#32 Schizophrenic and Dissociative Disorders

It's perhaps the most stigmatized and misunderstood psychological disorder of them all, even among psychologists. Maybe because it's pretty rare, affecting about 1% of the population, schizophrenia causes more anxiety in the media, in the public, and even in doctors' offices than any other mental illness. As a result, its sufferers have often been shunned, abused, or locked up. And among the many fallacies that surround the disorder is simply what it means. *The word "schizophrenia" literally means "split mind" but contrary to popular belief, the condition has nothing to do with a split in personality or multiple personalities.* The term refers instead to what's sometimes called a "split from reality."

Multiple Personality Disorder, now known as Dissociative Identity Disorder, is a totally different type of condition. And these two are shrouded in misconceptions, partly because they were the subject of, probably, the greatest psychological hoax of all time. While many of us can relate on some level to the emotional swings, nervousness, and compulsions that come with mood and anxiety disorders, it can be a lot harder for those without direct experience to relate to the symptoms of

schizophrenia and dissociation. Unfortunately we tend to fear and avoid what we don't understand in each other, whether it's a friend of family member or just some stranger on the bus. But thankfully part of the psychologist's job is to demystify the things that can happen in our heads, and is often the case, understanding may be the key to compassion.

Schizophrenia is a chronic condition that usually surfaces for men in their early to mid-20s, and for women in their late 20s. For some the disorder comes on gradually, but for others it could arise more suddenly, perhaps triggered by stress or trauma, although no one event can actually cause the disorder. Once thought of as a single discrete condition, schizophrenia is now included in the DSM-5 as a point on a spectrum of disorders that vary in how they're expressed and how long they last, but they share similar symptoms. *Schizophrenia Spectrum Disorders are currently thought of as characterized by disorganized thinking; emotions and behaviors that are often incongruent with their situations; and disturbed perceptions, including delusions and hallucinations.*

They all involve a kind of loss of contact with reality on some level. The resulting behaviors and mental states associated with this break from reality are generally called "psychotic symptoms" and they usually impair a person's ability to function. *When someone is experiencing psychotic symptoms, their thinking and speech can become disorganized, rambling and fragmented.* This tendency to pick up one train of thought and suddenly switch to another and then another can make communication painfully difficult. People exhibiting these symptoms can also suffer a breakdown in selective attention,

losing the ability to focus on one thing while filtering others out. In extreme cases, speech may become so fragmented it becomes little more than a string of meaningless words, a condition given a name that sounds like its own kind of non sequitur, "word salad."

Classic schizophrenia is also often marked by delusions or false beliefs not based in reality. These delusions can be rooted in ideas of grandeur like "I'm the queen of England!" or "I won an Olympic gold medal for the luge!" Or they can become narratives of persecution and paranoia, believing your thoughts and actions are being controlled by an outside force or that you're being spied on or followed or that you're on the verge of a major catastrophe. And there are some complicated variations on these delusions, like feeling that you've died or don't exist anymore or that someone's madly in love with you or that you're infested with parasites. *Delusions of one kind of another strike as many as four out of five people with schizophrenia.* While some delusions can seem fairly logical, they can also be severe and bizarre and frightening.

Maybe the most memorable examples of people suffering from severe delusions come from serial killers and yeah, while Son of Sam did claim that he was taking orders from his neighbor's dog, that kind of delusional experience is extremely rare among schizophrenics. Brian Wilson of The Beach Boys and Syd Barrett of Pink Floyd both suffered psychotic symptoms. And then of course there's John Nash, the Nobel Prize winning American mathematician and subject of "A Beautiful Mind." *Through proper treatment, some people with*

schizophrenia have not only learned to live with their illness but also made fantastic creative contributions to the world.

Maybe people with schizophrenia also suffer from perceptual disturbances, or sensory experiences that come without any apparent sensory stimulation, like hallucinations. This is when a person sees or hears something that isn't there, often lacking the ability to understand what is real and what isn't. Auditory hallucinations, or hearing voices, are the most common form, and these voices are often abusive. It's as if you're inner monologue, that conversation that you have with yourself or the random things that float through your head, are somehow coming from outside of you. It's as if you couldn't sort out whether the voices in your mind were internal and self-generated, or external and other-generated. To me, it sounds terrifying. Other common symptoms include disorganized, abnormal, or incongruent behavior and emotions. This could mean laughing when recalling a loved one's death or crying while others are laughing. Acting like a goofy child one minute then becoming unpredictably angry or agitated the next. Movements may become inappropriate and compulsive, like continually rocking back and forth or remaining motionless for hours.

Broadly, most psychotic symptoms fall into three general categories traditionally used by psychologists: *positive*, *negative*, and *disorganized* symptoms. *Positive symptoms are not what they sound like. They're the type that adds something to the experience of the patient. Like, for example, hallucinations or inappropriate laughter or tears or delusional thoughts.* Negative symptoms refer to those that subtract from

normal behavior, like a reduced ability to function, neglect of personal hygiene, lack of emotion, toneless voice, expressionless face, or withdrawal from family and friends. Finally, disorganized symptoms are those jumbles of thought or speech that could include word salad and other problems with attention and organization.

****

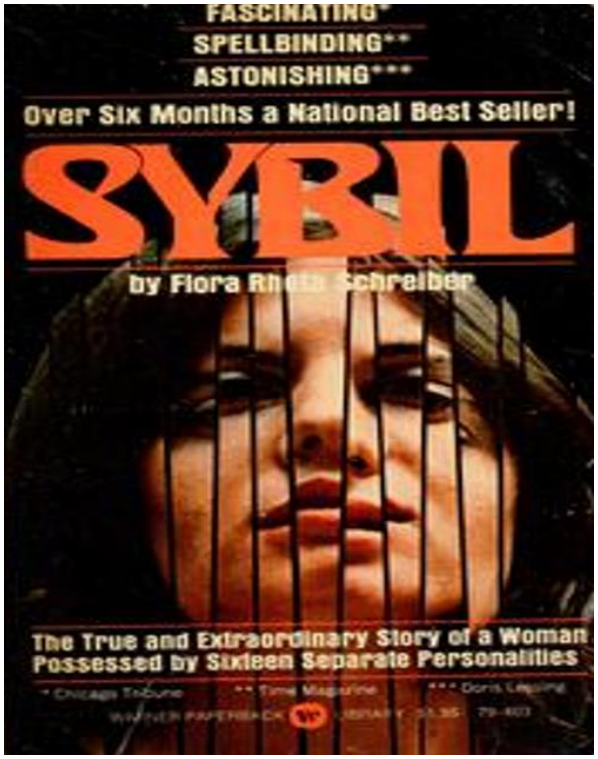
Post mortem research on schizophrenia patients has found that many have extra receptors for dopamine, a neurotransmitter involved in emotion regulation and the brain's pleasure and reward centers. *Some researchers think that overly responsive dopamine systems might magnify brain activity in some way, perhaps creating hallucinations and other so-called positive symptoms* as the brain loses its capacity to tell the difference between internal and external stimuli. For this reason, dopamine blocking drugs are often used as anti-psychotic medications in treatment.

Modern neuroimaging studies also show that some people with schizophrenia have abnormal brain activity in several different parts of the brain. *One study noted that when patients were hallucinating, for example, there was unusually high activity in the thalamus, which is involved in filtering incoming sensory signals.* Another study noted that patients with paranoid symptoms showed over-

activity in the fear processing amygdala. So, schizophrenia seems to involve not just problems with one part of the brain, but abnormalities in several areas and their interconnections. But what might be causing these abnormalities?

Earlier I mentioned how a stressful event might trigger psychotic symptoms for the first time, even though it can't actually create the disorder. Psychologists call this the "diathesis-stress model." This way of thinking involves a combination of biological and genetic vulnerabilities -- diathesis -- and environmental stressors -- stress -- that both contribute to the onset of schizophrenia. This model helps explain why some people with genetic vulnerability might not always develop schizophrenia and why the rates of schizophrenia tend to be higher with some degree of poverty or socioeconomic stress. And it seems too that there is some kind of genetic predisposition for the disorder. *The one-in-a-hundred odds of developing schizophrenia jumped to nearly one in ten if you have a parent or sibling with the disorder, with about 50/50 odds if that sibling is an identical twin,* even if those twins were raised apart. One recent landmark seven year study looked at genetic samples across 35 countries, examining more than 35,000 people with schizophrenia, and another 110,000 without the disorder. The study identified more than 100 genes that may increase the risk of schizophrenia. As expected, some of these genes involve dopamine regulation, but others are related to immune system functioning. Researchers continue to tease out what is exactly going on here, but many are hopeful that these new findings will lead to better treatment.

Clearly, schizophrenia is a challenging disorder to live with and one that's hard for outsiders to understand, but maybe even more rare and more elusive are the dissociative disorders. *These are disorders of consciousness, called dissociative because they're marked by an interruption in conscious awareness. Patients can become separated from the thoughts or feelings that they use to have, which can result in a sudden loss of memory or even change in identity.* Now, we might all experience minor dissociation at times, like maybe the sense that you're watching yourself from above, as in a movie, or like you're driving home and get so zoned out that suddenly you find yourself in front of Taco Bell thinking, like, "How did I get here?" Those things would generally fall into the normal range of dissociation, but most of us don't develop different personalities. Dissociative disorders come in several different forms, but the most infamous of the bunch is probably Dissociative Identity Disorder. This has long been known as Multiple Personality Disorder and, yes, it is a thing.



It's a rare and flashy disorder in which a person exhibits two or more distinct and alternating identities and the best known case was that of Shirley Mason, whose story was famously rendered in *the 1973 best seller "Sybil" and later in a popular mini-series. The book was marketed as the true story of a woman who suffered great childhood trauma and ended up*

with 16 different personalities, ranging from Vicky, a selfish French Woman, to handyman Syd, to the religious and critical Clara. *The book became a craze and within a few years reported cases of multiple personality skyrocketed from scarcely 100 to nearly 40,000.* Many people think the book was essentially responsible for creating a new psychiatric diagnosis. It turns out though, Sybil's story was a big fat lie. Yes, Shirley Mason was a real person and one with a troubled, traumatic past and a number of psychological issues. As a student in New York in the 1950s she started seeing a therapist named Connie Wilbur and taking some heavy medications. And somewhere in there, maybe because she was coaxed, or maybe because she wanted more attention, Shirley started expressing different personalities.

Dr. Wilbur built a career and a book deal out of her star patient, even after Shirley confessed that her split personality was a ruse. *This simple case is a powerful reminder that we really don't understand dissociative disorders very well or even know if they're always real. Indeed, some people question if Dissociative Identity Disorder is an actual disorder at all.* But some studies have shown distinct body and brain states that seem to appear in different identities, things like one personality being right handed while the other is left handed, or different personalities having variations in their eye sight that ophthalmologists could actually detect. In these cases, dissociations of identity may be in response to stress or anxiety, a sort of extreme coping mechanism. Either way, the debate and the research continue.

Today we learned about the major symptoms associated with schizophrenia spectrum disorders, including disorganized thinking, inappropriate emotions and behaviors, and disturbed perceptions. We also discussed brain activity associated with these disorders and talked about their possible origins including the diathesis stress model. You also learned about dissociative disorders, and Dissociative Identity Disorder in particular, and the scandal that was the Sybil case.

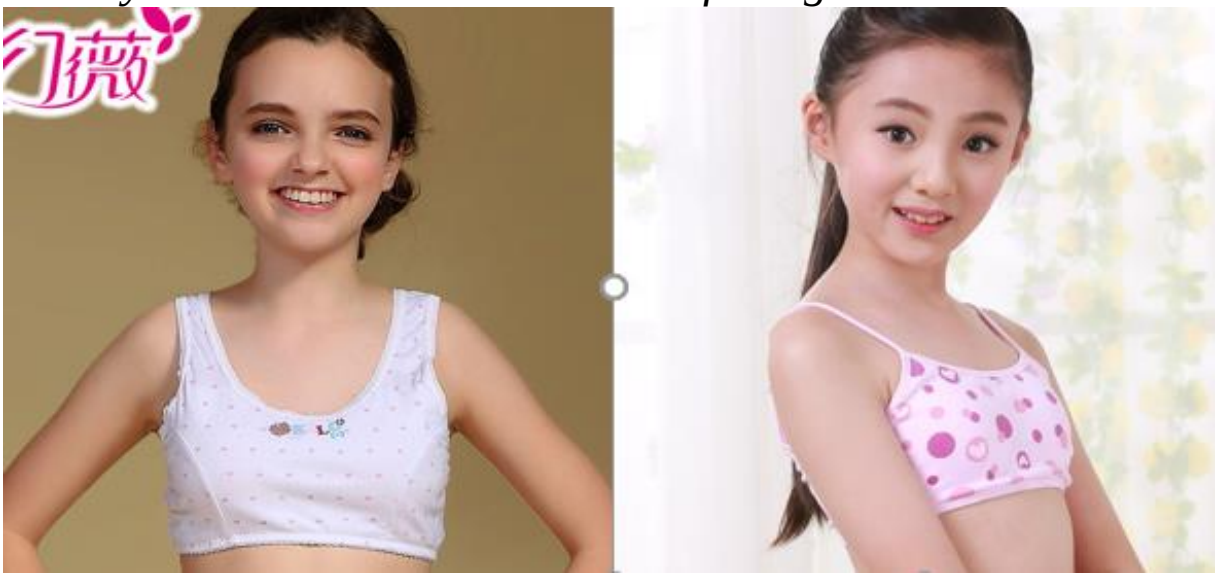
#33 Eating and Body Dysmorphic Disorders

[Adapted from Crash Course Psychology with Hank Green, written by Kathleen Yale, edited by Blake de Pastino, with psychology consultant Dr. Ranjit Bhagwat]

Introduction

When Lauren was fifteen years old, her family moved across the country and she started going to a new school. Already shy, Lauren suffered from low self-confidence and had a hard time transitioning; nothing felt right and soon her changing body became a source of insecurity. *Eventually, she began thinking that maybe if she lost weight and focused on fitness, she'd make more friends and feel better about herself and life would get better.* Soon she became obsessed with dieting and it quickly spiraled into her subsisting only on rice cakes and apples and candy corn and celery.

She liked this new feeling of control every time she stood on the scale and saw a lower number. She was achieving something, and that made her feel good. Soon, she thought of nothing else. *But what Lauren couldn't see was that she was no longer healthy. Even when her hair started falling out and her skin*



grew dry and cracked, and when she could never get warm. When she looked in the mirror, she still saw a chubby girl. Her family, though, did notice, and yet, at a visit to the doctor, she was just told to eat more. She didn't.

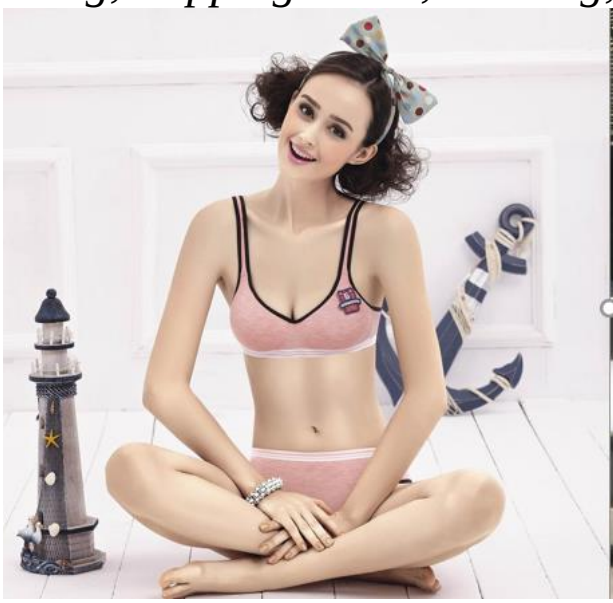
One day while jogging, she had a heart attack and collapsed. *As a teenager, she was 5 feet 7 inches and weighed eighty-two pounds. Lauren was finally admitted to a psychiatric hospital where she was treated for anorexia nervosa.* She was put on bed rest, saw a therapist twice a week, joined a support group and slowly began eating small amounts of food again.

Her recovery was slow but, with the support of her family and doctors, she was released eight months later. Though Lauren suffered a few relapses over the years, she is now healthy. Ultimately, she was lucky. *Anorexia, bulimia, and other eating and body dysmorphic disorders can kill.*

Eating disorders are among the deadliest psychological disorders, with some of the highest rates of death directly attributable to the illness. They slowly ruin the body, but, in order for these conditions to be recognized and treated successfully, they have to be understood as disorders of the mind.

Anorexia, Bulimia, Binge-Eating Disorder

Here's some scary figures: According to the National Eating Disorder Association, forty-two percent of first to third grade girls want to be thinner; eighty-one percent of ten year olds are afraid of being fat; *over half of teenage girls and nearly a third of teenage boys have used troubling weight control methods like fasting, skipping meals, smoking, vomiting, or taking laxatives.*




The rate of new cases of eating disorders in Western culture has been increasing since the 1950s, and today in the US, *an estimated twenty million women and ten million men have suffered from a clinically significant eating disorder at some point in their lives.*

But get this straight: we're not talking about fad diets or lifestyle choices spurred by vanity. Eating disorders are psychological illnesses that often come with serious consequences. *These disorders tend to fall into three main categories: anorexia, bulimia, and binge eating disorders.*

Those suffering from anorexia nervosa, most often adolescent females, essentially maintain a starving diet and, eventually, an abnormally low body weight. As in Lauren's case, *anorexia can begin as a diet that quickly spirals out of control as a person becomes obsessed with continued weight loss, all while still feeling overweight.*

Our old friend, the DSM V, actually delineates two sub types of the disorder. The first involves restriction, which usually consists of an extremely low-calorie diet, excessive exercise, or purging, like vomiting or the use of laxatives. The second type is the binge/purge sub type, which involves episodes of binge eating combined with the restriction behavior.

As you can easily imagine, the physiological effects of this psychological condition can be devastating. *As the body is denied crucial nutrients, it slows down to conserve what little energy it has,* often resulting in abnormally slow heart rate, loss of bone density, fatigue, muscle weakness, hair loss, severe dehydration, and an extremely low body mass index.

And it's that low body mass that's the defining characteristic of anorexia nervosa - a refusal to maintain a weight at or above what would normally be considered minimally healthy. If this condition persists, of course, it can be deadly, which is why anorexia has what's often estimated to be the highest mortality rate of any psychiatric disorder.

That might surprise you, given the host of troubling disorders we've already covered here on Crash Course Psychology, but *mortality rates associated with, say, major depression or PTSD or schizophrenia tend to be the result of secondary behavior, like suicide*. But with anorexia, the mortality rate is especially high because people can die as a direct result of extreme weight loss and physiological damage.

Another common eating disorder is bulimia nervosa. While anorexia is characterized primarily by the refusal to maintain a minimal body weight, bulimia is not. *People with bulimia tend to maintain an apparently normal, or at least minimally healthy, body weight, but alternate between binge eating, followed by fasting or purging, often by vomiting or using laxatives*.

A bulimic body may not be as obviously underweight as an anorexic one, but *the addictive cycle of binging and purging can seriously damage the whole digestive system, leading to irregular heartbeat, inflammation of the esophagus and mouth, tooth decay and staining, irregular bowel movements, peptic ulcers, pancreatitis, and other organ damage.*

Sometimes the two diagnoses can be difficult to discern, especially because someone may shift back and forth between

anorexic diagnostic features and bulimic diagnostic features. *The DSM V recently added a third category called binge-eating disorder, which is marked by significant binge-eating, followed by emotional distress, feelings of lack of control, disgust, or guilt, but <u>without</u> purging or fasting*.

Although sometimes triggered by stress or a need for, or lack of, control, the presence of an eating disorder is not a tell-tale sign of childhood sexual abuse, as was once commonly thought. Instead, *these disorders are often predictive indicators of a person's feelings of low self-worth, need to be perfect, falling short of expectations, and concern with others perceptions*.

Although the prevalence of bulimia and binge-eating is similar among ethnic groups in the United States, anorexia is much more common among white women, often of higher socioeconomic status.

****

Types of Body Dysmorphic Disorders

The prevalence of eating disorders is rising in males, too. Today, between ten and twenty percent of people diagnosed with eating disorders are men who feel the same pressure to attain what they imagine is physical perfection, and that's worth noting. These disorders have strong cultural and gender components; the so-called "ideal standard of beauty" varies wildly among cultures and time, and thinness is far from a universal desire, especially in countries where malnutrition and starvation are problems.

But in the Western world, and increasingly in other countries, thinness is a common pursuit. And being bombarded with images of unrealistically slender models and jacked celebrities has increased many people's dissatisfaction, or even shame and disgust, with their own bodies. These are all attitudes that can contribute to eating disorders.

Some people have even had plastic surgery to look more like Beyonce, or J-Lo, or... Barbie. When taken to extremes, this kind of behavior starts inching into the realm of body dysmorphic disorder.

Body dysmorphic disorder is another psychological illness, one that centers on a person's obsession with physical flaws - either minor or just imagined. Those suffering from this disorder often obsess over their appearance, often staring into mirrors for hours, and feel distressed or ashamed by what they see.

Although it's often lumped in with the eating disorders, our

growing understanding of body dysmorphia suggests that it actually shares some traits with obsessive-compulsive disorder, particularly the obsession with some imagined bodily perfection and the compulsion to check oneself over and over to discern perceived flaws.

Not surprisingly, BDD and OCD may share some similar neurophysiological features, although that's still being researched. *People suffering from BDD may exercise excessively, groom themselves excessively, or seek out extreme cosmetic procedures, but, unless treated, they usually remain critical and unsatisfied with their looks, to the point of fearing that they have a deformity.*

People with BDD may suffer from anxiety and depression, start avoiding social situations, and stay home for fear that others will notice and judge their appearance negatively. Obviously, this causes a lot of emotional distress and dysfunction. *Some bodybuilders suffer from a particular type of BDD called muscle dysmorphia, sort of the opposite of anorexia, where they become obsessed with the notion that they aren't muscular enough,* even if they're ripping shirts like the Hulk. And again, this isn't mere vanity; people suffering from body dysmorphia disorder look in the mirror and often see a distorted, even grotesque, image in their reflection.

Psychological And Environmental Roots

So, how do these disorders come about? Well, to be honest, we still have a lot of dots to connect. Neurologically, there are a few compelling clues. *In the case of eating disorders, for example,*

research has long suggested that neurotransmitters like serotonin and dopamine may play a role.

Dopamine is involved in regions of the brain connected to hunger and eating, like the hypothalamus and nucleus accumbens, and some research has found that binge eating appears to alter the regulation of dopamine production in a way that can reinforce further binging.

The result is a neurological pattern that can resemble drug addiction, although the addiction comparison is still pretty controversial.

Genetics appear to play a role, too, as there seems to be increased risk among genetic relatives with eating disorders as compared to controls. But a lot of attention is also being paid to environmental and familial factors, particularly the behavioral modeling and learning processes that shape how we think about

ourselves and our bodies. Specifically, children who grow up observing problematic or unhealthy eating behavior in parents may be at higher risk for developing an eating disorder. And explicitly learning unreasonable or unhealthy values about your weight or your shape from your family, and definitely from your peers, can have a powerful effect.

Conclusion

Eating and body dysmorphic disorders are serious business, but they are treatable - and perhaps even preventable. If cultural learning contributes to how we eat and how we want to look, then maybe education can help increase our acceptance of our own appearance, and be more accepting of others.

What You Learned

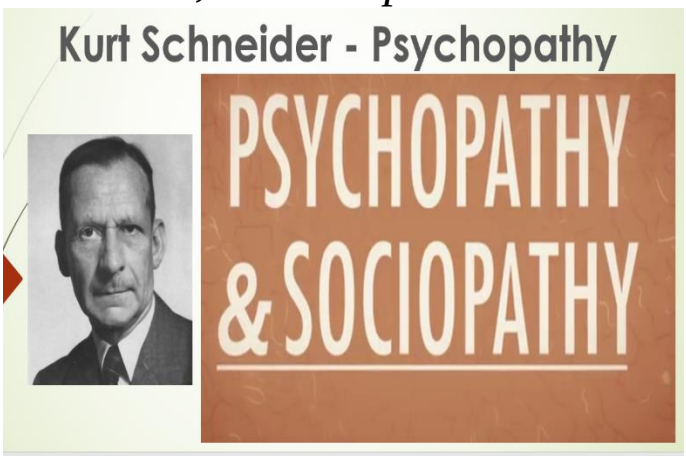
Today, you learned about the symptoms and sub types of anorexia, bulimia, and binge-eating disorder, as well as various types of body dysmorphic disorder, and some of the physiological and environmental roots of these conditions.

#34 Personality Disorders

[Adapted from Crash Course Psychology with Hank Green, written by Kathleen Yale, edited by Blake de Pastino, with psychology consultant Dr. Ranjit Bhagwat]

I can be smooth and charming and slick. I can make a very confident impression and it is hard to leave me at a loss for words. Sometimes I find myself fantasizing about unlimited success and power, and beauty. I have repeatedly used deceit to cheat, con, or defraud others for my personal gain. To be honest, I don't have much concern for the feelings of other people, or their suffering.

Doesn't sound like the Hank you know, does it? These are all statements from *the Self-Assessment measure for Personality Disorders, that lets patients describe themselves*, ranking each statement in terms of how accurate they think it is.



To be honest, you can't rely too much on this kind of self-reporting to access what we are talking about today because while some people who are over-confident or obsessed with power or downright deceitful might tell you that they are, there is a certain subset that won't.

Many of the disorders that we have talked about so far are considered, "ego-distonic" meaning that people who have them are aware that they have a problem and tend to be distressed by their symptoms. Like a person with Bipolar Disorder or OCD generally knows that they have a psychological condition and

they don't like what it does to them.

But some disorders are trickier than that. They are "ego-syntonic", the person experiencing them doesn't necessarily think that they have a problem and sometimes, they think the problem is with everyone else. Personality disorders fall into

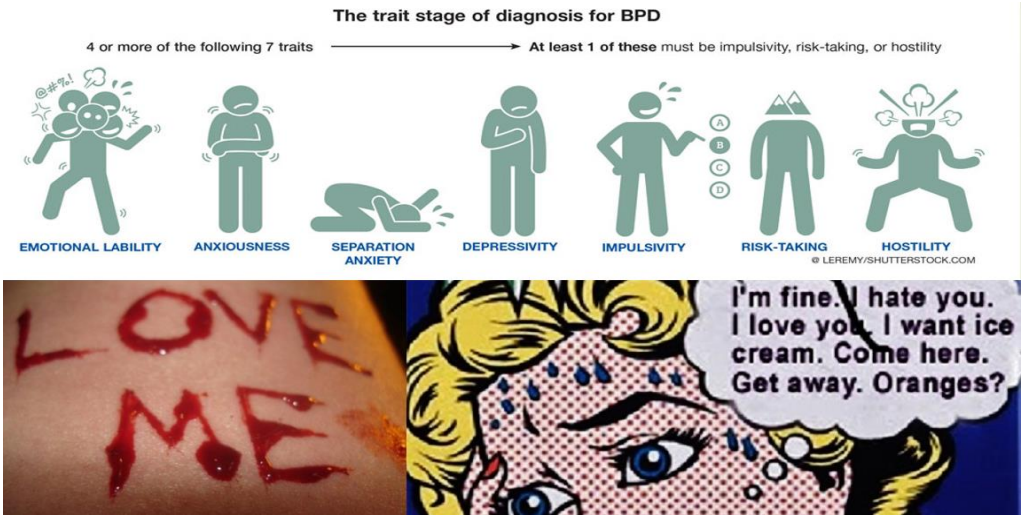
this category. These are psychological disorders marked by inflexible, disruptive, and enduring behavior patterns that impair social and other functioning-whether the sufferer recognizes that or not.

Unlike many other conditions that we've talked about, personality disorders are often considered to be chronic and enduring syndromes that create noticeable problems in life. And as you can tell from these *self-assessment statements, they can range from relatively harmless displays of narcissism, to a true and troubling lack of empathy for other people.*

Not only can personality disorders be difficult to diagnose and understand, they can also be downright scary. *Most of the extreme and severe disorders go by names that you probably recognize: psychopathy and sociopathy. I'm talking, like, serial killers here, mob bosses, and Adolf Hitler.*

Today, the DSM 5 contains ten distinct personality disorder diagnoses, grouped into three clusters. *The first cluster, cluster A, includes what are often labeled simply as "odd" or "eccentric" personality characteristics*. For example, someone with paranoid personality disorder may feel a pervasive distrust of others and be constantly guarded and suspicious while a person with a schizoid personality disorder would seem overly aloof and indifferent, showing no interest in relationships and few emotional responses.

Cluster B encompasses dramatic emotional or impulsive personality characteristics. For example, a narcissistic personality can display a selfish grandiose sense of self-importance and entitlement. Meanwhile, a histrionic personality might seem like they're acting a part to get attention, even putting themselves at risk with dramatic, dangerous and even suicidal gestures and behaviors. *Cluster B can be truly self-destructive and frightening and these disorders are often associated with frequent hospitalization.*



Finally, Cluster C encompasses anxious, fearful, or avoidant personality traits. For example, those with avoid and independent personality disorders often avoid meeting new people or taking risks and show a lack of confidence, an excessive need to be taken care of and a tremendous fear of being abandoned. Now, in the past, and, to a great extent, today, some of these categories have been controversial. Many researchers argue that some of these conditions overlap with each other so much that it can be impossible to keep them apart. Narcissistic personality disorder, for example, has many traits that resemble histrionic personality disorder.

Because of this gray area, the most commonly diagnosed personality disorder is actually personality disorder not otherwise specified or PDNOS. The prevalence of this diagnosis suggests that while clinicians can identify a personality disorder in a patient, figuring out the details of the condition can be messy and difficult.

One proposed alternative for diagnosing these disorders is the Dimensional Model, which, in essence, gets rid of discrete disorders and replaces them with a range of personality traits or symptoms, rating each person on each dimension. So the Dimensional Model would assess a patient not with the aim of diagnosing one disorder or another, but instead, simply finding out that they rank high on say, narcissism and avoidance. It's a work in progress, so with another generation, the clinical definition of 'personality disorder' may evolve pretty radically.

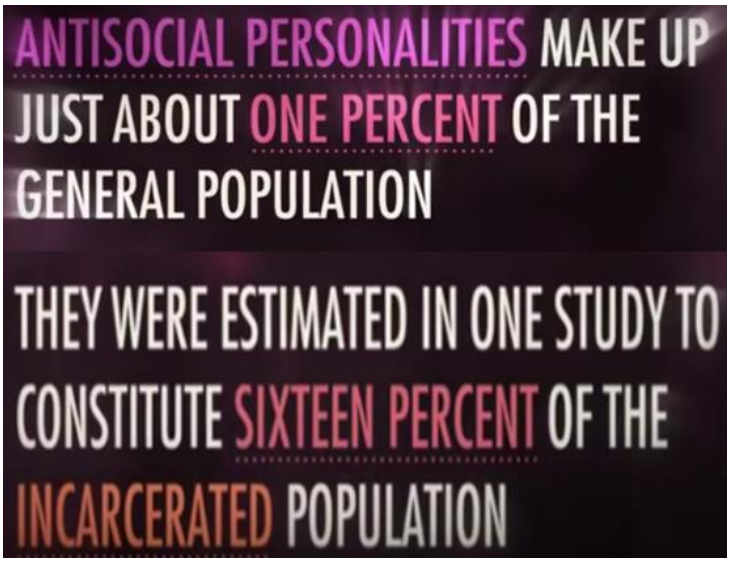
****

One of the best-studied personality disorders right now is Borderline Personality Disorder, or BPD. Borderline makes it sounds like patients are like, pretty close to being healthy, but not quite, but that is not at all the case. *BPD sufferers have often learned to use dysfunctional, unhealthy ways to get their basic psychological needs met, like love and validation,* by using things like outbursts of rage, or on the other end of the spectrum, self-injury behaviors like cutting or worse. People with BPD were once commonly maligned by clinicians as 'difficult' or 'attention-seeking', but we now understand BPD as a complicated set of learned behaviors and emotional responses to traumatic or neglectful environments, particularly in childhood. In a sense, people with this disorder learn that rage or self-harm help them cope with traumatic situations, but as a result, they also end up using them in non-traumatic situations.

But probably the most famous well-established, and frankly, troubling personality disorder is Antisocial Personality Disorder. Now, you've heard of this before, but maybe by one of its now somewhat out of vogue synonyms, 'psychopathy' or 'sociopathy'. *People with Antisocial Personality Disorder, usually men, exhibit a lack of conscience for wrongdoing, even towards friends and family members.*

The behavior of those with Antisocial Personality Disorder surfaces in childhood or adolescence, beginning with excessive lying, fighting, stealing, violence, or manipulation. As adults, people with this disorder are thought to generally end up in one of two situations: either they are unable to keep a job and engage

in violent criminal or similarly dysfunctional behavior, or they become clever, charming con-artists, or ruthless executives who make their way to positions of power.



Despite this classic remorselessness, lack of empathy, and sometimes criminal behavior, criminality is not always a component of antisocial behavior. Certainly many people with criminal records don't fit that psychopathic profile. *Most show remorse, love, and concern for friends and family, but still, although anti-social personalities make up just about 1% of the general population, they were estimated in one study to constitute about 16% of the incarcerated population.*

So, how might someone end up with such a disturbing disorder? Well, as you might expect, the causes are probably a tangled combination of biological and psychological threads, both genetic and environmental. *Although no one has found a single genetic predictor of Antisocial Personality Disorder, twin and adoption studies do show that relatives of those with psychopathic features do have a higher likelihood of engaging in psychopathic behavior themselves.* And early signs are sometimes detected as young as age three or four, often as an impairment in fear conditioning, in other words, lower than normal response to things that typically startle or frighten

children like loud and unpleasant noises. Most kids only need to get burned by a hot dish to know to stay away, but kids who end up displaying Antisocial Personalities as adults don't necessarily connect or care about the learned consequences when they're little.

Meanwhile, studies exploring the neural basis of Antisocial Disorder have revealed that when shown evocative photographs, like a child being hit or a woman with a knife at her throat, those with psychopathic personality features showed little change in heart rate and perspiration, as compared to control groups. The classic antisocial lack of impulse control and other symptoms have also been linked to deficits in certain brain structures.

One study compared PET scans from 41 people convicted of murder to those of non-criminals and found that the convicted killers had greatly reduced activity in the frontal lobe, an area associated with impulse control and keeping aggressive behavior in check. In fact, violent repeat offenders had as much as 11% less frontal lobe tissue than the average brain. Their brains also responded less to facial displays of stress or anguish, something that's also observed in childhood, so it's possible that some antisocial personalities lack empathy because they simply don't or can't register others feelings. Research has also suggested an overly reactive dopamine reward system, suggesting that the drive to act on an impulse to gain stimulation or short-term rewards regardless of the consequences may be more intense than the average person's.

As we mentioned before, because *personality disorders are pretty much egosyntonic by definition, people don't often*

acknowledge that they have a problem or the need for treatment. According to American psychiatrist Donald W. Black, among others, many kids diagnosed with Conduct Disorder, the diagnostic precursor to Antisocial Disorder, are at high-risk for developing Antisocial Personalities as adults. But by identifying warning signs early on and by working with these kids and families to correct their behavior and remove negative influences, some of that impulse fearlessness could be channeled into healthier directions, like promoting athleticism, or a spirit of adventure.

#35 Getting Help

[Adapted from Crash Course Psychology with Hank Green, written by Kathleen Yale, edited by Blake de Pastino, with psychology consultant Dr. Ranjit Bhagwat]

Major Types of Psychotherapy

Bernice has issues, and sure we all do, but hers are getting out of hand. At times she goes through bouts of depression that make it hard for her to even get out of bed. Sometimes she suffers from serious anxiety around things like test taking, flying, lots of things. All of which are brutalizing her self-worth and affecting her performance in work and life.

She's ready to get some help and, lucky for Bernice, she has a lot of options. *Psychotherapy, perhaps the predominant type of psychological treatment, involves a therapist using a range of techniques to help a patient overcome troubles, gain insight, and achieve personal growth.*

Now you know by now that there are kinds of perspectives on the human mind and lots of different philosophies on how to approach it. So it may not come as a surprise that there is also a variety of ways that experts analyze and treat ailments of the mind. They each create their own kind of experience for a person seeking help and to be honest some approaches are better suited for treating certain psychological conditions than others.

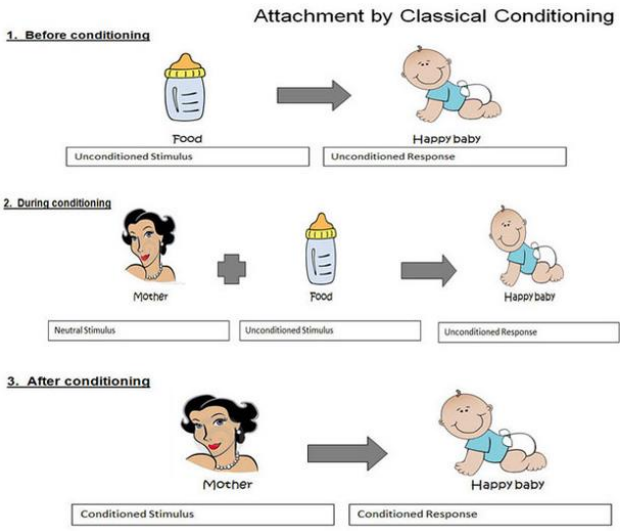
But with Bernice as our guide we can see how each of these techniques works and maybe in the end we can get her out of bed, feeling more calm and confident, and back in the swing of things……. He's back!

If we're going to talk about psychotherapy, we've got to start with Freud, right? In essence, Freud assumed that we didn't really know or at least fully understand ourselves or our motivations. So *psychoanalysis served as a kind of historical reconstruction that helped patients access repressed feelings and memories and unconscious thoughts, until they gained some self-insight.*

As you free associate, talk about your past and answer questions, your psychoanalyst picks up on sensitive subjects around which you appear to show resistance. Mental blocks that keep you from your consciousness because they cause you anxiety. The psychoanalyst notes these resistances and offers interpretations of what might be going on to help promote insight. Today, traditional psychoanalysis is less common. Critics have pointed out that *psychoanalysis tends to involve many sessions, sometimes 4 or 5 a week over a long period of time, and health insurance just won't cover that anymore.*

Behaviorist

Now if Bernice were to make her appointments with a behavior therapist, she'd experience quite a different session. Behavior therapists argue that simply knowing that you're afraid of flying, for example, won't help you from freaking out at the thought of getting on a plane. Instead *behavior therapists suggest that the problem behavior is the actual issue and the best way to get rid of unwanted automatic behavior is to replace it with more functional behavior through new learning and conditioning*. In other words, behavior therapy aims to change behavior in order to change emotions and moods. Behavior therapy is rooted in the experiments of Ivan Pavlov work by B F Skinner on operant conditioning or changing behavior by using positive or negative reinforcement.



So say Bernice is seeing a behavior therapist because of an intense fear of flying. Her therapist might use counter-conditioning, or she may use other behavior therapy methods like exposure, systematic desensitization, and aversive conditioning to help Bernice modify her reactions and behavior. *Bernice's therapist doesn't dwell on having Bernice relive old memories or helping her self-actualize, her therapist just wants to fix Bernice's problem behavior.*

Aversive conditioning is less common and usually involves pairing an unpleasant stimulus with the targeted behavior. *A classic example of adversive conditioning is giving someone with an alcohol problem a pill called Antebuse that makes them puke when they drink.*

Group and Family Therapy

But all of these different psychotherapies don't always mean being alone with your therapist and your thoughts. Most of them can be done in groups, too. *Group therapy fosters the therapeutic effect you get from interacting with other people. Not only does it help with the social aspects of mental health, but it also may remind clients that they're not alone.*

In a similar way, *family therapy treats the family as a system and views an individual's problem behaviors as being influenced by, or directed at, other family members.* Family therapists work with multiple family members to heal relationships, improve insight and communication and mobilize communal resources.

Conclusion

So, the big question remains. All evidence suggests that it does. On this final lesson we've learned about the major types of psychotherapy. These include Freud's famous psychoanalysis, and behavior and cognitive therapies. We also took a quick look at group and family therapy.