
PSY1102

Introduction to Applied Psychology

Class 16

Psychological disorders (continued)

Victor Emerson
vemerson@uottawa.ca

Agenda for today

1. Somatoform disorders
2. Dissociative disorders
 - a. Dissociative identity disorder
 - b. Understanding dissociative identity disorder
3. Mood disorders
 - a. Major depressive disorder
 - b. Bipolar disorder
 - c. Understanding mood disorders

1. Somatoform disorders

- The term “soma” is from the Greek, and means “body”.
 - Psychosomatic disorders involve the body and the mind.
 - “Somatoform” implies “relating to the body”.
- A somatoform disorder is a disorder in which the individual seeks medical attention, but no physical cause for the symptoms can be found.
 - Symptoms can include dizziness, pain, difficulty swallowing, etc.
- By default, a psychological disorder of the somatoform type may be diagnosed.
 - In effect, this diagnosis indicates that a physical disease is unverifiable, and that the underlying cause is a psychological disorder.
 - Reported symptoms may differ across cultures.

1. Somatoform: conversion disorders

- Freud diagnosed conversion disorder, where anxiety is converted into a physical symptom.
- In some cases, the loss of sensation (or, alternatively, pain) do not make medical sense. Nevertheless, the individual's reactions to stimuli appear to support the subjective report.

1. Somatoform: hypochondriasis

- Someone labelled as a hypochondriac reports symptoms that are unverifiable and may change in a way that makes no medical sense – for example, headache today, stomach cramp tomorrow, and so on.
- In some cases, the individual interprets these as symptoms of a serious disease, and suffers anxiety about his or her general state of health. The physician, finds nothing serious, so the patient “shops” for a physician who will corroborate the self-diagnosis.
- Such reports are relatively common among medical students.
- An extreme case of hypochondriasis is known as Munchausen syndrome
(http://my.clevelandclinic.org/disorders/factitious_disorders/hic_munchausen_syndrome.aspx).

2. Dissociative disorders

What are dissociative disorders, and why are they controversial?

- As noted in the textbook, dissociative disorder are bewildering.
- In a dissociative disorder, a person is dissociated by a stressful situation from his or her normal life, perhaps by:
 - A lapse of consciousness; or
 - A change in identity.

2. 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.

2a. 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.

2a. 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.

2b. Understanding dissociative identity disorder

- Is DID a true disorder?
- Hypnotised “normal” students were able to create a second personality.
- 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 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”.

2b. 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.

3. Mood disorders

What are mood disorders, and what forms do they take?

- There are two principal forms of mood disorders:
 - Major depressive disorder, and
 - Bipolar disorder.
- We'll consider these in turn.

3a. Major depressive disorder

- Depression has been called the “common cold” of psychological disorders because it is so pervasive, appearing across many cultures. However, this expression diminishes its seriousness.
- Phobias are more common than depression, but depression – which affects about 1/8 of Americans and Canadians – is the main reason people seek help from mental health services.
- Depression is the leading cause of disability around the world.
- In any single year, nearly 10% of women and nearly 6% of men will experience a depressive episode.

3a. Major depressive disorder (continued)

- A major depressive disorder occurs when at least 5 signs of depression last two or more weeks and are not caused by drugs or a medical condition.
- These 5 signs of depression include:
 - Lethargy
 - Feelings of worthlessness
 - Loss of interest or pleasure in family, friends, and activities.
- Episodes of major depression usually end with or without therapy.

3b. Bipolar disorder

- Bipolar disorder is a mood disorder in which the person alternates between the hopelessness and lethargy of depression and the overexcited state of mania.
- Although episodes of major depression end, instead of returning to the normal equilibrium of everyday life some people appear to be on a pendulum that swings too far in the other direction, into an episode of mania.
 - Mania is a hyperactive, wildly optimistic state.
- This alternation between episodes of depression and episodes of mania is typical of bipolar disorder.

3b. Bipolar disorder: is it real?

- As noted in the textbook (p. 613), in the decade between 1994 and 2003 the number of diagnoses of bipolar disorder in Americans 19 and under rose from 20,000 to 800,000, a 40-fold increase, and about 2/3 of these in boys.
- Although these diagnoses have sold a lot of drugs, what are we seeing here: more diagnoses or better diagnoses?

3b. Bipolar disorder and creativity

- Many composers, writers, and artists have had extraordinary periods of creativity during episodes of mild mania.
- Indeed, many people in the creative arts seem susceptible to bipolar disorder ... or is it the other way around?

www.youtube.com/watch?v=Hvfzrffto2I

3c. Understanding mood disorders

What causes mood disorders, and what might explain the Western world's rising incidence of depression among youth and young adults?

- Background
- The biological perspective
- The social-cognitive perspective

3c. Understanding mood disorders: background

- Looking across many studies, Lewisohn and his colleagues have identified issues that a theory of depression must explain, including:
 - Behavioural and cognitive changes that accompany depression, including inactivity, lack of motivation, and a focus on negative aspects of events. Half also exhibit anxiety or substance abuse.
 - Geographic and cultural extent of depression.
 - Women exhibit major depression about twice as often as men, but only after adolescence. Women tend to focus internally, men externally.
 - Self-termination of most depressive episodes.
 - Stressful events often precede depression, whether related to work, death, finances, love, victimisation.
 - Earlier onset and greater incidence of depression with each new generation.

3c. Understanding mood disorders: biological

- Genetic influences
 - Mood disorders run in families with a greater risk of depression and bipolar disorder with an afflicted immediate relative.
 - Identical twins: A 50% incidence if an identical twin is diagnosed with major depression, and 70% in the case of bipolar disorder (vs. 20% in fraternal twins).
 - Heritability of major depression estimated to be 35-40%.
 - Linkage analysis is a cross-generational genetic analysis that has narrowed the search for a specific gene or set of genes, but we're not there yet.

3c. Understanding mood disorders: biological (cont'd.)

- The depressed brain
 - Functional MRI (magnetic resonance imaging) and PET scans (positron emission tomography) are tools used to identify areas of the brain that are particularly active or inactive, for example by injecting a person with a radioactive version of glucose and then observing which parts of the brain take up (or use) the most or least glucose (or oxygen) during an experimental treatment.

PET scans: <http://legacyweb.triumf.ca/welcome/petscan.html>

Functional MRI (or fMRI): www.nrc-cnrc.gc.ca/eng/projects/ibd/fmri-overview.html

3c. Understanding mood disorders: biological (cont'd.)

- The depressed brain
 - fMRI suggests brain activity patterns experimentally induced moods that mimic brain activity in depression.
 - Lower brain activity (e.g., in left frontal lobe) during depressed stages and higher activity during manic stages.
 - Smaller frontal lobes in people with severe depression.
 - Neurotransmitter influences, including lower norepinephrine (noradrenaline) levels in depression and higher levels in mania.
 - Higher incidence of smoking among people with depression, perhaps because nicotine stimulates norepinephrine release.
 - Serotonin is lower during depression, perhaps with a genetic link, suggesting a stress-gene interaction.
 - Drugs used to treat depression tend to increase norepinephrine or serotonin. Also, physical exercise increases serotonin and reduces depression.

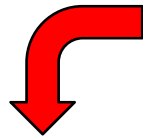
3c. Understanding mood disorders: social-cognitive

- We'll consider two aspects of the social-cognitive perspective:
 - Negative thoughts and negative moods interact; and
 - Depression's vicious cycle.

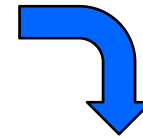
3c. Understanding mood disorders: social-cognitive

- Biological influences don't explain all of depression. The social-cognitive approach looks at behaviour and thoughts, including self-defeating beliefs and negative explanatory style.
- Interaction of negative thoughts and moods. Self-defeating beliefs may be a product of learned helplessness in both humans and some other mammals. Learned helplessness is more common in women than in men. Is this attributable to overthinking?
- Explanatory style may contribute, by assigning blame for negative events (such as failing a test) to an external source or to oneself. (See next slide.) According to Seligman, a pessimistic outlook contributes to severe depression.
- Greater individualism and the decline of religion has been proposed as a contributing factor in Western societies.

3c. Understanding mood disorders: social-cognitive



Breakup with a romantic partner



Stable view

“I’ll never get over this.”

Temporary view

“I can get through this.”

Global view

“Alone, I can’t do anything right.”

Specific view

“I still have family and friends.”

Internal view

“The breakup was all my fault.”

External view

“It takes two to make a relationship.”

Depression

Successful coping

3c. Understanding mood disorders: social-cognitive

- However, there is a chicken-and-egg issue with the social-cognitive approach.
- The link between self-defeating beliefs, negative attributions, self-blame and depression may be correlational without being causal.
 - For example, do negative thoughts cause depression, does depression cause negative thoughts, or neither? That is, both could be cause – independently or together – by something else.

3c. Understanding mood disorders: social-cognitive

Depression's vicious cycle (see Figure 14.8, page 621.)

- We all suffer setbacks in our lives. Serious setbacks can cause us to question ourselves and our value as human beings.
- If these thoughts lead to a negative explanatory style (“I’m no good”), which can lead to a depressed mood.
- The depressed mood can affect how the depressed person sees the world and thinks and acts. (“What’s the use?”)
- This leads once again to stressful experiences, where (for example) other people may react negatively to the depressed person.

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