PSYCHOLOGY MONTH 2025

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Le mois de la psychologie • Psychology Month •

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Psychology 2030B

Lecture 6
Schizophrenia and Dissociative Disorders

Week of 10 February 2025

Western SocialScience

THE JOURNAL OF
ABNORMAL PSYCHOLOGY

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ORIGINAL ARTICLES

THE PSYCHOGENESIS OF MULTIPLE PERSONALITY[1]

BY MORTON PRINCE

LECTURE I

FOREWORD

As an introduction let me say that in a previous lecture (The Unconscious, Lecture VIII) I pointed out that in a general way alteration of personality is effected through the primary organization by experience and later coming into dominating activity of particular systems of ideas with their affects, on the one hand, and the displacement by dissociation or inhibition of other conflicting systems on the other. In slighter degrees and when transient this alteration may be regarded as a mood. When the alteration is more enduring and so marked by contrast with the preceding and normal condition as to obtrusively alter the character and behaviour of the individual and his capacity for adjustment to his environment, we have a pathological condition. When the alteration is slight and affects few systems it may be easily overlooked; or when it is accompanied, as it often is, by physiological disturbances, it may be so masked by them as to be mistaken for so-called neurasthenia. It is when the dissociation is so comprehensive as to deprive the individual of memory of his previous phase of personality, or of certain acquired knowledge or other particular experiences that the personality is easily recognized as a dissociated one. When the inhibiting or repressing force that induces dissociation ceases to be effective, that is when the dissociated systems

A CASE OF MULTIPLE PERSONALITY

CORBETT H. THIGPEN AND HERVEY CLECKLEY
Department of Psychiatry and Neurology, Medical College of Georgia

THE psychiatric manifestation called multiple personality has been extensively discussed. So too have the unicorn and the centaur. Who has not read of these legendary quadrupeds? Their pictures are, perhaps tiresomely, familiar to any schoolboy. Can one doubt that during medieval times many twilight encounters with the unicorn were convincingly reported? Surely in the days of Homer there were men of Thessaly or Beotia who had seen, or even ridden, centaurs almost as wise as Chiron.

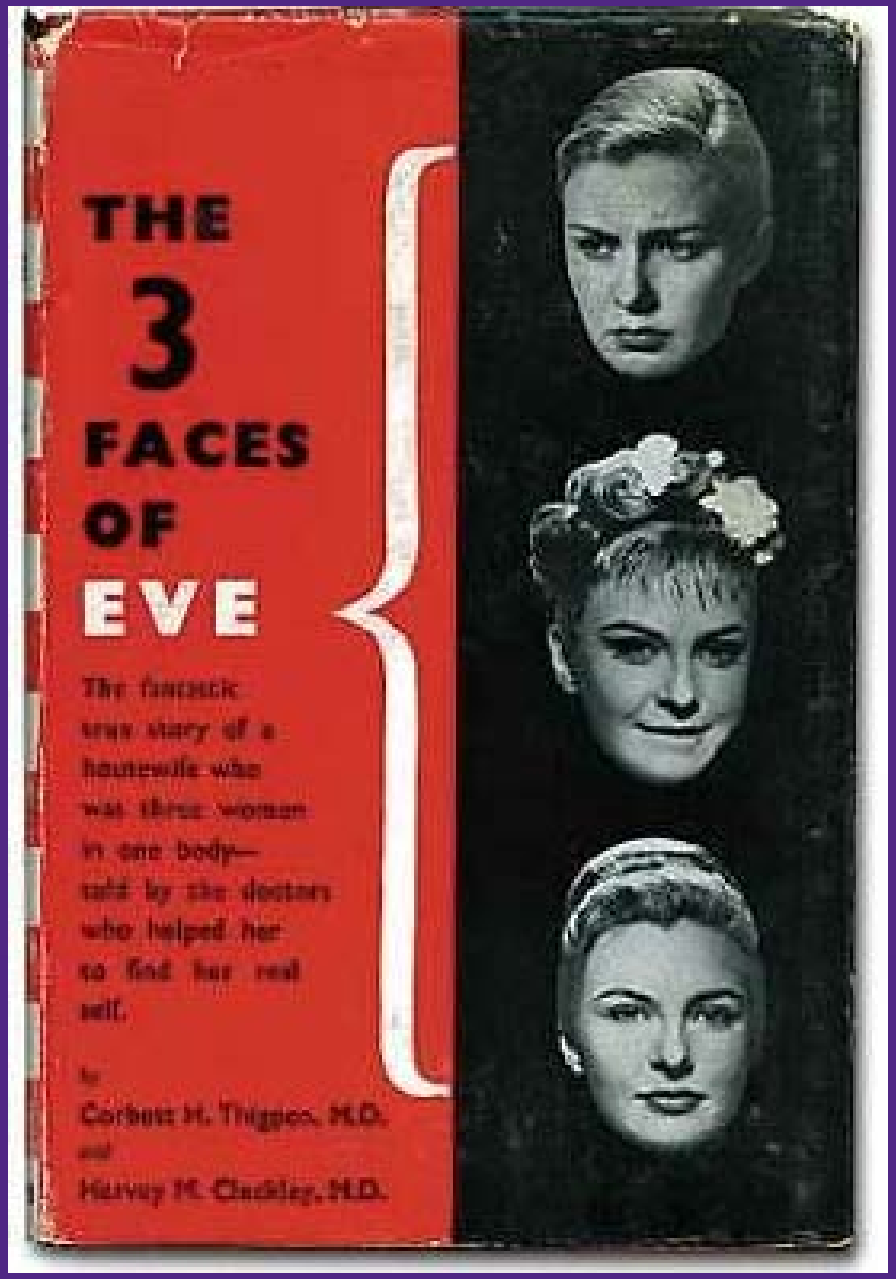
The layman who at college took a course in psychology may feel that for him *dual personality*, or *multiple personality*, is a familiar subject. Some psychiatrists' reactions suggest they are inclined to dismiss this subject as old hat. Nevertheless, like the unicorn and the centaur in some respects, multiple personality, despite vivid appearances in popularized books on psychology (2), is not commonly encountered in the full reality of life (1, 16, 17). Nearly all those perplexing reports of two or more people in one body, so to speak, that arouse a unique interest in the classroom, are reports of observations made in a relatively distant past. The most significant manifestations of this sort discussed in the current literature occurred in patients studied half a century or more ago (13, 23). It is scarcely surprising that practical psychiatrists today, never having directly observed such things as Morton Prince found in Miss Beauchamp or as Azam reported of Felida, might hold a tacitly skeptical attitude toward such archaic marvels and miracles. In the fields of internal medicine and chemistry the last, or even the middle, decades of the nineteenth century are close to us. In the relatively new field of psychopathology they are almost primeval, a dim dawn era in which we find it easy to suspect that a glimpse of a rhinoceros might have led to descriptions of the unicorn, or the sound of thunder been misinterpreted as God's literal voice.

A reserved judgment toward what cannot be regularly demonstrated is not necessarily deplorable. Some current tendencies suggest that our youthful branch of medicine may not yet have emerged from its primordial and prerational phase. The discovery of *orgone* by one of our erstwhile leaders in the development of "psychodynamics" should not be ignored (4, 25). Enthusiastically adduced "proof" from an adult's dream that he was as an embryo significantly traumatized by fear of his father's penis, which during intercourse threatened him from his mother's vagina, is, we believe, the sort of evidence toward which our "resistance" is not without value (21). Despite Morton Prince's exquisitely thorough study of the celebrated Miss Beauchamp (23, 24) it is not surprising that decades ago McDougall should have warned us:

> It has been suggested by many critics that, in the course of Prince's long and intimate dealings with the case, involving as it did the frequent use of hypnosis, both for exploratory and therapeutic purposes, he may have moulded the course of its development to a degree that cannot be determined. This possibility cannot be denied (16, p. 497).

It is perhaps significant to note that, despite the light (or at least the half-light) they throw on most of the puzzling manifestations of psychiatric disorder, the studies of Prince and others on multiple personality are not even mentioned in some of the best and most popular textbooks of psychiatry used in our medical schools today (19, 26). When mentioned at all in such works, the subject is usually dismissed with a few words (11, 20). It is particularly noteworthy that Freud, during his years of assiduous investigation, apparently displayed no appreciable interest in the development of this disorder. Erickson and Kubie cite one brief allusion (9) which they term his "only reference to the problem" (6).

Psychiatrists who would not deny outright the truly remarkable things reported long ago about multiple personality, even when accepting them passively in good faith seem often to do so perfunctorily. In the midst of clinical work, with its interesting immediate experi-


THE
3
FACES
OF
EVE
The fantastic
true story of a
housewife who
was three women
in one body—
told by the doctors
who helped her
to find her real
self.
by
Corbett H. Thigpen, M.D.
and
Hervey M. Cleckley, M.D.

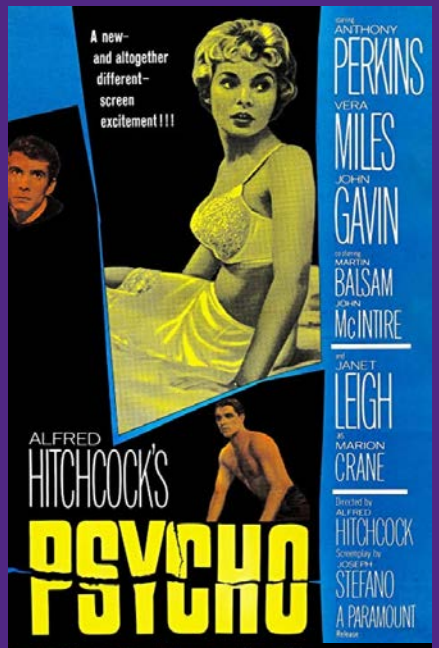
Dissociative Identity Disorder

Used to be known as

split personality

multiple personality disorder

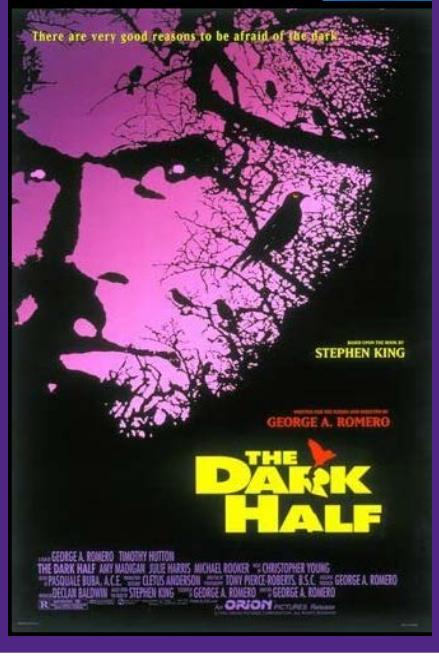

KEVIN HAS 23 DISTINCT PERSONALITIES.
THE 24TH IS ABOUT TO BE UNLEASHED.
THE NEW THRILLER FROM M. NIGHT SHYAMALAN
JAMES McAVOY
SPLIT
IN CINEMAS JANUARY 20

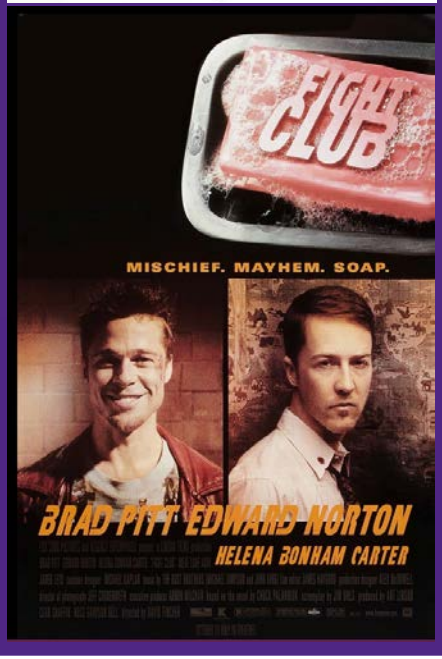

A new- and altogether different- screen excitement!!!
ANTHONY PERKINS
VERA MILES
JOHN GAVIN
MARTIN BALSAM
JOHN McINTIRE
JANET LEIGH
MARION CRANE
ALFRED HITCHCOCK'S
PSYCHO
Directed by ALFRED HITCHCOCK
Screenplay by JOSEPH STEFANO
A PARAMOUNT Release


SCHIZOPHRENIA...
WHEN THE LEFT HAND DOESN'T KNOW WHO THE RIGHT HAND IS KILLING!!
SCHIZO
LYNNE FREDERICK · JOHN LEYTON · STEPHANIE BEACHAM and JOHN FRASER
A NILES INTERNATIONAL RELEASE
A PETE WALKER PRODUCTION


DE MENTED. DE RANGED. DE CEPTIVE. DE PALMA.
JOHN LITHGOW
LOLITA DAVIDOVICH
When Jenny cheated on her husband, he didn't just leave...
he split.
A BRIAN DE PALMA FILM
RAISING CAIN

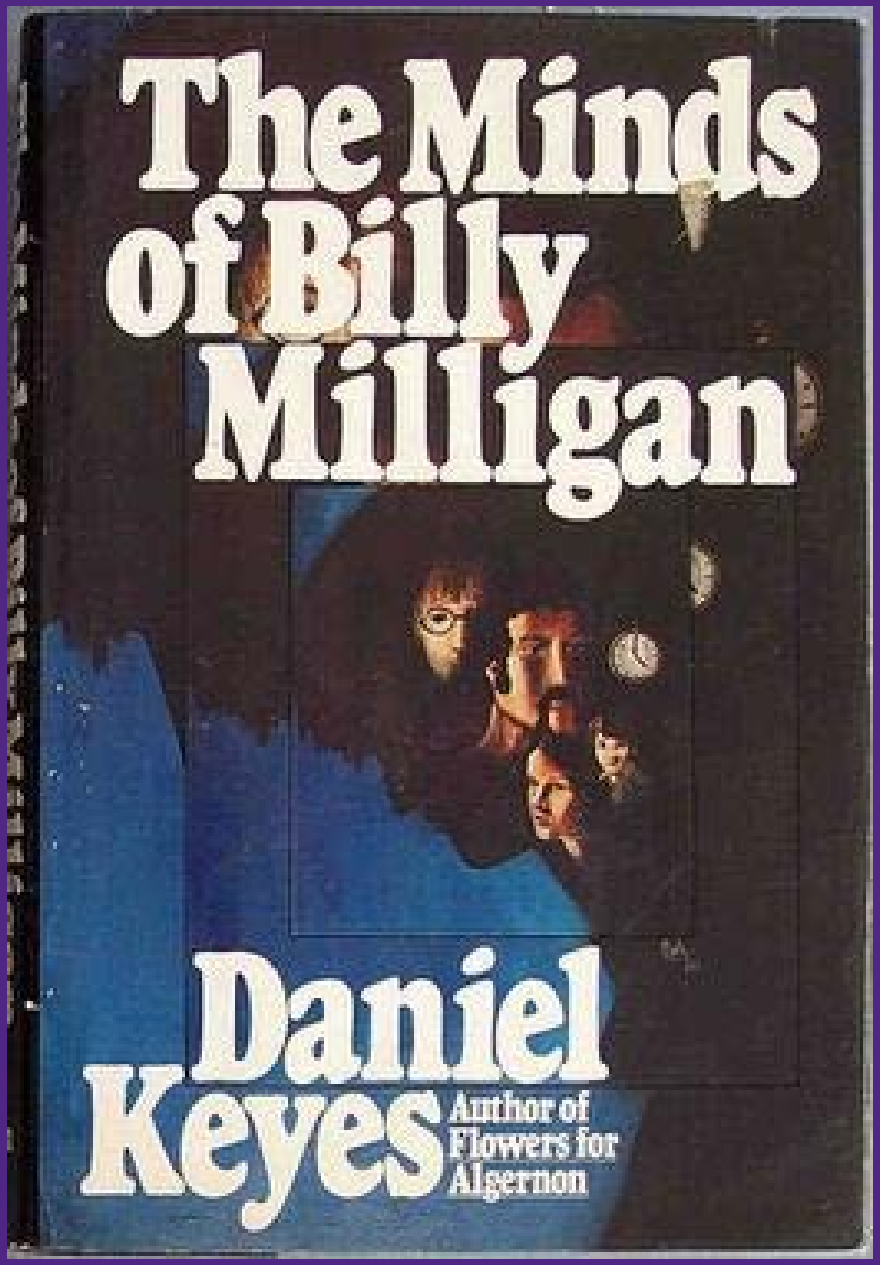

"CARPENTER PROVES HE IS STILL THE MASTER OF SHOCK."
AMBER HEARD
MAMIE GUMMER
DANIELLE PANABAKER
AND JARED HARRIS
JOHN CARPENTER'S
THE WARD


There are very good reasons to be afraid of the dark.
STEPHEN KING
GEORGE A. ROMERO
THE DARK HALF
GEORGE A. ROMERO TIMOTHY HUTTON
THE DARK HALF AMY MADIGAN JULIE HARRIS MICHAEL ROOKER and CHRISTOPHER YOUNG
PASQUALE BUBA, A.C.E. CLETUS ANDERSON TONY PIERCE-ROBERTS, N.S.C. GEORGE A. ROMERO
DECLAN BALDWIN STEPHEN KING GEORGE A. ROMERO and GEORGE A. ROMERO
An ORION PICTURES Release


FIGHT CLUB
MISCHIEF. MAYHEM. SOAP.
BRAD PITT EDWARD NORTON
HELENA BONHAM CARTER


JIM CARREY
RENÉE ZELLWEGER
FROM GENTLE TO MENTAL
Me, Myself & Irene
JUNE 23


THE
CROWDED
ROOM
JUNE 9 | tv+
TOM HOLLAND
AMANDA SEYFRIED


The Minds of Billy Milligan
Daniel Keyes
Author of Flowers for Algernon

Myths about DID

- People with DID can "switch" their personalities *("**alters**")*
- People with DID have alters that look and act differently with dramatic shifts
- People with DID are violent and/or psychotic

Myths about DID

- There is complete amnesia between alters *(“interpersonality amnesia”)*
- Only people with DID show different personalities
- Only people with DID can experience dissociation

Myths about DID

- Integration is the only possible treatment goal
- DID is due to a weak personality
- People fake DID for attention


DISSOCIATIVE
IDENTITY
DISORDER
Show
PSYCH

Common Memory Myth

Memory is like a video recorder which means we can trust our memories

Car Accident

Lost in the mall technique

DID Diagnostic Criteria

A. Disruption of identity characterized by **two** or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

DID Diagnostic Criteria

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is **not** a normal part of a broadly accepted cultural or religious practice.

Note: In children, the symptoms are **not** better explained by imaginary playmates or other fantasy play.

E. The symptoms are **not** attributable to the physiological effects of a substance *(e.g., blackouts or chaotic behavior during alcohol intoxication)* or another medical condition *(e.g., complex partial seizures).*


60 MINUTES
EXTRA MINUTES
60 MINUTES

Other disorders with dissociation

- Post-traumatic stress disorder
- Substance-induced disorder
- Severe personality disorders
- Severe panic
- Depersonalization-derealization
- Dissociative amnesia

MRS. CHRISTIE FOUND AT HARROGATE

Dramatic Re-union With Husband in Famous Hydro.

"HER MEMORY GONE"

How Missing Novelist Spent Time While Police and Public Looked for Her

Mrs. Christie, the missing inventor of detective stories, was traced last night to the Hydro, Harrogate, by her husband, Colonel Christie.

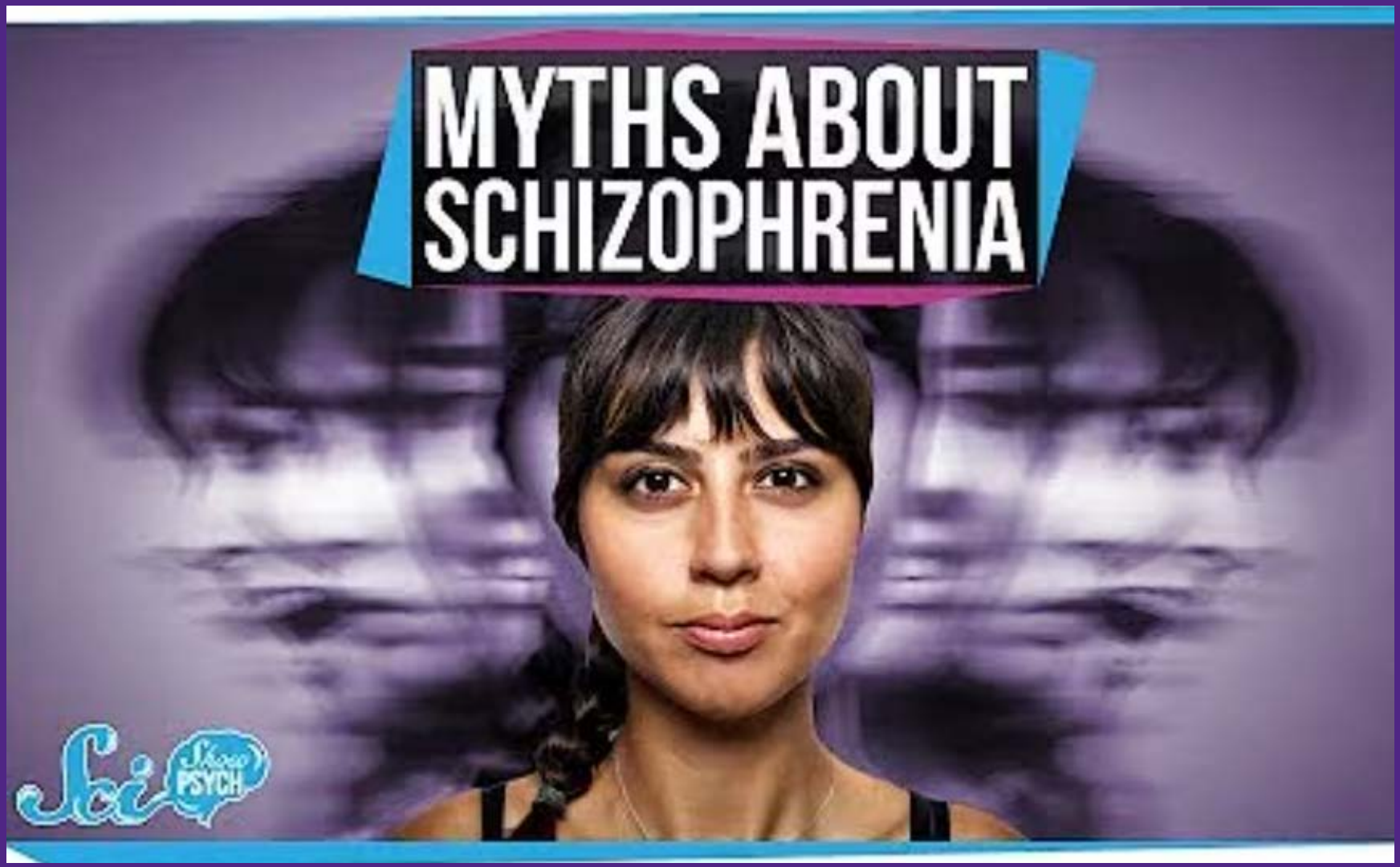
In an interview after a dramatic meeting between the pair, Colonel Christie told the DAILY HERALD that his wife had suffered from the "most complete loss of memory." She did not even recognise him, he added.

"She does not know why she is here."
—Col. Christie

Mrs. Christie

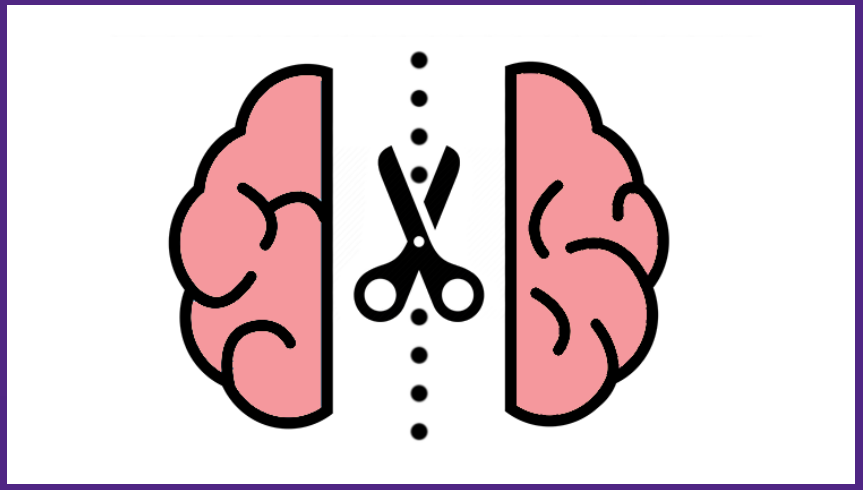
Col. Christie

Western SocialScience


MYTHS ABOUT
SCHIZOPHRENIA
PSYCH

Schizophrenia

- Dementia Praecox
  - Cognitive deterioration that occurs prematurely
- Schizophrenia
  - “Split Mind”
  - Split between mind and reality



Gerald – Part 1

Delusions

Delusions are fixed beliefs that are **not** amenable to change despite conflicting evidence

Delusions are deemed **bizarre** if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences.

Delusions

Persecutory delusions *(i.e., belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group)*

Referential delusions *(i.e., belief that certain gestures, comments, environmental cues, and so forth are directed at oneself*)

Grandiose delusions *(i.e., when an individual believes that he or she has exceptional abilities, wealth, or fame)*

Erotomanic delusions *(i.e., when an individual believes falsely that another person is in love with him or her)*

Nihilistic delusions *(i.e., a major catastrophe will occur)*

Somatic delusions *(i.e., preoccupations regarding health and organ function)*

Delusions

Delusions can be difficult to separate from **"overvalued ideas"**

- unreasonable ideas that a person holds (but may have at least some level of doubt that it is true)
- it is possible to understand the development of these ideas based on previous experience

People with Delusions

- in simple, affectively neutral decision-making paradigms, a deluded person needs less information to arrive at a definite decision than people without a delusion

- reduced ability to form a valid hypothesis about another person's state of mind with regard to oneself - **"Theory of Mind"**

People with Delusions

in comparison to healthy persons, deluded patients tend to attribute negative events or situations more often to other people or to external circumstances and not to themselves

- this is also true for topics that have nothing to do with the actual delusional theme


HALLUCINATIONS

Hallucinations

- Hallucinations are perception-like experiences that occur without an external stimulus
- They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control

Hallucinations

- They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders
- Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual's own thoughts

Hallucinations

There can be hallucinations that are *unrelated* to psychotic phenomena

Hypnagogic hallucinations

- Vivid experiences that begin at the start of sleep and are said to be unbelievably realistic
- Include sight, hearing, touch, and sometimes the sensation of body movement

Hypnopompic Hallucinations

- Similar to hypnagogic, but occur while a person is waking up

Both are considered normal but may sometimes occur in conjunction with sleep paralysis


EXECUTIVE
OFFICER IN
CHARGE OF
RADISHES

Disorganized Thinking (Speech)

- Disorganized thinking *(formal thought disorder)* is typically inferred from the individual's speech
- The individual may switch from one topic to another *(derailment or loose associations)*
- Answers to questions may be obliquely related or completely unrelated *(tangentiality)*

Disorganized Thinking (Speech)

- Rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization *(incoherence or "word salad")*
- Because mildly disorganized speech is common and nonspecific, the symptom **must be severe enough** to substantially impair effective communication

Negative Symptoms

Negative symptoms account for a substantial portion of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders.

- **Diminished emotional expression** includes reductions in the expression of emotions in the face, eye contact, intonation of speech (prosody), and movements of the hand, head, and face that normally give an emotional emphasis to speech

- **Avolition** is a decrease in motivated self-initiated purposeful activities. The individual may sit for long periods of time and show little interest in participating in work or social activities

Negative Symptoms

Negative symptoms account for a substantial portion of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders.

- **Alogia** is manifested by diminished speech output
- **Anhedonia** is the decreased ability to experience pleasure from positive stimuli or a degradation in the recollection of pleasure previously experienced
- **Asociality** refers to the apparent lack of interest in social interactions and may be associated with avolition, but it can also be a manifestation of limited opportunities for social interactions


BBC
SUBSCRIBE

Diagnostic Criteria for Schizophrenia

A. **Two** (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least *one* of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized speech
   (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms
   (i.e., diminished emotional expression or avolition)

Diagnostic Criteria for Schizophrenia

B. For a significant portion of the time since the onset of the disturbance, **level of functioning** in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset *(or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).*

C. **Continuous signs of the disturbance** persist for at least 6 months. This 6-month period must include at least 1 month of symptoms *(or less if successfully treated)* that meet Criterion A *(i.e., active-phase symptoms)* and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form *(e.g., odd beliefs, unusual perceptual experiences).*

Diagnostic Criteria for Schizophrenia

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been **ruled out** because either:

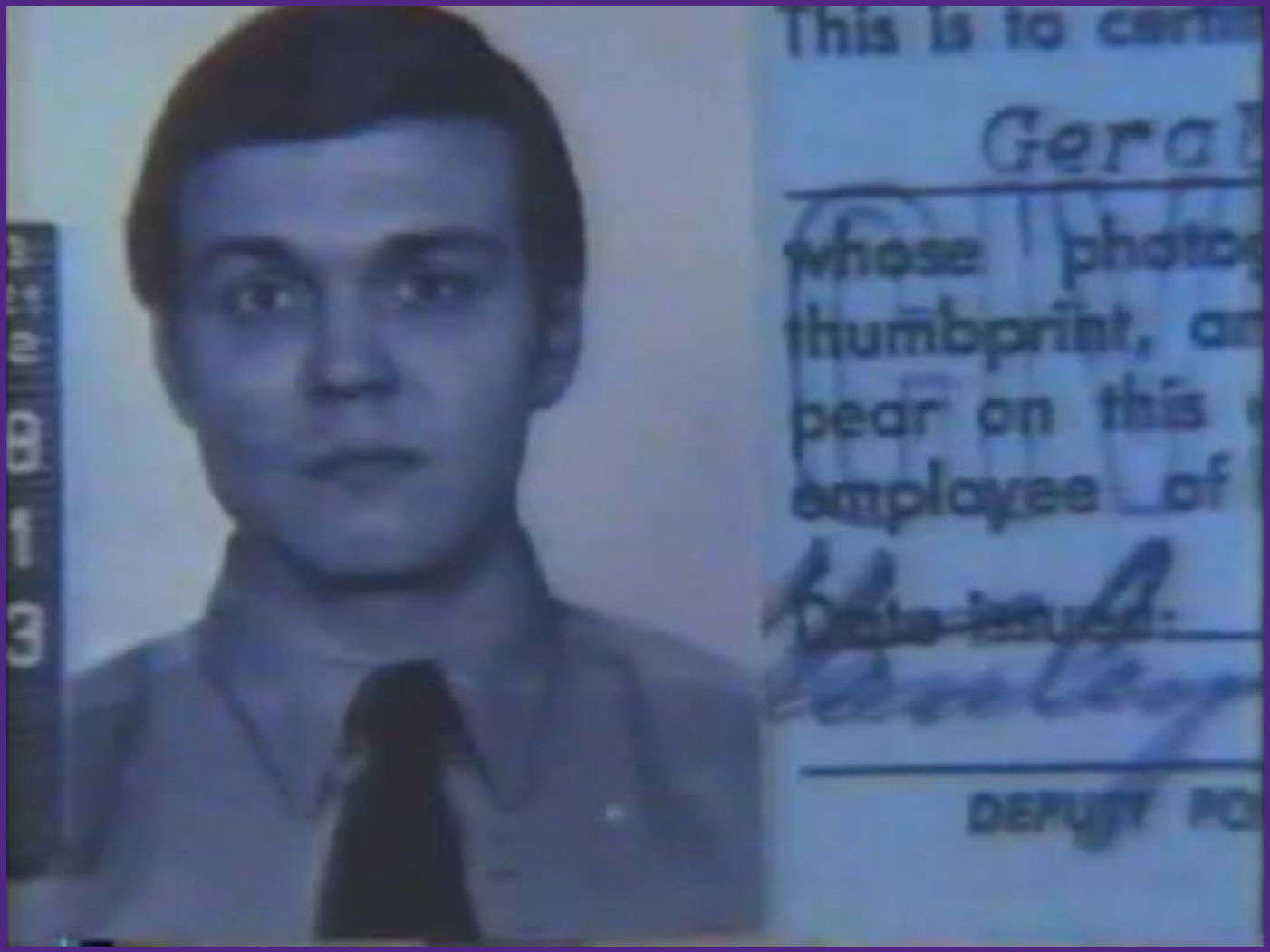
   1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or

   2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is **not** attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a **history of autism** spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

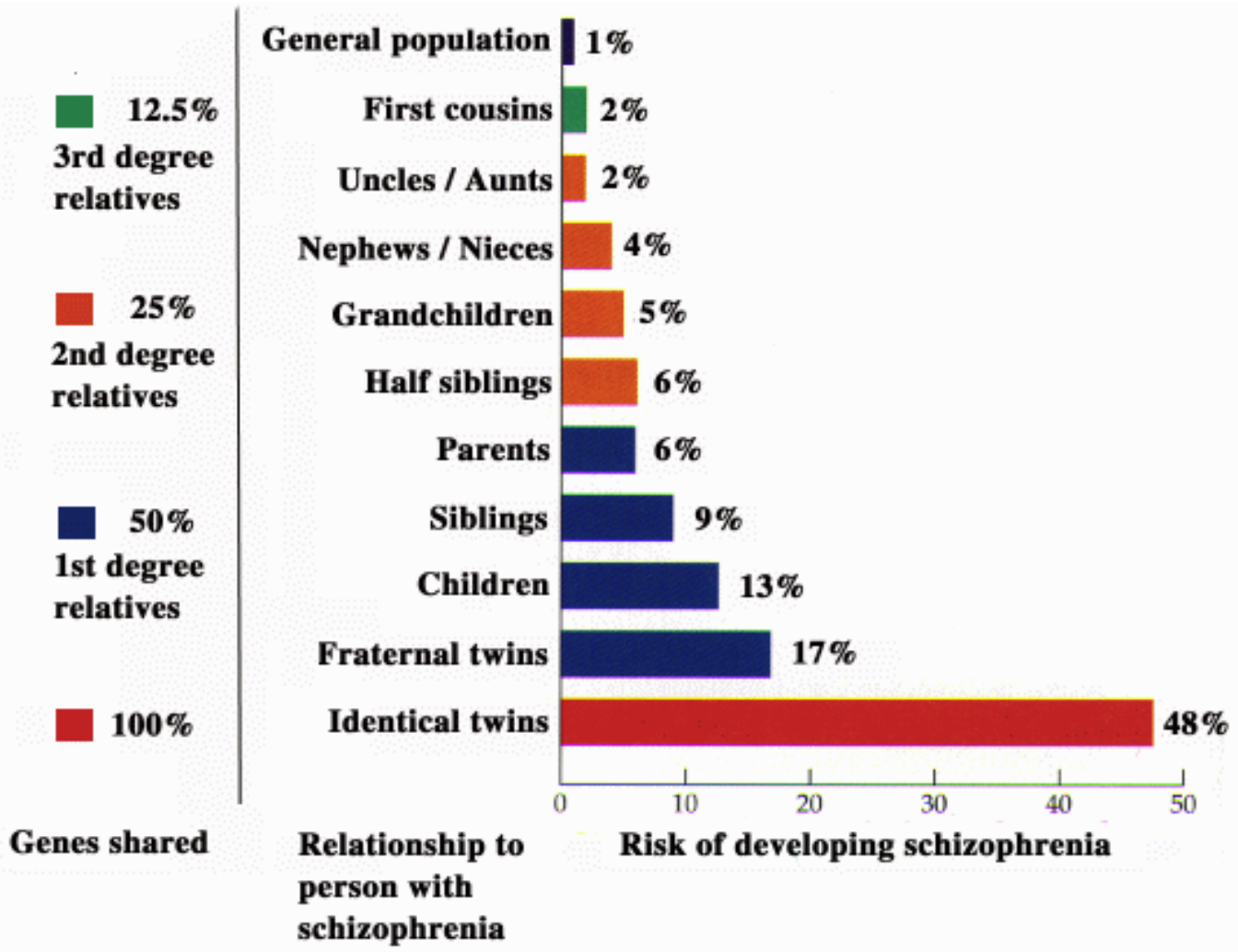
Gerald – Part 2



…with Catatonia

- Catatonic behavior is a **marked decrease** in reactivity to the environment.
- This ranges from:
  - resistance to instructions *(**negativism**);*
  - to maintaining a rigid, inappropriate or bizarre posture;
  - to a complete lack of verbal and motor responses *(**mutism and stupor**).*
- It can also include purposeless and excessive motor activity without obvious cause *(**catatonic excitement**).*
- Other features are repeated stereotyped movements, staring, grimacing, mutism, and the echoing of speech.

Genetics of Schizophrenia



Diathesis-Stress Model

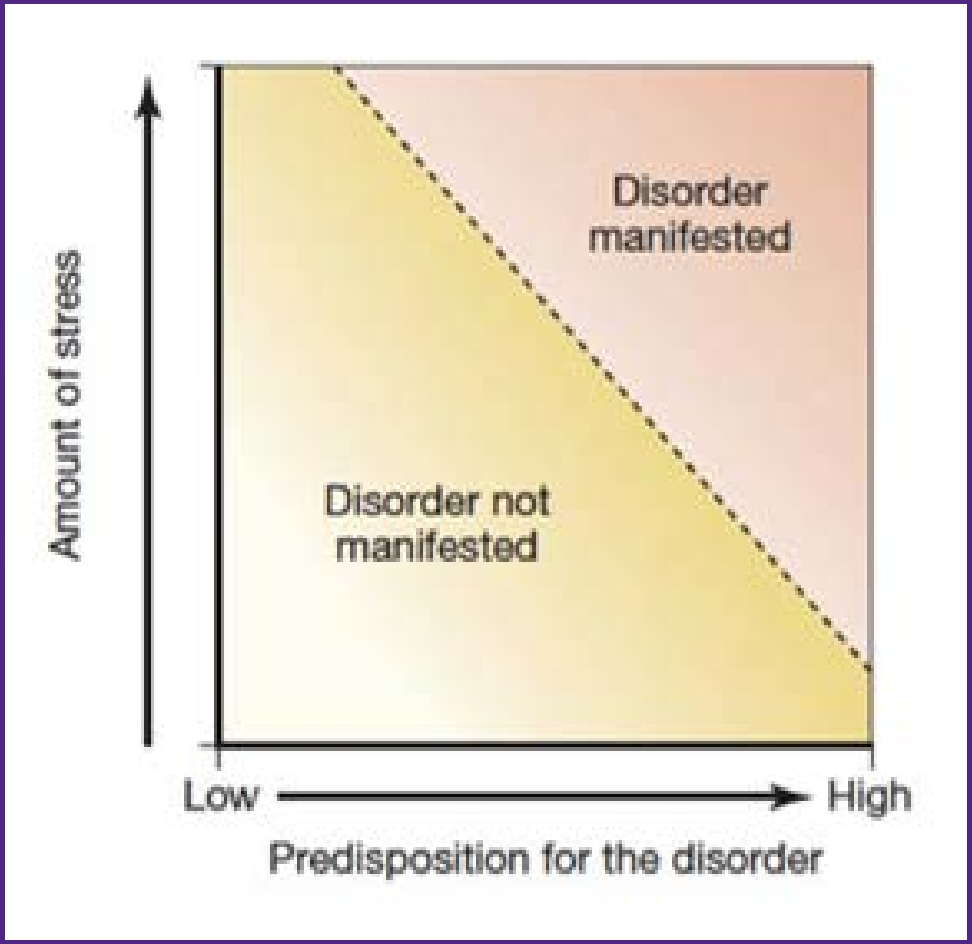


FIGURE 1 REPRESENTING DIATHESIS-STRESS WITH THE CUP ANALOGY

CBT for Schizophrenia

- Strong research support
- The goal is **not** to “cure” schizophrenia
- The goals are to:
  - improve the person’s ability to function independently
  - cope with and manage the symptoms of the disorder
  - reduce the distress they experience in their daily life
  - reduce the potential for future relapse

Cognitive Behavioral Therapy for Schizophrenia

CBT for Schizophrenia

- Unique considerations include:
  - Non-confrontational
  - Normalizing psychotic experiences as they are seen on a continuum with non-psychotic experiences
  - While CBT usually focuses on psychotic symptoms, also helpful with associated depression and anxiety that result
  - Collaboration with medication management
  - More likely to be long-term treatment than CBT for other disorders

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