorders: Binge-eating disorder

• Someone who engages in binge eating and is later remorseful – but who does not purge, fast, or exercise excessively – exhibits binge-eating disorder.

• As a result, they may become overweight.

- **Binge eating disorder:** significant binge eating episodes, followed by distress, disgust, or guilt but without the compensatory purging or fasting that marks bulimia nervosa.

3d. Eating disorders: Incidence

• The US National Institute of Mental Health (NIMH) has reported that at some point during their life:

– 2.8% meet the criteria for binge-eating disorder
– 1% meet the criteria for bulimia
– 0.6% of people meet the criteria for anorexia

3e. Understanding eating disorders: Contributing factors

- Contributing factors may include:
  - – A mother who focuses on her own weight as well as her daughter's weight and appearance;
  - – A familial link to bulimia causes an increase in childhood obesity and negative self-evaluation;
  - – A familial link to anorexia causes competitiveness, high achieving, and protectiveness.
- People with eating disorders may have:
  - – Low self-evaluations
  - – Perfectionist standards
  - – Fear of falling short of expectations
  - – Concern about how others perceive them (e.g., too heavy / not muscular enough)

3e. Eating disorders: Contributing factors (cont'd.)

- Genetics appear to be relevant:
  - – Identical twins share an eating disorder more often than do fraternal twins.
  - Having a gene which reduces serotonin - can increase the risk of anorexia and bulimia
- Cultural and gender components are relevant:
  - – The "ideal" body shape varies as a function of culture
    - In poorer countries (africa) - being plump means health and wealth
    - Bigger is not better in western countries - thus they have a rise in eating disorders
  - – The fashion industry has promoted an "ideal" body shape for women; more recently, there has been a social (and industry) backlash against this.

People at risk for eating disorders are - women and gay men - as rhey idolize thinness and have the greatest body dissatisfaction.

- Like when women see models they feel ashamed, dissatisfied with their own bodies - and this pre disposes eating disorders.
- Females with model magazine subscriptions had greater dissatisfaction with their bodies than girls who didn't have the magazines

Media, peer influences (teatsing), influence of increased marriage age (competing for mates) - can all lead to an increase in eating disorders. .

- Weight obsessed culture causes them - saying fat is bad - this causes women to be in constant diet - binge and semistarvation always.

Prevention programs - can help increase acceptance of one's body