Module 69

Other Disorders

Module Learning Objectives

69-1 Describe somatic symptom and related disorders.
69-2 Describe dissociative disorders, and discuss why they are controversial.
69-3 Explain how anorexia nervosa, bulimia nervosa, and binge-eating disorder demonstrate the influence of psychological and genetic forces.
69-4 Contrast the three clusters of personality disorders, and describe the behaviors and brain activity that characterize the antisocial personality.

Somatic Symptom and Related Disorders

69-1 What are somatic symptom and related disorders?

Among the most common problems bringing people into doctors' offices are "medically unexplained illnesses" (Johnson, 2008). Ellen becomes dizzy and nauseated in the late afternoon—shortly before she expects her husband home. Neither her primary care physician nor the neurologist she sent her to could identify a physical cause. They suspect her symptoms have an unconscious psychological origin, possibly triggered by her mixed feelings about her husband. In a somatic symptom disorder such as Ellen's, the distressing symptoms take a somatic (bodily) form without apparent physical causes. One person may have a variety of complaints—vomiting, dizziness, blurred vision, difficulty in swallowing. Another may experience severe and prolonged pain.

Culture has a big effect on people's physical complaints and how they explain them (Kirmayer & Sartorius, 2007). In China, psychological explanations of anxiety and depression are socially less acceptable than in many Western countries, and people less often express the emotional aspects of distress. The Chinese are more sensitive to—and more willing to report—the physical symptoms of their distress (Ryder et al., 2008). Mr. Wu, a 35-year-old technician in Hunan, illustrates one of China's most common psychological disorders (Spitzer & Skodol, 2000). He finds work difficult because of his insomnia, fatigue, weakness, and headaches. Chinese herbs and Western medicines provide no relief. To his Chinese clinician, who treats the bodily symptoms, he seems not so much depressed as exhausted. Similar, generalized bodily complaints have often been observed in African cultures (Birnsteil, 1975).
Constitutional disorders are a disorder in which a person experiences very specific genuine physical symptoms for which no physiological basis can be found. (Also called functional somatomotor symptom disorder.)

Illness anxiety disorder is a disorder in which a person interprets normal physical sensations or symptoms as signs of a disease. (Formerly called hypochondriasis.)

Dissociative disorders are disorders in which conscious awareness becomes separated (dissociated) from previous memories, thoughts, and feelings.

Even to people in the West, somatic symptoms are familiar. To a lesser extent, we have all experienced unexplainable physical sensations under stress. It is little comfort to be told that the problem is “all in your head.” Although the symptoms may be psychological in origin, they are nevertheless genuinely felt.

One rare type of disorder, more common in Freud’s day than in ours, is conversion disorder (also known as functional neurological symptom disorder), so called because anxiety-presumably is converted into a physical symptom. (As we noted in Module 55, Freud’s effort to treat and understand psychological disorders stemmed from his puzzlement over ailments that had no physiological basis.) A patient with a conversion disorder might, for example, lose sensation in a way that makes no neurological sense. Yet the physical symptoms would be real; sticking pins in the affected area would produce no response. Other conversion disorder symptoms might be unexplained paralysis, blindness, or an inability to swallow. In each case, the person would be strangely indifferent to the problem.

As you can imagine, somatic symptom and related disorders send people not to a psychologist or psychiatrist but to a physician. This is especially true of those who experience illness anxiety disorder (formerly called hypochondriasis). In this relatively common disorder, people interpret normal sensations (a stomach cramp today, a headache tomorrow) as symptoms of a dreaded disease. Sympathy or temporary relief from everyday demands may reinforce such complaints. No amount of reassurance by any physician convinces the patient that the trivial symptoms do not reflect a serious illness. So the patient moves on to another physician, seeking and receiving more medical attention—but failing to confront the disorder’s psychological root.

Before You Move On

▶ Ask Yourself
What does somatic mean?

▶ Test Yourself
Can you recall (as most people can) times when you have fretted needlessly over a normal bodily sensation?

Answers to the Test Yourself questions can be found in Appendix E at the end of the book.

Dissociative Disorders

69-2 What are dissociative disorders, and why are they controversial?

Among the most bewildering disorders are the rare dissociative disorders. These are disorders of consciousness, in which a person appears to experience a sudden loss of memory or change in identity, often in response to an overwhelmingly stressful situation. Chris Sizemore’s story, told in the book and movie The Three Faces of Eve, gave early visibility to what is now called dissociative identity disorder. One Vietnam veteran who had been tortured by his comrades’ deaths, and who had left his World Trade Center office shortly before the 9/11 attack, disappeared en route to work one day and was discovered six months later in a Chicago homeless shelter, reportedly with no memory of his identity or family (Stone, 2006). In such fugue state cases, the person’s conscious awareness is said to dissociate (become separated) from painful memories, thoughts, and feelings. (Note that this explanation presumes memories, which, as we noted in Modules 35 and 56, have been questioned by memory researchers.)

Dissociation itself is not so rare. Now and then, many people may have a sense of being unreal, of being separated from their body, of watching themselves as if in a movie. Sometimes we may say, “I was not myself at the time.” Perhaps you can recall getting up to grab a glass of water somewhere, and when you arrived at the sink, you were surprised to find yourself staring at a stranger’s face. Or perhaps you can play a well-practiced tune on a guitar or piano while talking to someone. Facing trauma, dissociative detachment may actually protect a person from being overwhelmed by emotion.

Dissociative Identity Disorder

A pervasive dissociation of self from ordinary consciousness characterizes those with dissociative identity disorder (DID), in which two or more distinct identities are said to alternately control the person’s behavior. Each personality has its own voice and mannerisms. Thus the person may be prim and proper one moment, loud and flirtatious the next. Typically, the original personality denies any awareness of the other(s). People diagnosed with DID (formerly called multiple personality disorder) are usually not violent, but cases have been reported of dissociations into a “good” and a “bad” (or aggressive) personality—a modest version of the Dr. Jekyll/Mr. Hyde split immortalized in Robert Louis Stevenson’s story. One unusual case involved Kenneth Bianchi, accused in the “Hillside Strangler” rapes and murders of 10 California women. During a hypnotic session with Bianchi, psychologist John Watkins (1984) called forth a hidden personality: “I’ve talked a bit to Ken, but I think that perhaps there might be another part of Ken that…. maybe feels somewhat differently from the part that I’ve talked to…. Would you talk with me, Pat, by saying, ‘I’m here?’ Bianchi answered ‘yes’ and then claimed to be ‘Steve.’”

Speaking as Steve, Bianchi stated that he hated Ken because Ken was nice and that he (Steve), aided by a cousin, had murdered women. He also claimed Ken knew nothing about Steve’s existence and was innocent of the murders. Was Bianchi’s second personality a ruse, simply a way of disavowing responsibility for his actions? Indeed, Bianchi—a practiced liar who had read about multiple personality in psychology books—was later convicted.

Understanding Dissociative Identity Disorder

Skeptic questions whether DID is a genuine disorder or an extension of our normal capacity for personality shifts. Nicholas Spanos (1986, 1994, 1996) asked college students to pretend they were accused murderers being examined by a psychiatrist. Given the same hypnotic treatment Bianchi received, most spontaneously expressed a second personality. This discovery made Spanos wonder: Are dissociative identities simply a more extreme version of our capacity to vary the “selves” we present—as when we display a goofy, loud self while hanging out with friends, and a subdued, respectful self around grandparents? Are clinicians who discover multiple personalities merely triggering role-playing by fantasy-prone people? Do these patients, like actors who commonly report “losing themselves” in their roles, then convince themselves of the authenticity of their own role enactments? Spanos was no stranger to this line of thinking. In a related research area, he had also raised these questions about the hypnotic state. Given that most DID patients are highly hypnotizable, whatever explains one condition—dissociation or role-playing—may help explain the other.

Skeptic also find it suspicious that the disorder is so localized in time and space. Between 1936 and 1960, the number of DID diagnoses in North America was 2 per decade. In the 1980s, when the DSM contained the first formal code for this disorder, the number of reported cases had exploded to more than 20,000 (McHugh, 1995a). The average number of displayed personalities also mushroomed—from 3 to 12 per person (Goff & Simms, 1995). Outside North America, the disorder is much less prevalent, although in other cultures some people are said to be “possessed” by an alien spirit (Aldridge-Morris, 1989; Kluft, 1991). In Britain, DID—which some have considered “a wacky American fad” (Cohen, 1995)—is rare. In India and Japan, it is essentially nonexistent (or at least unreported).
Such findings, skeptics say, point to a cultural phenomenon—a disorder created by therapists in a particular social context (Menke, 1992). Rather than being provoked by trauma, dissociative symptoms tend to be exhibited by suggestible, fantasy-prone people (Giesbrecht et al., 2008, 2010). Patients do not enter therapy saying “Allow me to introduce myself.” Rather, note these skeptics, some therapists go fishing for multiple personalities: “Have you ever felt like another part of you does things you can’t control? Does this part of you have a name? Can I talk to the angry part of you?” Once patients permit a therapist to talk, by “name to the part of you that says those angry things,” they begin acting out the fantasy. Like actors who lose themselves in their roles, vulnerable patients may “become” the parts they are acting out. The result may be the experience of another self.

Other researchers and clinicians believe DID is a real disorder. They find support for this view in the distinct brain and body states associated with differing personalities (Putnam, 1991). Handedness, for example, sometimes switches with personality (Henningre, 1992). Ophthalmologists have detected shifting visual acuity and eye-muscle balance as patients switched personalities, changes that did not occur among control group members trying to simulate DID (Miller et al., 1991). Dissociative disorder patients also have exhibited heightened activity in brain areas associated with the control and inhibition of traumatic memories (Ehlers et al., 2007).

Researchers and clinicians have interpreted DID symptoms from psychodynamic and learning perspectives. Both views agree that the symptoms are ways of dealing with anxiety. Psychodynamic theorists see them as defenses against the anxiety caused by the eruption of unacceptable impulses; a wanton second personality enables the discharge of forbidden impulses. Learning theorists see dissociative disorders as behaviors reinforced by anxiety reduction.

Other clinicians include dissociative disorders under the umbrella of posttraumatic stress disorder—a natural, protective response to “histories of childhood trauma” (Putnam, 1995; Spiegel, 2008). Many DID patients recall suffering physical, sexual, or emotional abuse as children (Gleaves, 1996; Lilienfeld et al., 1999). In one study of 12 murderers diagnosed with DID, 11 had suffered severe, torturous child abuse (Lewis et al., 1997). One was set afire by his parents. Another was used in child pornography and was scared from being raised to sit on a stove burner. Some critics wonder, however, whether vivid imagination or therapist suggestion contributed to such recollections (Kihlstrom, 2005).

So the debate continues. On one side are those who believe multiple personalities are the desperate efforts of the traumatized to detach from a horrific existence. On the other are the skeptics who think DID is a condition contrived by fantasy-prone, emotionally vulnerable people, and constructed out of the therapist-patient interaction. If the skeptics’ view wins, predicted psychiatrist Paul McHugh (1995), “this epidemic will end in the way that the witch craze ended in Salem. The [multiple personality phenomenon] will be seen as manufactured.”

Before You Move On

► ASK YOURSELF
In a more normal way, do you ever flip between displays of different aspects of your personality?

► TEST YOURSELF
The psychodynamic and learning perspectives agree that dissociative identity disorder symptoms are ways of dealing with anxiety. How do their explanations differ? Answers to the Test Yourself questions can be found in Appendix E at the end of the book.

Eating Disorders

How do anorexia nervosa, bulimia nervosa, and binge-eating disorder demonstrate the influence of psychological and genetic forces?

Our bodies are naturally disposed to maintain a steady weight, including stored energy reserves for times when food becomes unavailable. Yet, sometimes psychological influences overwhelm biological wisdom. This becomes painfully clear in three eating disorders.

Anorexia nervosa typically begins as a weight-loss diet. People with anorexia—usually adolescents and 9 times out of 10 females—drop significantly below normal weight. Yet, they feel fat, fear being fat, and remain obsessed with losing weight, and sometimes exercise excessively. About half of those with anorexia display a binge-purge depression cycle.

Bulimia nervosa may also be triggered by a weight-loss diet, broken by binging on forbidden foods. Binge-purge eaters—mostly women in their late teens or early twenties—eat in spurts, sometimes influenced by friends who are bingeting (Crandall, 1988). In a cycle of repeating episodes, overeating is followed by compulsory purging (through vomiting or laxative use), fasting, or excessive exercise (Wunderlich et al., 2007). Preoccupied with food (eating sweet and high-fat foods), and fearful of becoming overweight, binge-purge eaters experience bouts of depression and anxiety during and following binges (Himz & Williamson, 1987; Johnson et al., 2002). Unlike anorexia, bulimia is marked by weight fluctuations within or above normal ranges, making the condition easy to hide.

Those who do significant binge eating, followed by remorse—but do not purge, fast, or exercise excessively—are said to have binge-eating disorder.

A national study funded by the U.S. National Institute of Mental Health reported that, at some point during their lifetime, 0.6 percent of people meet the criteria for anorexia, 1 percent for bulimia, and 2.8 percent for binge-eating disorder (Hudson et al., 2007). So, how can we explain these disorders?

Eating disorders do not provide (as some have speculated) a telltale sign of childhood sexual abuse (Smolak & Murnen, 2002; Stice, 2002). The family environment may provide a fertile ground for the growth of eating disorders in other ways, however:

• Mothers of girls with eating disorders tend to focus on their own weight and on their daughters’ weight and appearance (Pate & Rodin, 1993).

• Families of bulimia patients have a higher-than-usual incidence of childhood obesity and negative self-evaluation (Jacob et al., 2004).

• Families of anorexia patients tend to be competitive, high-achieving, and protective (Pate et al., 1992; Yates, 1989, 1990).

Those with eating disorders often have low self-evaluations, set perfectionist standards, fret about falling short of expectations, and are intensely concerned about how others perceive them (Peters et al., 2007; Foley & Herman, 2002; Sherry & Hall, 2009). Some of these factors also predict teen boys’ pursuit of unrealistic masculinity (Riccioielli & McCabe, 2004).

Genetics also influence susceptibility to eating disorders. Twins are more likely to share the disorder if they are identical rather than fraternal (Calbert et al., 2009; Klump et al., 2009; Root et al., 2010). Scientists are now searching for culprit genes, which may influence the body’s available serotonin and estrogen (Klump & Cubert, 2007). But these disorders also have a high degree of gender components. Ideal shapes vary across culture and time. In impoverished areas of the world, including much of Africa—where plumpness means prosperity and thinness can signal poverty or illness—bigger

Dying to be thin. Anorexia was identified and named in the 1870s, when it appeared among affluent adolescent girls (Bleumng, 2000). Many modern-day celebrities, including Lady Gaga, have struggled publicly with eating disorders.
Personality Disorders

What are the three clusters of personality disorders? What behaviors and brain activity characterize the antisocial personality?

Some dysfunctional behavior patterns impair people's social functioning without depression or delusions. Among them are personality disorders—disruptive, inflexible, and enduring behavior patterns that impair one's social functioning. Anxiety is a feature of one cluster of these disorders, such as a fearful sensitivity to rejection that predisposes the withdrawn avoidant personality disorder. A second cluster expresses eccentric or odd behaviors, such as the emotionless disengagement of the schizoid personality disorder. A third cluster exhibits dramatic or impulsive behaviors, such as the attention-getting histrionic personality disorder and the self-focused and self-inflating narcissistic personality disorder.

Antisocial Personality Disorder

The most troubling and heavily researched personality disorder is the antisocial personality disorder. The person (sometimes called a sociopath or a psychopath) is typically a male whose lack of conscience becomes plain before age 15, as he begins to lie, steal, fight, or display unrestrained sexual behavior (Cale & Lilienfeld, 2002). About half of such children become antisocial adults—unable to keep a job, irresponsible as a spouse and parent, and assaultive or otherwise criminal (Farrington, 1991). When the antisocial personality combines a keen intelligence with amorality, the result may be a charming and clever con artist, a ruthless corporate executive (Smiles in Suit is a book on antisocial behavior in business—or worse). Despite their remorseless and sometimes criminal behavior, criminality is not an essential component of antisocial behavior (Skeem & Cooke, 2010). Moreover, many criminals do not fit the description of antisocial personality disorder. Why? Because they actually show responsible concern for their friends and family members.

Antisocial personalities behave impulsively, and then feel and fear little (Fowles & Dindo, 2009). The results sometimes are horrifying, as they were in the case of Henry Lee Lucas. He killed his first victim when he was 13. He felt little regret then or later. He confessed that, during his 32 years of crime, he had brutally beaten, suffocated, stabbed, shot, or mutilated some 360 women, men, and children. For the last 6 years of his reign of terror, Lucas teamed with Elwood Tolle, who reportedly slaughtered about 50 people he "didn’t think was worth living anyhow" (Darrach & Norris, 1984).

Understanding Antisocial Personality Disorder

Antisocial personality disorder is woven of both biological and psychological strands. No single gene codes for a compulse behavior such as crime, but twin and adoption studies reveal that biological relatives of those with antisocial and unemotional tendencies are at increased risk for antisocial behavior (Larsson et al., 2007; Livesley & Jang, 2008). Molecular geneticists have identified some specific genes that are more common in those with antisocial personality disorder (Gunter et al., 2010). The genetic vulnerability of people...
Before You Move On

3 What contribution do genes make to the development of an individual's personality development?

4 How much does you think you have learned about the following steps in the development of personality development?

5 How important is it for us to understand the development of personality development?

6 How do you think the development of personality development is influenced by the environment?

7 How do you think the development of personality development is influenced by the individual's personality characteristics?

8 How do you think the development of personality development is influenced by the interaction of the environment and the individual's personality characteristics?

9 How do you think the development of personality development is influenced by the individual's personality characteristics and the environment?

10 How do you think the development of personality development is influenced by the interaction of the environment and the individual's personality characteristics?
Module 69 Review

69-1 What are somatic symptom and related disorders?
- Somatic symptom disorder presents a somatic (bodily) symptom—some physiologically unexplained but genuinely felt ailment.
- With conversion disorder (also called functional neurological symptom disorder), anxiety appears converted to a physical symptom that has no reasonable neurological basis.
- The more common illness anxiety disorder is the interpretation of normal sensations as a dreaded disorder.

69-2 What are dissociative disorders, and why are they controversial?
- Dissociative disorders are conditions in which conscious awareness seems to become separated from previous memories, thoughts, and feelings.
- Skeptics note that dissociative identity disorder, formerly known as multiple personality disorder, increased dramatically in the late twentieth century, that it is rarely found outside North America, and that it may reflect role-playing by people who are vulnerable to therapists' suggestions. Others view this disorder as a manifestation of feelings of anxiety, or as a response learned when behaviors are reinforced by anxiety-reduction.

69-3 How do anorexia nervosa, bulimia nervosa, and binge-eating disorder demonstrate the influence of psychological and genetic forces?
- In these eating disorders, psychological factors may overwhelm the homeostatic drive to maintain a balanced internal state.
- Despite being significantly underweight, people with anorexia nervosa (usually adolescent females) continue to diet because they view themselves as fat.
- Those with bulimia nervosa (usually females in their teens and twenties) secretly binge and then compensate by purging, fasting, or excessively exercising.
- Those with binge-eating disorder binge but do not follow binging with purging, fasting, or exercise.
- Cultural pressures, low self-esteem, and negative emotions interact with stressful life experiences and genetics to produce eating disorders.

69-4 What are the three clusters of personality disorders? What behaviors and brain activity characterize the antisocial personality?
- Personality disorders are disruptive, inflexible, and enduring behavior patterns that impair social functioning.
- These disorders form clusters, based on three main characteristics: (1) anxiety; (2) eccentric or odd behaviors; and (3) dramatic or impulsive behaviors.
- Antisocial personality disorder is characterized by a lack of conscience and, sometimes, by aggressive and fearless behavior. Genetic predispositions may interact with the environment to produce the altered brain activity associated with antisocial personality disorder.

Multiple-Choice Questions

1. Adela regularly interprets ordinary physical symptoms like stomach cramps and headaches as serious medical problems. Her doctor is unable to convince her that her problems are not serious. Adela suffers from
a. illness anxiety disorder.
b. conversion disorder.
c. fugue state.
d. dissociative identity disorder.
e. anorexia nervosa.

2. Which of the following is the defining characteristic of antisocial personality disorder?
a. Violence
b. Lack of conscience
c. Mood swings
d. Unexplained physical symptoms
e. Committing serial murders

Practice FRQs
3. Which of the following is the defining characteristic of antisocial personality disorder?
   a. Violence
   b. Lack of conscience
   c. Mood swings
   d. Unexplained physical symptoms
   e. Committing serial murders

   1. Name and briefly describe three eating disorders.

   Answer
   1 point: Anorexia nervosa is a disorder in which the individual starves themselves despite being significantly underweight.
   1 point: Bulimia nervosa is a disorder in which the individual alternates between binging and purging.
   1 point: Binge-eating disorder is a disorder in which the individual binges without purging.

   2. Dissociative identity disorder (DID) is among the most controversial of all psychological disorders. Briefly describe the disorder. Then, provide one piece of evidence that supports the existence of the disorder and one piece of evidence that would indicate the disorder might not be genuine.

   (3 points)