Chapter 14: Personality: Mental and Behavioral Disorders

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Personality: Mental and Behavioral Disorders

Nonprofessionals -- friends or colleagues -- usually make the first judgment that someone's behavior is abnormal. Defining what is abnormal can be done in terms of statistical norms, personal comfort, or social definitions of normal behavior. A working definition of behavior includes subjective discomfort, eccentricity in behavior, and any changes in your behavior. Some people studying about abnormal personalities begin to think the symptoms about which they're reading apply to them. This is an error of judgment to be avoided. A number of assessments allow us to estimate the magnitude of mental health problems in today's society.

The earliest modern diagnostic systems of abnormal behavior classified only symptoms. Such labels cause problems. Labeling

may be dangerous because it leads some people to ignore the persons affected and encourages some disturbed people not to feel responsible for themselves. Labeling people may stigmatize them long after the abnormal behavior that caused the label has changed. A full diagnosis of psychological problems relies on both a medical examination and a psychological assessment though many initial diagnoses are performed by friends of the affected person.

The newest listing of mental disorders identifies many new categories of abnormal behavior that reflect changing social customs and views. Mild disorders normally involve anxiety, attempts by the person to avoid or reduce that anxiety, and self-defeating behaviors. Among those experiencing an anxiety disorders, the generalized anxiety which is present is in excess of the anxiety most of us feel at times. Phobic disorders involve fears out of proportion with the potential dangers of a situation. Obsession and compulsion are also anxiety-based disorders.

Somatoform disorders involve physical symptoms for which no physical explanation can be found. Among these are somatization disorders, hypochondriasis, and conversion disorders involving loss of sensory skills or physical disabilities. Dissociative disorders such as amnesia (loss of memory), fugue (amnesia and travel to a new environment), and multiple personalities involve a sudden change in memory and/or identity.

The large number of symptoms and the broad variety of severe disorders make precise diagnosis of some disorders very difficult. Diagnosing Schizophrenia is particularly challenging -- whether paranoid, disorganized, catatonic, undifferentiated, or residual. For both process and reactive schizophrenias there seem to be many complex causes. Similar difficulties can occur in identifying the various forms of mood disorders, which include variations in mood from severely depressed to manic. Other enduring personality disorders include a wide range of disorders from Paranoid Personality Disorder to the antisocial personality.

WHAT'S THE ANSWER?

"Wilma, I just can't go on!"

"What's the problem, Rudy? It seemed to me that you were finally getting things under control."

"True, but I've got all these courses! We've got finals coming up in the next two weeks, and I can't possibly be ready. I'm so nervous my stomach is always in knots. I start studying one thing and then spend half my time worrying about something else I should be doing. Study all this week. Work at my part-

time job on Saturdays. Take exams next week. I can't even get to sleep when I go to bed!"

"Why do you suddenly think you can't go on, Rudy?"

"It seems as if it's gotten worse these last two weeks. I get the feeling I'm going to have a nervous breakdown. I've just got to drop out of school." *What's going on here? Should Rudy drop out of school? Is he likely to suffer a "nervous breakdown"?*

People who have experienced severe automobile accidents sometimes find that they are unable to recall anything about the accident itself, or of events immediately (sometimes even days) before the accident. *Is this loss of memory abnormal?*

What is "Abnormal" Behavior?

What is abnormal behavior? That's one of the most difficult questions psychologists have to answer. It's difficult because it is also hard to define what is normal. It's hard because what's normal at one point in time may be abnormal at another. And what's normal in one environment may be quite abnormal somewhere else.

Typically, a psychologist (or psychiatrist) qualified to judge whether behavior is normal or abnormal doesn't get involved in that decision at the beginning. Usually someone's behavior has already been judged abnormal by one or more friends, family members, or co-workers before they are consulted.

What does that mean? Consider the following. Some person close to you may follow a course of behavior that after a while puts you in a state of constant anger, fear, or anxiety. You would then want to call in a professional to see whether a label should be placed on this person's pattern of behavior. If a label -- a diagnosis -- can be found, you would feel justified in trying to persuade that person to accept treatment that would try to change his or her behavior back to normal.

Judgment of abnormality is complex but important in several ways. For instance, in a job situation, you first need to know what others think is normal behavior. Abnormal behavior at work can have serious results not only for the person involved but for those dependent on him or her for support. A number of different sets of factors -- individual, environmental, and societal -- must be brought to bear in diagnosing someone's behavior as "abnormal." Though infrequent, abnormal behavior reflecting mental illness does occur. In Feature 14.1 read

about one possible source of influence that many people have thought affects our behavior.

FEATURE 14.1

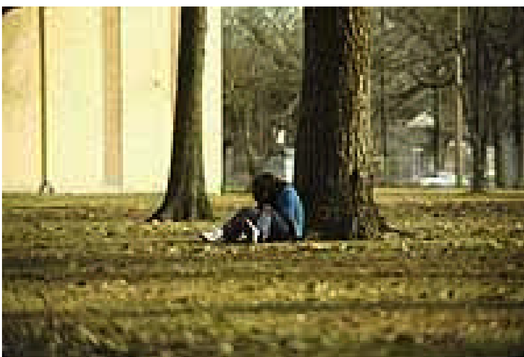
"WHERE WERE YOU WHILE THE LIGHTS WERE OUT?"

It has long, long been a subject of argument. Does the phase of the moon affect human behavior? Even the word "lunatic" shares its derivation with "lunar," but does the moon really cause people to act in unusual ways?

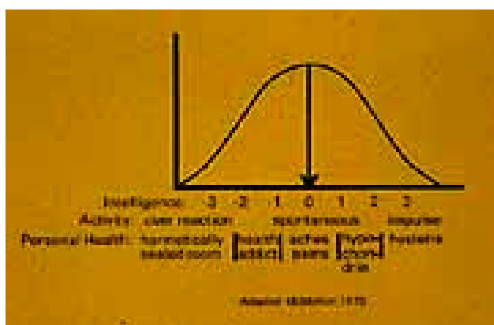
A study of this question completed in the late 1970s did an unusual thing. Rather than studying the effect itself, the researchers simply analyzed a large number of published reports on the impact of the moon on human behavior. Some researchers found one time of the lunar cycle to be most active, others found another. Poems and literature have long pointed to the romantic qualities of the full moon. But what did these modern researchers find when they pulled all the data together? There was no trend. No lunar phase was any more likely than another to be related to human behaviors that often lead to psychiatric hospital admissions, suicides, or homicides.

Bases for Defining Abnormality

Attempts to define "abnormal", or deviant, behavior fall broadly into three categories -- statistical, personal, and social. We'll study each of them briefly.



As an example of a statistical definition of normality, consider a behavior that applies to almost all humans -- how clean we keep our home. Someone who walks around with a cleaning rag all the time would be considered compulsively (we define it elsewhere) neat. Someone who who simply drops papers, clothes, or whatever, at the moment he or she is done with them, would be considered abnormally sloppy. By this definition, to be normal demands conformity.



Abnormality is hard to define since the behavior being measured is on a continuum. The range of intelligence is another good example of how gradually differences in ability shade into "abnormality." Moreover, to be abnormally clean -- a surgeon can't be too clean! -- or smart may have different values in our society than being abnormally sloppy or mentally below average. The borders between normal and abnormal can be very hard both to define and to defend.

It must be admitted that the personal feelings of happiness and adequacy should play a role in our definition of abnormal behavior. Any of us may at some time seek professional help for problems that are not even visible to our friends or family. Yet, even here there are difficulties in definition. The internal discomfort that would cause one person to seek help might be considered normal wear-and-tear by another. And we've got to exclude organic (physical) causes before we can say a purely psychological problem is involved. Sometimes we may seek professional psychological help because we think we've got an emotional-behavioral problem. Actually, however, there may be a physiological explanation for our feelings -- perhaps an internal chemical imbalance or a disease.

We describe elsewhere, oft-times the first judgment of abnormality may be made by our friends. This is an example of where our eccentric behavior, if judged eccentric by social norms, may be called abnormal. If you always go out to water your yard only when it's raining outside, people may begin to watch you more closely. If you act as if you are mortally afraid of some harmless thing, (called having a phobia), again people will call your behavior abnormal. An example of this latter effect is described in Feature 14.2.

FEATURE 14.2

VOODOO?

The power of the environment in helping each of us maintain contact with reality is often underestimated. One example of the adverse power of purely outside forces to affect us internally is provided by voodoo. Stories of voodoo hexes have been often told in modern times. Probably you have read about voodoo dolls being stuck with pins and of other voodoo practices. What some have called the only complete study of the power of voodoo death cites a number of instances where tribal members were hexed, "boned," or bewitched. The end result was death. But why? Citing a wide variety of scraps and bits of findings that seem to confirm these stories, one investigator has suggested three factors. Notice how each factor is environmental, not mysterious in any way.

The three factors are (1) the devastating effects on the body of continuing intense fear -- it can have a number of demonstrable physical effects. (2) The power attributed to the customs (superstitions) of the society. Suppose you've heard of the power of voodoo actions all your life and seen its effects a number of times. If you have the misfortune to be "hexed," then it's likely you will respond as you've seen (or heard of) so many others doing. Finally, (3) each member of the community may aid the effects of voodoo hexes by isolating the victim. Without the benefit of people with whom to talk, friends to offer support, food to eat, or a task to perform, and with everyone treating you as if you were already dead, essentially all emotional and personal support is removed. The effects can be devastating.

The major difficulty with such socially based definitions of what is normal and abnormal is that social norms change or differ from place to place. It would not now be normal for a member of Congress to show up in formal suit wearing a powdered white wig for a day's debate. Yet, not to have done so would have been considered abnormal 200 years ago. Whereas it might be abnormal to wear a cowboy hat all the time in Boston, it would not be abnormal to do so in Dallas!

Still, there are some other ways to define normal social behavior. In a court of law, your behavior may be declared abnormal simply because of the professional judgment of a

psychologist or psychiatrist. In this sense you are abnormal if a professional says you are. Such a judgment is usually based on statistical averages, repeated testings of "normal" performance, and so forth.

There are a number of sources that may lead to abnormal human behavior -- environment, chemicals, inherited inclinations. One psychiatrist phrased the dilemma about as well as anyone. Thomas Szasz said, "Whenever we try to give a definition of what mental health is, we simply state our preference for a certain type of cultural, social and ethical order." Any time any one starts to lay out a definition of what constitutes abnormal behavior, they are -- to a certain extent -- making a value judgment; those can become very argumentative.

A Working Definition of Abnormal Behavior

One of the best means of identifying abnormal behavior is to start by acknowledging the wide variety of sources of influence of our behavior. This leads to a wide range of human behaviors that are or may be acceptable. Thus, developing a precise definition of abnormal behavior is very difficult. Let's try it this way: Abnormal behavior exists if we find that one or more of three conditions exists. First is subjective discomfort. If you feel uncomfortable and it influences (a) others around you, (b) your ability to maintain yourself personally and (c) your ability to do your work, then you probably do need help.

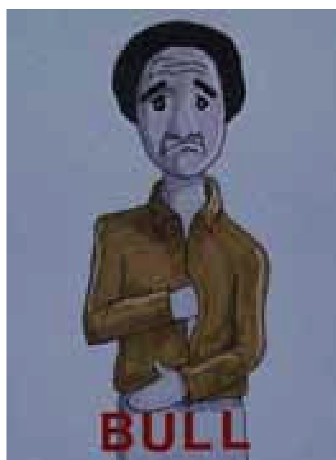
Second is eccentricity in behavior. If you are not behaving predictably relative to your environment, then your behavior is abnormal. Speech normally reflects rational thinking, so incoherent speech is a good indicator of eccentric behavior. It is important that this eccentricity causes you discomfort and that it noticeably affects the comfort of others around you.

Third, if there is a change in your behavior in relation to your previously accepted behavior, then in some sense you are acting abnormally. A comparable physical example would exist if you have always perspired easily, and suddenly found that even on very hot days you were not perspiring. You would begin to suspect something was wrong. "Normal" for you, however, might be a rate of perspiring that would cause others to think they were sick. The same applies to your behavior. Such changes might mean that you need professional help.

Beware of "Abnormal" Behavior

It happened quite rapidly. Maria was a first-year medical student studying some of the wide variety of illnesses medical doctors are now able to diagnose. One morning Maria was reading about lung infarctions (collapses) resulting from impeded blood circulation through the lungs. As she read she thought she was beginning to feel some slight pains in her chest. When she studied rashes, she began to notice some small red spots on her arms.

Later, Maria again felt as if the text authors were writing about her when she came to the section on latent melancholia. (It's despondency brought on by worrying too much about things like lung infarctions and rashes.)



As our difficulties in defining abnormal behavior show you, no one is "normal," even though very few of us are seriously abnormal. Maria was not suffering from any of the maladies she was reading about other than a slight feeling of melancholy, perhaps.

Some of the descriptions of abnormalities that we review in this chapter may seem to apply to you. This is

frequently the case with medical students, who tend to recognize all types of symptoms and ailments in themselves. Many things read about in medical journals and psychology texts can sound uncomfortably familiar. But remember the old Mark Twain saying: "Anyone who has himself as a lawyer has a fool as a client." Beware of the Medical Student Syndrome; and then continue learning about abnormal behaviors!

How Widespread are the Problems of Mental Illness?

A large group of investigators undertook the interviewing of a sample of 1,660 people who lived on the East Side of New York's Manhattan. During the interview each person was also given a questionnaire. By assessing the mental health of this sample the investigators hoped to gain an overall estimate of mental health and abnormal behavioral problems.

Table 14.1 shows the percentage of people interviewed and tested who were diagnosed as having varying degrees of abnormality.

Table 14.1

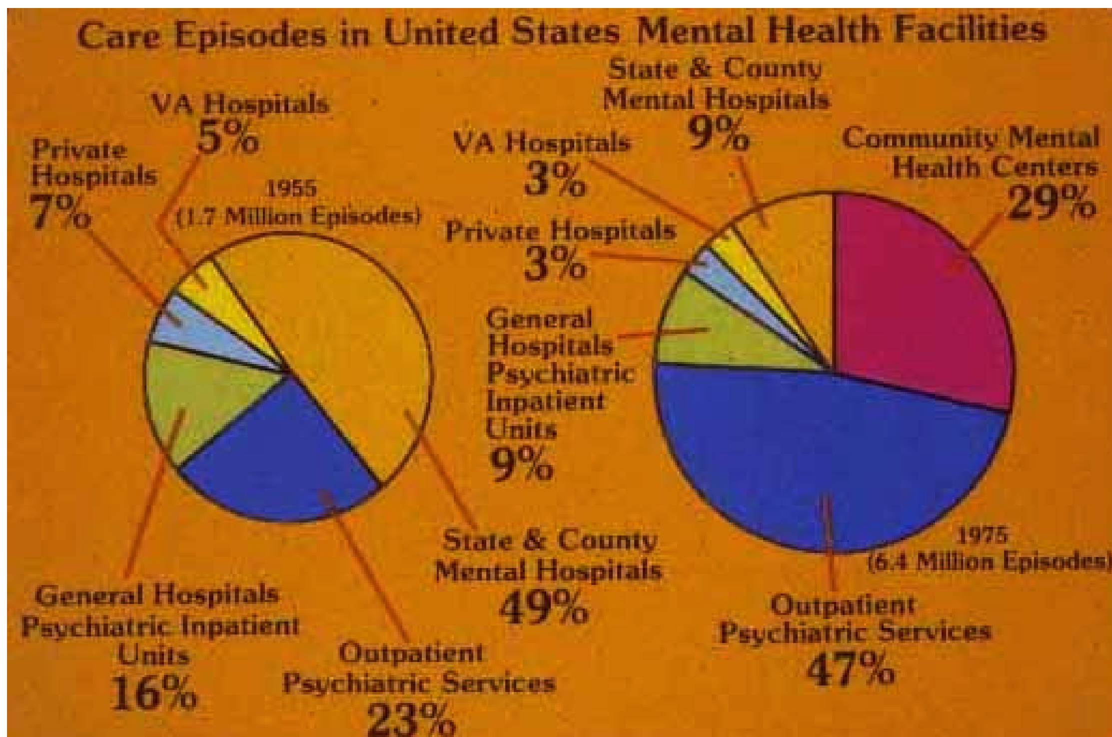
Diagnosing Abnormality

Diagnosis	Percent
Well	18.5
Mild	36.3
Moderate	21.8
Marked	13.2
Severe	7.5
Unable to Function	2.7

Let's combine only the last two classifications -- severely impaired and totally incapacitated. Doing so we still end up with about ten percent of the citizenry experiencing problems severe enough to qualify as abnormal behavior.

Despite the large number of people who may be experiencing mental problems, the average rate of admissions to mental hospitals has been going down since the mid-1950s! Why is that? There are several explanations. First and foremost,

tranquilizers were developed in the mid-1940s. By a decade later their impact was beginning to be observed. Patients previously too disturbed to be treated could be calmed down with chemicals. These subdued patients were soon able to return to their homes. Second, as we discuss in Personality: Psychotherapy Chapter, modern patterns of treatment have emphasized growing use of community-based mental health centers. Third, more personnel are available for the treatment of severely disturbed patients. The net result is that each patient is getting more attention these days and thus stands a better chance of recovery.



Nonetheless, mental illness is a very expensive drain on the nation's resources. It's a drain in terms of lost productivity, of increased expenses for treatment, and of large numbers of workers who must care for and treat these patients. The very process of diagnosing those with abnormal behaviors is problematic.

Problems of Diagnosis

In order to treat abnormal behavior and assist the processes of personal adjustment, we must first be able to diagnose the problem. It wasn't until this century that the

problem of mental disorder came to be recognized as an illness. Well into the 19th century abnormal behavior was much more likely to be blamed on evil spirits, or "possession." Mental illness still clearly carries some of the stigma attached to it by humanity's earlier views on the subject.

The original broad system of behavioral descriptions was devised by Emil Kraepelin in 1909. Though not without its problems, it was the first modern system for dividing "possession by evil spirits" into a more logical system of diagnosis based on the analysis of symptoms. Eugen Bleuler followed this by devising a system of identifying terms that stressed the internal processes occurring within the affected person. However, both Kraepelin and Bleuler were mainly concerned with serious personality disorders. Sigmund Freud, in turn, made many contributions to our understanding of abnormal behavior. One was his detailed analysis of the causes, symptoms, and treatment of the milder mental disorders that he called neuroses, now called anxiety-based disorders.

In modern times the Diagnostic and Statistical Manual (DSM-IV) published by the American Psychiatric Association is the most complete listing of symptoms, labels, prognoses, and sample cases. The newest version of that manual, called DSM-IV, was published in 1994. We analyze some of the logic behind DSM-IV and the various conditions it diagnoses in anxiety-based disorders.

Dangers

Using a formal list of behavioral disorders such as the DSM-IV does cause some problems. One is that sometimes we attach more importance to the label than to the behaviors being diagnosed. What does that mean? Simply that sometimes friends and neighbors, as well as professionals, seem to take smug satisfaction in finding someone already labeled as a "catatonic schizophrenic" or as having a " passive-aggressive personality disorder." The labels cause people to ignore the person and to become less sensitive to any changes in that person's behavior. Having labeled somebody, we must still remain sensitive to how changes in his or her behavior may indicate progress or change in the nature of that disorder from which the person suffers.

Another problem is that by labeling someone's behavior you may begin to remove from that person a feeling of responsibility for improving or correcting his or her own problem. Some personality disorders involve a large proportion of self-controlled behavior. Thus, it's always possible that people may begin to act in some manner because it's "expected" of them.

People may say to themselves, "I'm sick. I've been labeled as having a '(fill in your own title) disorder,' so I should act accordingly."

Percentage of Patients in Each Diagnostic Group Showing Specific Symptoms

Sympton	All patients (N=793)	Schizophrenia (N=287)	Manic-Depression (N=75)	Neurotic (N=152)	Character Disorder (N=279)
Depression	38	28	64	58	31
Suspicious	35	65	25	16	17
Hallucinations	19	35	11	4	12
Suicidal attempt	16	12	24	19	15
Suicidal ideas	15	8	29	23	15
Withdrawn	14	25	4	12	7
Irresponsible behavior	14	24	9	9	8
Perplexed	12	5	5	6	18
Assaultive	10	7	4	11	14
Threaten assault	9	12	11	6	7
Maniacal outburst	9	20	11	1	2
Bizarre ideas	8	11	8	8	4
Apathetic	7	7	3	7	9
Perversions	5	2	0	5	10

A third problem is that people's lives change. A particular set of circumstances -- probably never to be experienced again -- may cause a unique, temporary problem for someone. Labeling the person "disordered" under those circumstances may saddle them for many years with a label and imply limits to their abilities that long ago ceased to exist.

Fourth, most systems of classification are based on acts or behaviors. However, once a person's behavior has been diagnosed and labeled, it often happens that the label becomes attached to the actor rather than to the act. This doesn't give enough importance to the environment in which we each find ourselves. Something may cause us to behave in an abnormal manner, but the label then seems to gain the upper hand.

All of these problems were demonstrated in an interesting experiment performed in the early 1970s. Eight people with no history of mental disorder (a psychiatrist, several psychologists, a psychology graduate student, a housewife, and a painter) went to hospitals complaining of hearing voices saying words like "empty," "hollow," and "thud." Once admitted to the hospital -- and they all were -- each followed his or her normal

behavior. These pseudo-patients were interested in seeing how long it would take the hospital staff to detect their normalcy.

The surprising and discouraging thing is that it never was detected! The eight quickly switched to being seriously worried about how and whether they would get out! They were detained in the hospital from seven to 52 days, averaging 19 days each. When they were released, their records indicated a diagnosis of "schizophrenia in remission." Consider the dangers we've just listed. First, notice how the label "schizophrenia" seemed to interfere with the staff's ability to detect normal behavior. Second, notice that despite the patients' return to completely normal behavior (after gaining admission with their stories about voices), the staff did not recognize normal behavior as such. Rather, the staff made the behavior (such as note taking which the investigators did) fit the label. Third, notice that the patients' records upon release showed only that their "schizophrenia" was "in remission" -- not that it was cured or removed, or that it never existed. Each patient, without the help of the people running the experiment, would have been stuck with that diagnosis. Finally, notice that the eight people simply said they "heard voices." Yet, the label was ultimately applied to them as people, not to the behavior (hearing voices) that had gained them admission to the hospital.

These problems of diagnosis have several causes. First, the number, variety, and combinations of behaviors that may lead to a particular diagnosis are tremendous. The labeling system is not as complex as the conditions and behaviors to which it must be applied. Second, time pressures in most mental health treatment facilities still limit the amount of time that can be directed to the observation of each individual patient. (Interestingly, other patients detected that the investigators above were not "sick.") Third, getting into such a facility is much easier than getting out. The procedures for committing a person are better defined than those for releasing someone. In one sense there are more "watchdogs" (meaning average citizens such as fellow workers or family members) to call abnormal behavior to the attention of the proper personnel. It is also harder to detect improved behavior in the limited conditions existing in mental treatment facilities. Feature 14.3 includes comment on assessing mental illness.

FEATURE 14.3
ASSESSING MENTAL ILLNESS

Special terms are used when talking about mental Illness. Some have to do with the Illness, while others involve the

likelihood of correcting the problem. We will define each term for you.

Suppose a person who is behaving abnormally is brought in to a community mental health center. The person is suffering delusions and hallucinations. She is incoherent, unable to maintain a logical line of thought. In fact, she's markedly illogical, and she's showing badly disorganized behavior. A psychologist, knowing there is no known organic explanation, might then ask the following questions about her behavior:

(1) Are symptoms under voluntary control?
  No = Go to question #3
  Yes = Ask Question #2
(2) Does the person have an obvious goal?
  Yes = Malingering
  No = Factitious disorder
(3) Have symptoms started within past 7 days?
  Yes = Ask question #4
  No = Ask question #5
(4) Are symptoms related to a very upsetting environmental stressor?
  Yes = Brief reactive psychosis
  No = Atypical psychosis
(5) Other similar questions that the psychologist feels are appropriate.

This is a *diagnosis* being performed. It's an attempt to assign a label to a condition, based on the symptoms being presented. Since many people with particular patterns of symptoms have been studied, it is also possible to predict how likely it is that an abnormal behavior can be corrected. This is giving a *prognosis*.

Once diagnosis and prognosis are specified, either or both of two things may happen: Treatment may be started if corrective measures have already been developed. Or, research may be conducted (or continued) to identify the cause (etiological agent) of the behavior.

Diagnosis (assessment), prognosis (probable outcome), treatment, and etiology (cause) are four terms with which you should become familiar.

Diagnosis: Human or computer?

Anyone whose behavior is being analyzed usually has his or her examination divided into two parts -- medical and psychological. Although we will not focus on such disorders to any extent, certain of behavioral disorders are caused by

medically identifiable problems. For instance, during the late months of his presidency, George H. W. Bush suffered a problem with his thyroid gland. Once the problem was identified, newscasters could look back at the President's news conferences during the preceding several weeks and note that President Bush -- normally very easy-going at such meetings -- had become increasingly irritable. After the fact, it was realized that the change in behavior could be attributed to his hyperthyroidism. Such physical ills can be detected through a normal physical check-up, through detailed examination of the person's nervous system, and through use of the EEG measures of brain-wave activity that we discussed in the physiological processes Chapter. Data from any of these sources are combined with psychological assessment to lend greater accuracy to the diagnosis.

Psychological assessment has traditionally stressed the behavior of the individual. Modern means of analysis also stress the cultural and social environment from which the person comes, yet the focus is still on the individual. There are two major sources of information for such assessments: interviews and personality tests, which we will discuss in the Testing Chapter. Such testing may involve direct observation of how a person behaves (perhaps in a group situation), and/or the use of a wide range of psychological tests -- everything from achievement and aptitude to intelligence and personality. Integrating data from many or all of these sources can be, as you must by now suspect, a very complex job of diagnosis.

In the past, a single psychologist or psychiatrist, who then made the diagnosis, often analyzed data such as these. More recently teams including a psychologist, a psychiatrist, and perhaps a psychiatric nurse and a social worker have been used. In addition, some tests, and some procedures of diagnosis, now rely on computers. Computer diagnosis, of course, is only as accurate as the information fed into the computer (the "input"). However, it is excellent for matching a complex set of inputs (describing a patient's behavior) with a wide variety of possible symptoms. From these various matchings a "best-guess" diagnosis of a person's behavioral problem often emerges. The role of computers in such diagnoses is likely to increase markedly in coming decades. In

fact, one of the classic early studies of diagnostic accuracy pitted teams of psychologists against a computer. Both working with the same data yielded the startling finding that the computer was more accurate with its diagnoses than the team. A controversy developed about these findings because it was suggested that a substantial amount of the psychologists' disagreement was based on difficulties in agreeing on the diagnostic categories. In turn, this difficulty was an important factor leading to the development of the early versions of the Diagnostic and Statistical Manual of Mental Disorder (DSM).

USING PSYCHOLOGY:
How Can You Judge What is Abnormal?

What often starts the process of admitting a person to a hospital for observation or analysis of abnormal behavior? The first judgment that the person's behavior is abnormal is made, not by a professional, but by the person's friends, neighbors, family, or fellow workers. If one of your friends began behaving strangely, at what point would you decide to encourage him or her to seek professional help? How would you make the judgment that the behavior was abnormal?

A group of psychologists was interested in answering exactly that question. They asked a large number of students, and a similarly large number of public health nurses, police, social workers, ministers, and physicians (not psychiatrists) to react to items from a widely used test of normal human behavior. These people were asked to indicate which items identified abnormal behavior. For example, one item usually said, "I have frequent attacks of nausea and vomiting." That item was changed to "He has frequent attacks of nausea and vomiting." People reviewing the 190 statements like that were asked to indicate how concerned they would be about a person's being a disturbed psychiatric patient if they observed such behaviors. These people were asked whether they would show no, some, or much concern.

What do you think they found? What would you use to judge the behavior of one of your friends as abnormal? Table 14.2 contains the results.

Table 14.2

Information Provided by DSM-IV Diagnostic Labels

CATEGORY FOR AXIS	DIAGNOSTIC ASSESSMENT INFORMATION PROVIDED
I CLINICAL DISORDERS	A specific label identifying the disorder except for Personality Disorders and Mental Retardation, taking as much of the available information into account as possible.
II PERSONALITY DISORDERS	Report of any accompanying Personality Disorders and/or Mental Retardation. May also include (a) prominent personality features which impede adaptation and/or (b) obvious defense mechanisms
III GENERAL MEDICAL CONDITIONS	Includes any related (aggravating) physical disorders. For example, diabetes might make treatment of depression (which includes loss of appetite) difficult, but it does not result from depression. Thus it is an aggravating physical disorder.
IV PSYCHOSOCIAL and ENVIRONMENTAL PROBLEMS	Factors that might impede diagnosis, treatment and prognosis of Axis I and II disorders. Stressors may include such factors as family, job, living arrangements, financial or legal matters, stage of life, illness, or injury.
V GLOBAL ASSESSMENT of FUNCTIONING	Diagnosis also includes an estimate of the highest level of functioning based on social relations, performance on job, and positive use of leisure time; numerical scale, 1 to 100, higher being better.

Listed there are each of the general types of behavior, which this large sample of people watched. As indicated, there

are three major types of deviant behavior most people use to judge someone's behavior to be abnormal. The first type concerns social inadequacy, which means behavior contrary to normal moral, social, or legal expectations. The second cluster of symptoms involves personal inadequacy, or being unable to perform at normal levels of personal confidence and ability. The last factor focuses on tendencies that involve a variety of abnormal personal actions. They emphasize behaviors not closely related to our normal environment.

If you look at the items being measured in the Table, you will note that they can be grouped into six clusters: (a) drug and alcohol abuse, (b) social maladjustment, (c) destructive tendencies, (d) personal inadequacy, (e) thought disorder, and (f) unusual preoccupations. These are the behaviors to which you should pay attention. They will help you make what is never an easy judgment -- deciding when a behavior is abnormal enough to require professional help.

Diagnostic and Statistical Manual of Mental Disorders-IV

The *Diagnostic and Statistical Manual* describes several categories of abnormal behavior differently now than in earlier editions. Some psychologists assert that, as a result, DSM-IV places too much emphasis on medical causes of behavioral problems and too little emphasis on psychological causes. Table 14.3 lists the major features of various mental disorders which are described on the five diagnostic axes (or categories) of DSM-IV.

Table 14.3

Major Diagnostic Categories (Axis I) of the Diagnostic and Statistical Manual Of Mental Disorders (DSM-IV)

Disorders Usually First Diagnosed before/during Adolescence
Delerium, Dementia, and Amnestic and other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders

Schizophrenia and other Psychotic Disorders
Mood Disorders
Anxiety Disorders

Somatoform Disorders

Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders

Eating Disorders
Sleep Disorders

Impulse-Control Disorders
Adjustment Disorders
Personality Disorders (Coded on Axis II)

The disorders may be life-long conditions, but generally tend to be short-term or episodic; they tend to be subject to modification through some form of therapy.

In comparison to the earliest editions of the DSM, a major shift in emphasis has occurred in what used to be called the neuroses. In the earliest editions a person might be identified as experiencing a neurotic disorder, dissociative type. What used to be sub-types of neurosis are now identified more precisely as anxiety, somatoform, dissociative, and sexual disorders on Axis I. Why was this change made? There are several reasons. First, the category "neurosis" was so broad that very few neurotic disorders had many symptoms in common. Moreover, neurosis is associated mainly with psychoanalysis. Thus, many clinical psychologists now use a descriptive term such as "anxiety-based disorders" to identify what were traditionally neuroses. The change was, however, a bit of a slap in the face of traditional psychoanalysis, and it was not accomplished without substantial controversy.

The DSM-IV divides abnormal behavior into 15 categories covering three broad arrays of roughly 220 disorders. One array includes those disorders that have an identifiable physical cause, such as a brain injury, the effects of aging, or the use of drugs. Sleep and eating disorders are also included under this large grouping. A second broad group of disorders has less of an organic base. These range from schizophrenia and emotional (mood) problems to disorders that often arise during childhood or adolescence. The third array, consisting of milder disorders formerly called neuroses, are those disorders thought to be mainly psychological or environmental in origin. Table 14.4 lists most of the major Axis 1 diagnostic labels used in diagnosing such mental disorders.

Table 14.4

Symptoms of schizophrenia

SYMPTOM	**EVIDENCE**
LACK OF EMOTIONS	Person shows little emotional responsiveness; emotion is absent or inappropriate.
WITHDRAWAL	Little contact with others and with reality.
DISTURBED THOUGHT	Illogical thought sequences, inability to hold a coherent line of thought.
INCOHERENT SPEECH	Speech may wander, seem poorly connected.
DELUSIONS	Shows delusions that are hard to understand: persecution, sexual, religious, grandeur.
HALLUCINATIONS	May show sensory disturbances of hearing or vision; may involve distortions of body sense.
ABNORMAL BEHAVIOR	Behavior may be physically abnormal in showing weird or unusual body positions or gait; lack of facial expressions.
UNRELIABILITY	May show lack of consistency; likely not to be trustworthy regarding responses to questions

We don't have enough space here to discuss all of these disorders. Instead, we'll concentrate on a couple of the milder ones that occur most frequently, and we'll discuss schizophrenia, the most severe of personal abnormalities.

You should understand that even though we are able to list all of the patterns of abnormal behavior in a single table, it does not mean that they have much in common. Identifying specific mental disorders is a very complex diagnostic problem. Once having labeled a disorder, there are still other dangers that occur if we identify too closely with the labels and not

closely enough with the behaviors on which the labels are based. Those of us who are perfectly healthy differ in some ways from those suffering from mild disorders and in quite different ways from those burdened with any form of schizophrenia.

Anxiety-Based Disorders

Among the full array of mental and behavioral disorders there is considerable similarity across the anxiety-based disorders. Specifically, there are three key elements that these disorders share in common. These elements often operate in a kind of "vicious circle" -- one event causing another event, which causes the initial event to reoccur, and on and on.

The first element is feelings of anxiety and inadequacy. Anxiety, as the term is being used here, should be separated from similar feelings many of us may have. Some of us fear the dark. Our fear is related to a specific situation. Anxiety, however, is more general, more diffuse, and present all the time. We all experience normal anxiety -- the pressures of school, of home responsibilities, of personal and social obligation -- but neurotic anxiety is much more severe, and much more likely to interfere with normal living. The anxiety we all experience sometimes is what is called state anxiety -- it's acute, but temporary. The person burdened with an anxiety-based disorder experiences trait anxiety. It's permanent, chronic, and typical of that person. Such anxiety is likely to be aggravated under stress. An anxiety-ridden person will not stand up well under stress.

A second element of the mild disorders is that of avoidance. Freud offered many detailed comments on this aspect of neurotic behavior, as he identified it. Avoidance means that instead of dealing with whatever event in the environment is causing a person stress, the person tries to repress, escape, disguise, or modify the source of the stress. Freud thought that neurotic anxiety occurred as a pattern of symptoms. This anxiety aroused the defense mechanisms -- the first line of defense used by each of us. Defense mechanisms are adaptive -- meaning they allow us to tolerate our anxiety. They are also unconscious. We are not aware when they are operating, according to Freud.

We will review briefly certain types of defense mechanisms. Simple repression forces anxiety-provoking thoughts or occurrences from consciousness. Afraid to go to the dentist? Repression might well cause you to forget the appointment you scheduled for a week from Tuesday.

A second group of defense mechanisms involve escape or flight, and there are several possibilities. Amnesia (you forget your problems), denial (you reject intolerable reality or you daydream), and phobias -- inappropriate, exaggerated fears of an object or situation, discussed in Anxiety Disorders.

Disguise, the third type of defense mechanism, is even more subtle. One of the best examples of disguise is rationalization. You substitute a good reason for your behavior in order to hide the bad or true reason(s) from yourself and others. Do you unconsciously want the larger of the last two pieces of cake? If so, you might take it and say, "Oh, I thought you were on a diet!"

Finally, modifying an anxiety-causing impulse may involve a defense such as reaction formation. Do you hate your boss? Then you might go out of your way to smile at him or her, be courteous, laugh at the jokes, and so forth. Feature 14.4 has some more examples with which you may already be familiar -- excuses for motorists' behavior as reported in insurance claims files. Don't they sound defensive?

FEATURE 14.4

"IN THE MATTER OF FREUD VS. FENDER. . ."

Some have called them good creative writing." Psychoanalysts would call them overt indications of defense mechanisms. In either case, we re talking about the excuses people send to insurance companies to explain why the accident they were in wasn't their fault Consider the following samples:

(1) "I ran into the car in front of me because he was driving too close to me,"

(2) "A pedestrian hit me and went under my car."

(3) "I don't think I was to blame, or the driver of the other car either; but if either was to blame it was him."

(4) "Ever since 1967, when I inhaled acid fumes at work, I have had to drink large quantities of alcohol in order to breathe."

(5) "Either Mr. Brown's brakes or brains were defective."

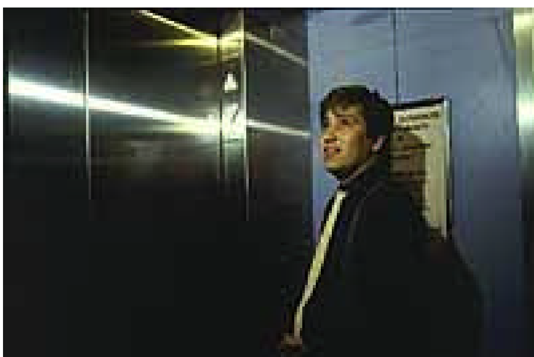
Based on reports published in *The State*, February 26, 1973, Columbia, South Carolina.

Defense mechanisms are very appealing. They seem to describe behaviors with which we are all quite familiar -- maybe you've used them yourself sometimes. For instance, projection occurs when we attribute our own personality traits or attitudes to others. Freud thought that in this way we could avoid recognizing those traits in ourselves. Recent research, however, has not confirmed that projection operates unconsciously or that it reduces our anxiety. Obviously, we still need more research, but personality is not turning out to be as simple as early theorists may have thought it was.

The last key element of the anxiety-based disorders is self-centered, self-defeating kinds of behavior. If you think the world is hostile, your resulting behavior may be defensive and rigid. It is rarely appropriate, and very likely often does not respond to the demands of the environment as seen by "normal" people.

The result of all this is that people with these anxiety-based disorders manage to maintain contact with reality. In one sense they must do so in order to develop the appropriate defense mechanisms! They know what is normal, and they may often seem quite well adjusted to the untrained eye. This apparent normality, however, covers a very anxious person who will not behave well under stress. Such conditions lead to a variety of behavioral disorders, including anxiety disorders, phobic disorders, an obsessive/compulsive disorder, somatoform disorders, and dissociative disorders.

Anxiety Disorders



The most common form of personal discomfort is simple anxiety. Anxiety is a constant element in many disorders. The usual "vicious cycle" aspect of this disorder is nowhere more obvious than here. The cause is often obscure and complex. (Freud would suggest the cause is hidden by defense mechanisms.) A panic attack involves the sudden appearance of intense apprehension, palpitations of the heart, labored

breathing, chest pains, dizziness, sweating, trembling, a feeling of smothering or choking, nausea, a feeling of unreality, fear of going crazy or dying, numbness or tingling, faintness, or even hot flashes. Thirteen symptoms are listed in DSM-IV as criteria for a panic attack; four (or more) must occur suddenly and peak in 10 minutes for such an experience to qualify as a panic attack. Such detail in DSM-IV aiding diagnosis of a panic attack is a factor contributing to the increased reliability of diagnoses of psychological disorders over the past two decades.

The symptoms leading to the identification of a panic disorder -- one of the forms of anxiety disorders -- fall into three categories. First, one must have a panic attack. Second, this must be followed by a month or more of concern about experiencing more attack, worry about consequences of the attack, or a significant change in behavior related to such an attack. And, third, all of this must occur in the context of recurrent unexpected panic attacks. If these symptoms last more than 6 months, this is considered a generalized anxiety disorder.

One of the interesting forms of anxiety disorder is agoraphobia -- anxiety about being in places or situations from which escape might be either difficult or embarrassing. In some cases this phobia results from anxiety about the lack of help available should another panic attack occur. But someone with agoraphobia would likely have difficulty sitting with you in a large lecture hall -- even if your instructor were very relaxed about students coming and going during class.

Are these anxiety disorders abnormal patterns of behavior? Think about our achievement-oriented world: the constant pressures to succeed, the uncertainties of holding a job, the complexities of paying monthly bills, and so forth. Isn't anxiety to be expected? Yes, but disabling anxiety is not. Disabling anxiety is usually brought on by a variety of other things. Prior experience with a highly stressful and/or insecure family life is one. Another would be your inability to handle dangerous ideas or urges, such as anger, in response to stress. Having to make important decisions such as whether or not to marry, to fire someone, or to quit a job can also be very anxiety provoking. Finally, if you have responded with anxiety to a threat in the past, then you may do so again if you mistakenly think your current environment is similarly threatening. As you respond -- this time incorrectly -- you will be getting anxious again to the same cues as last time.

Specific types of anxiety disorders include both a wide variety of phobias and post-traumatic stress disorder. Also included among anxiety disorders are obsessions and compulsions

which we discuss under their proper title, Obsessive-Compulsive Disorder. Other disorders traditionally called neurotic disorders that can be described as Anxiety-Based Disorders include Somatoform Disorders and Dissociative Disorders. We discuss therapy for these disorders in the Personality: Therapies Chapter.

Think About It

The question: At the beginning of the chapter we describe the current environment of Rudy, who was revealing to a friend his concerns that he was about to have a "nervous breakdown." Given the situation that was described, do you think he was about to experience a nervous breakdown?

The answer: It's not likely. The situation that Rudy described involved (1) approaching finals, (2) a part-time job demanding some of his time, (3) an inability to study, and (4) some problems in getting to sleep. What Rudy is experiencing is state anxiety.

Most of his problems probably result from concerns about the approaching exams. This fear boosts his motivation, which makes him jumpier. When he sits down to study, his fears grow a bit worse as he realizes how much he still has to learn. The result is that he spends time worrying about what he has to learn instead of actually studying. That raises his anxiety even further, and we have a vicious circle, eventually even causing Rudy trouble in getting to sleep.

But the source of fear is a specifiable one: the exams. Once they're past, it is very likely most of his problems will pass with them. Such fears or "nervousness" -- tied to specific environmental events or objects—are quite normal. Perhaps Rudy should devote more time to studying, but he certainly shouldn't drop out of school. There's very little in the "symptoms" he described to suggest any kind of "nervous breakdown."

Specific Phobia

Are you afraid to stand at the edge of the roof of a three- or four-story building? That's normal. Are you afraid even to go onto the roof of a one-story building? You may have a specific phobia, one of the dozen or so recognized forms of anxiety disorders.

If you organize your life so as to avoid an object or situation because of a fear that is out of proportion with the dangers, then you have a phobia. Some of us have an abnormal fear of strangers (xenophobia) or of spiders (arachnophobia) or of fears (phobophobia)! Table 14.5 lists some of the most common or most interesting forms of phobias.

Table 14.5

Phobias

NAME	ANXIETY Represented
Acrophobia	High places
Agoraphobia	Open places
Ailurophobia	Cats
Algophobia	Pain
Astrophobia	Thunder, lightning
Claustrophobia	Closed places
Hematophobia	Blood
Mysophobia	Germs
Nyctophobia	Darkness
Ochlophobia	Crowds
Pathophobia	Disease
Pyrophobia	Fire
Xenophobia	Strangers

One study revealed that almost eight percent of the general population has a phobia, although less than 1 in 400 would qualify as being abnormally phobic. Why? Because, for example, if you have a phobia about snakes, and live in the middle of New York City, you're very unlikely to meet any snakes as long as you stay away from museums and zoos. Since you wouldn't be seriously hampered by such an anxiety, you wouldn't be considered phobic.

Phobias can cause you problems, however. They may start with an abnormal (learned?) fear of a specific object that later begins to generalize. That is, while at first you are only afraid of snakes, you may come to fear worms, and then caterpillars . . . ropes . . . . Interestingly, people around the age of fifty seem to have the greatest problem with phobias, as reported in one study. Yet the likely age at which a phobic disorder may occur differs for different objects.

Some phobias seem to result from traumatic experiences in earlier life. Others have suggested they may come from a defense mechanism such as projection. An internal (unconscious) urge to burn oneself may lead to a phobic reaction to all open fires. In each case, the person experiencing a phobia may go to great extremes to avoid exposing him- or herself to the feared object.

Obsessive-Compulsive Disorder

Inappropriate repetition is the key symptom here. Inappropriate repetition is the key symptom here. If you keep thinking the same thought over and over and over and over and over . . . ., you have an obsession. If you perform the same act over and over, that's a compulsion.

Those definitions seem simple enough, so at what point does a repeated behavior become a compulsion? That line is reached when the repeated activity begins to hinder the normal activities of life. For instance, it's abnormal if the repeated thought or act consumes an hour or more a day or significantly interferes with a person's normal routines, occupational/educational efforts, or social functioning. A child's not stepping on a crack in the sidewalk is an interesting exercise in concentration and self-control -- but not a behavioral disorder. An adult, failing to talk with a person with whom she is walking because she is too busy avoiding such cracks, would be following a compulsion.

Obsessive and compulsive reactions often seem to occur together. We know that feelings of anxiety increase if the thought or action is prevented. While recognizing a need to resist the urge, an individual suffering from this disorder recognizes the inappropriateness of the urge. Whereas the compulsion or obsession is part of a person's conscious experiences, the cause for these urges is not. Identifying their cause is quite difficult. Anxiety plays a contributory role in the types of Anxiety Disorders we've discussed here, as well as Somatoform Disorders and Dissociative Disorders we discuss elsewhere.

Somatoform disorders

There are a half-dozen or so types of somatoform disorders. They involve physical symptoms that suggest a physical disorder. However, no organic or medical cause for the chronic disorder can be found, yet they must cause clinically significant

distress in normal everyday activities at work or play. Psychoanalysts suggest these symptoms permit a person to give expression to internal anxiety. One form -- somatization disorder -- may be based on the normal aches and pains that all of us experience during our life, but it is reported in excessively dramatic fashion. Interestingly, a somatization disorder starts before age 30, lasts for years, and involves a combination of serious pain and gastrointestinal, pseudo-neurological, or sexual symptoms. One form of this condition -- historically called hysteria -- is glove anesthesia, in which a person loses the sense of touch in the portion of the hand normally covered by a glove. This is almost impossible physiologically, because two separate nerves innervate the hands and forearms -- one for the thumb and two nearest fingers, the other for the remaining two.

In hypochondriasis, individuals also intensify common physical pains to unrealistic extremes. They develop an irrational concern about whether they have major diseases and (especially) about how to avoid them or have them treated. And when a doctor they've sought assures them there's no problem? A normal response would be, "I think I'll get another opinion!"

Some who develop somatization disorders or hypochondriasis report being raised in an environment where having an illness always drew attention and expressions of concern (both secondary gains). These disorders, in short, may be the result of prior reinforcement.

The source of physical complaint is more specific in a conversion disorder than it is in the two previous disorders. The symptoms traditionally linked with this problem involve physical paralysis, blindness, or deafness. However, in one recent study symptoms most commonly reported included pain, partial or complete paralysis, numbness, headache, a mock heart attack or chest pain, and dizziness and fainting. All of these involve voluntary sensory or motor functions. Symptoms of blindness and deafness were totally absent.

Dissociative Disorders

Dissociative disorders are quite different from Somatoform Disorders. Dissociative disorders involve a sudden but temporary change in consciousness (such as loss of memory), identity, or perception of the environment. Often related to critical life events, they may be quite extreme disorders involving loss of knowledge or skills too extensive to be explained as ordinary forgetting. A sample of these disorders follows.

Dissociative amnesia is one form of a dissociative disorder. If a severe, anxiety-provoking problem is encountered, it is simply forgotten along with the concerns raised by the problem. The amnesia may take one of several forms. Localized amnesia involves total forgetting of a specific event. Selective amnesia involves some but not all aspects of an event (or series of events) being forgotten. Generalized amnesia involves loss of all knowledge of the past, while continuous amnesia involves loss of all memory from a specific time or event onward. Regardless of form, onset is always sudden -- often caused by a traumatic or stressful event.

In a Dissociative Fugue state, the person not only experiences amnesia, but also moves to a new environment -- away from the home, or work, or both -- accompanied by a loss of memory of the previous environment. In both of these reactions the person seems to retain general knowledge. How to speak, how to move about a city isn't forgotten, yet no aspect of the event about which he or she is anxious can be recalled. Despite their popularity in fiction and on television, fugue states and amnesia are both quite rare.

Think About It

The question: Is the loss of memory for the events leading up to an accident normal or abnormal?

The answer: The answer here depends on the severity of the accident. According to some psychologists studying memory, a severe accident can interfere with the memory process called *consolidation*. This makes it difficult or impossible to remember information after an accident. Such an explanation could easily account for the loss of memory of events immediately before, during, and after an accident.

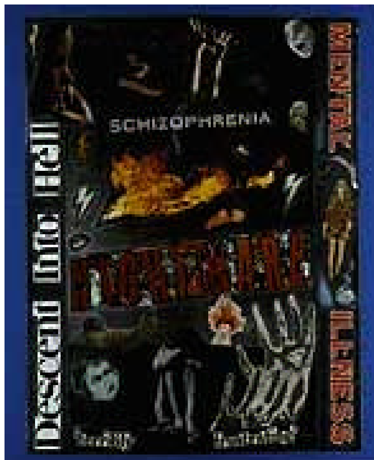
However, assuming there was no serious injury, such an explanation would not explain losses of memory for lengthier time periods -- certainly not any loss covering even a period of several hours. A more likely explanation in the latter case would be the dissociative disorder called amnesia—meaning an abnormal, perhaps anxiety-based, cause of the loss of memory.

One of the most interesting forms of dissociative disorder is the occurrence of multiple personalities -- again requiring amnesia. The classic example of this -- Dissociative Identity Disorder (formerly called Multiple Personality Disorder) -- is a movie and book entitled *The Three Faces of Eve*, about a woman who experienced three different personalities. Differing personalities such as these apparently occur as a person grows dissatisfied with a specific personality, or gives expression to

other portions of the total person. Quite often these other personalities are not known to the one dominating personality.

The woman named Eve in the book/movie was discovered in 1975 to be living in a suburb of Washington, D.C. when she published her side of her life story in a book called *I'm Eve*. She had remained quite happy after therapy. In all Chris Sizemore says she experienced 21 personalities before coming out of hiding to announce she had been the person(s) portrayed by Eve. A more recent book/movie, *Sybil*, also describes a disorder of the dissociative type.

Major Disorders Including Schizophrenia



The most severe mental disorders, sometimes called psychoses, include schizophrenia -- to which we turn now -- as well as (1) Mood Disorders which can occur in several different forms and (2) Personality Disorders. It could be said that although someone with an anxiety-based disorder builds "castles in the sky," someone with schizophrenia lives in one. One might be tempted, then, to suggest that a psychologist collects the rent?

Schizophrenia is hard to diagnose, hard to treat, and among the most difficult personality disorders for which to effect a cure. It is a disorder that involves extensive and severe disintegration of the personality. The disintegration is so severe that a person with schizophrenia is likely to be hospitalized for a time (once diagnosed). They usually experience a complete loss of contact with reality. This sometimes makes it extremely difficult to test and interview the person so afflicted. Data collected by these means lose some of their reliability.

Schizophrenia is especially hard to diagnose because there are many symptoms, which may appear in a wide range of combinations. The symptoms include: (1) delusions -- a mistaken belief firmly held even in the absence of any confirming evidence or logic to justify it. These may include delusions of grandeur (I am Ghandi!), persecution -- the most common (I am saving my people!), or religion. The presence of (2) hallucination -- a vivid, realistic, believable mental image

of such intensity that one is skeptical when challenged about the absence of any actual sensory stimulation -- is the symptom most widely associated with schizophrenia. (3) Disorganized speech -- sometimes described as "word salad" -- is either incoherent or features many derailments. Schizophrenic behavior may also feature (4) grossly disorganized, catatonic muscle actions in which the person demonstrates "waxy flexibility" or stuporous behavior, and/or (5) negative symptoms such as flattened affect or a lack of logic or will in thoughts and interactions. The initial diagnosis is made when two or more of these major symptoms have been present for a month or more with evidence that some of the symptoms have been present for 6 months or longer.

There are five types of schizophrenia, each with major accompanying symptoms. The Paranoid Personality Disorders share certain symptoms with schizophrenia, including unwarranted suspiciousness, hypersensitivity, eccentric behavior, and seclusiveness. However, the Paranoid Personality Disorders are not generally as severe disorders as any type of schizophrenia.

Types of Schizophrenia

Schizophrenia is not (as popularly thought) concerned with a "split mind." The closest condition that would lead to an apparently "split" mind is the Dissociative Identity Disorder that we discuss among the Dissociative Disorders. We can best view schizophrenia as a collection of disorders, all of which have a number of symptoms in common. Schizophrenics number almost half of the patients confined in state and county hospitals, and of all those patients who are middle-aged, about 60 percent are schizophrenic.

Schizophrenia, unlike the mood disorders discussed elsewhere, is rather a disorder of thought, involving one or more of the symptoms listed in Table 14.6.

Table 14.6

Symptoms of Abnormal Behavior

SYMPTOM	BEHAVIOR	SYMPTOM	BEHAVIOR
SOCIAL INADEQUACY	Drug abuse Alcohol abuse Sexual deviation	PERSONAL INADEQUACY	Lack of confidence Extreme sensitivity Task incompetence

Rejection of law		
Family discord	PSYCHOTIC TENDENCIES	Phobias
Personal neglect		Fanatically religious
Dangerous to others		Bizarre sensory experiences
Self-destructiveness		Lying
Sadism		Paranoid thinking
		Manic behavior

The primary symptom of schizophrenia is a loss of prior efficiency in the home, social, and work environment. While some view the subtypes below as distinct disorders with unique causes, most mental health professionals today view them simply as clusters of behavioral symptoms. The labels, however, remain in frequent use.

Undifferentiated (simple) schizophrenia often develops slowly. Gradually retreating from normalcy, the person shows an increasing loss of interest and emotion, of ambition, and of logical thought. Personal health and hygiene are neglected as the person becomes more and more inactive and apathetic. Of all the types of schizophrenics, the simple schizophrenic is most likely to be able to maintain him- or herself in the everyday world. The usual point of onset is early in life often during adolescence. As a result, the family may knowingly or otherwise be pulled into continuing to support a simple schizophrenic as his or her outside contacts with friends, school or job, and reality gradually deteriorate.

Disorganized schizophrenia -- historically called hebephrenia -- suffers from one of the most severe forms of the disorder. Often having an early onset, it may show up as an inappropriate, overwhelming concern with little things, or with philosophical or religious issues. This focus excludes everything else, interfering with even the simplest tasks of life such as showering, dressing, and preparing meals. As the condition becomes more severe, the thinking patterns become increasingly immature, distractible, or not even related to events in the immediate environment. What follows may be baby talk, incoherent conversation, even silliness, giggling, or babbling. The course of the conditions is progressive deterioration, often accompanied by a lack of response to therapeutic efforts. Thus, it is a progressive slide into total deterioration.

Catatonic schizophrenia is another severe form of the condition. It takes several forms, but it has been found that about 44 percent of those experiencing catatonic schizophrenia are withdrawn. They will show marked inactivity, even to the extent of demonstrating "waxy flexibility" in which they will hold one body position for hours at a time. If an arm or leg is placed in a new position, they will then continue to maintain that posture. Such a patient will often be mute, yet pass rapidly into an excited state. About 29 percent have been found to swing between states of withdrawal and agitation. The other 27 percent remain mainly excited or agitated.

The paranoid schizophrenic is less severely abnormal in his or her behavior, yet severe deficits are still obvious. Paranoid persons often experience delusional or illogical thoughts. They may hallucinate, or they may endure hallucinatory "complexes" of superiority, persecution, or grandeur. Those experiencing paranoid schizophrenia often retain quite acceptable verbal skills. If you grant their initial assumptions, they may well convince you of the truth of their delusional thoughts!

FEATURE 14.5

"THEY" GOT ME!

At age 23 Bill was diagnosed as a paranoid schizophrenic and hospitalized. The youngest of three brothers, he had no friends, little education, and no job skills. He suffered from epilepsy, and he'd always been thought of as an "oddball."

Just before he was admitted, things got markedly worse for him. He started referring to himself in the third person. He gave away his family's money to the church. This left his mother with no money to pay for the winter's heating fuel. As the winter progressed, he became more and more withdrawn and suspicious of others. After planning and starting a trip to Atlanta, he lost his job in a hardware store. Here he converses with his therapist.

Bill: In fact, now that Bill thinks about it, every time he's planned that trip to Atlanta he's lost his job. It's happened four times now. Bill's grandfather was a king. He was a millionaire, but he was cheated and robbed of his life's savings. They took all his money. That's the reason Bill's family is so poor.

Therapist: Who are "they"?

Bill: They're evil and cunning. They still have all that money and they live in a mansion. Everything they've got came from cheating Bill's grandfather. Bill gave his family's money to the church so they wouldn't get it. Bill *really* outsmarted them!

Therapist: Why do you call yourself "Bill" instead of "I" or "me"?

Bill: It sounds more important that way.

Bill's situation is not an unusual one. His whole family -- especially his mother -- treated him as they would an invalid. They never demanded much of him, and his family viewed his epileptic seizures as very distasteful. Bill's solution toward this atmosphere and his own (understandable) low self-esteem was to project blame for his shortcomings onto external events or other people ("they"). He also developed delusions of grandeur, importance ("Bill said. . .") and persecution ("they stole. . .").

In some people schizophrenia develops over a long period, only gradually becoming identifiable. This is a process schizophrenia, and it usually leads to lengthy hospitalization and poor likelihood of recovery. Others seem to have a good life history, and then they experience a sudden breakdown, sometimes following an increase in stress. This is a reactive schizophrenia. Here the prognosis is quite good -- usually the person recovers and again becomes a contributing member of society.

What causes schizophrenia? There are several possibilities. One is the environment. Perhaps conflict is the key here. If you view the environment as causing schizophrenia, then the condition can be considered a response to unanswerable pressures. Another explanation involves the double bind, as seen in the illustration. A poorly integrated family with

inadequate communications between parents may be involved. Traumatic experiences in childhood also may be a cause.

Indeed, a number of theoretical explanations have been offered to explain schizophrenia. Some credit inappropriate reliance on defense mechanisms. Unlike many other personal abnormalities, schizophrenia has even been linked to a variety of inherited factors. There is some evidence that schizophrenia tends to run in families. Yet, while it may be inherited, it may result from successive generations all tending to create environments in which schizophrenia is fostered. There is even evidence supporting biochemical and neuronal explanations of how schizophrenia is caused. In the Personality: Therapy Chapter we talk more about the treatment and prognosis for schizophrenia.

Mood Disorders: Episodes

The mood disorders are serious disturbances of feeling, emotion, or mood. These may lead to behavioral or thought abnormalities. The major feature, however, is exaggerated mood -- elated (called manic), depressed, or cycling back and forth from manic to depressed. People with mood disorders experience episodes in which they are happy or depressed far in excess of what is warranted by their environment. Depending on the distribution of various types of mood episodes, a number of different specific forms of mood disorder may be identified.

After a week's preparation for the football game, Saturday arrives. Everyone shows up at the stadium -- players, coaches, students, friends, and alumni. Members of any football team would surely feel depressed to lose in such a situation, yet half the teams do each Saturday during the fall. Members of the losing team are sad, yes, but it's not an abnormal condition. By Monday most team members are looking forward to the next week's game. But if more serious events "gang up" -- a death in the family, a severe accident, or other trauma within a short period of time, they may lead to a Major Depressive Disorder.

A Major Depressive Episode involves the presence of five or more of the following nine symptoms in a two week period, including a depressed mood or general loss of interest/pleasure: (1) Depressed mood most of the day. (2) Almost daily loss of interest or pleasure in most of the day's activities. (3) Loss of appetite sufficient to cause 5% weight loss in a month. (4) Almost daily insomnia or hypersomnia (too much sleep). (5) Almost daily episodes of high motor agitation or retarded activity. (6) Almost loss of energy or fatigue. (7) Almost daily feelings of worthlessness or excessive guilt. (8) Almost daily evidence of diminished cognitive ability, inability to

concentrate, or lack of decisiveness. (9) Evidence of a specific plan for suicide, recurrent thoughts of suicide or death.

By contrast, a Manic Episode is a period of at least a week during which persistent and abnormally elevated, expansive, or irritable moods are exhibited. During the period, three or more of the following symptoms must occur for the experience to qualify as a manic episode. (1) Inflated feelings of self-esteem or grandioseness. (2) Decreased sense of need for sleep. (3) Increases in talkativeness or sensed pressure to keep talking. (4) Speeded (racing) thought or flight of ideas. (5) Frequent distractibility -- often to irrelevant or trivial details. (6) Increase in apparent motor agitation and/or goal-directed activities. And, (7) significant involvement in pleasurable activities which -- -if continued -- are very likely to have painful consequences, such as unquestioned, impulsive business investment. A Hypomanic Episode involves this same pattern of symptoms appearing for at least 4 days.

A fourth type of episode is also identified in DSM-IV. A Mixed Episode occurs when the criteria for both a Major Depressive Episode and a Manic Episode are met almost daily over at least a week. The person will experience rapid shifts in mood -- from sad to irritable to euphoric -- accompanied by symptoms of a Manic Episode and a Major Depressive Episode.

Types of Mood Disorders

A variety of specific types of Mood Disorders can be identified by the occurrence of various combinations of the four types of episodes and varying numbers of the symptoms we list in our discussion of Mood Disorders: Episodes. The Mood Disorders are serious behavioral disorders often necessitating major therapeutic efforts to lead someone experiencing such a disorder back toward normal behavior. A Major Depressive Disorder is marked by the occurrence of at least one Major Depressive Episode -- meaning at least two weeks with the person's mood obviously depressed or showing significant loss of interest and four other symptoms of depression. Such depression may be simple, acute, or stuporous. In stuporous depression or melancholia the person may be almost totally inert and have to be fed intravenously even to survive. In contrast, Bipolar I Disorder involves the experience of one Manic Episode and no prior experience with Major Depressive Episodes.

A *Bipolar II Disorder* occurs when one or more Major Depressive Episodes is accompanied by at least one Hypomanic Episode, but no Manic or Mixed Episodes. The cyclical, or

circular, Bipolar II Disorder involves both manic and depressed states, with swings from one extreme to the other. All that is necessary for diagnosis as a bipolar disorder is one episode of each state. Only about one quarter of all persons suffering the bipolar disorder regularly cycle from one state to the other. Even fewer do so predictably.

In studying the Opponent-Process theory of emotion in the Emotions Chapter we see that depression normally follows the loss of a loved one. But over a period of time, recovery from such depression is also normal. At its extreme, depression may lead to suicide, especially if one views his or her problems as unsolvable. The "vicious circle" of depression can become a self-fulfilling prophecy. Being depressed, you work less, desiring less and less to be involved in the events of daily living. Soon fewer opportunities for action come your way, and the vicious-circle effect begins.

Although some say people with depressions feel helpless and blame themselves for their problems, this leads to a paradox. How can people accept blame for their condition if they are helpless? Again, we need more research.

The manic reaction involves inappropriate optimism and confidence far in excess of realistic expectations. As with depression, three general levels of mania are often distinguished: simple, acute, and delirious. A delirious manic reaction may involve almost uncontrolled motion -- gesturing, pacing back and forth, singing -- anything. Such behavior clearly reflects the average person's version of someone who is "crazy." Yet the mania comes and goes, not predictably. Maintaining contact with such a person is difficult, if not impossible.

Some experiments confirm psychoanalysts' views that depression is aggression turned inward, and mania is a defense against depression. Learning theorists think depression may be reinforced by sympathy from others. Other theorists have looked to faulty cognitive processes for an explanation. Evidence suggests that inheritance plays a role -- if one identical twin becomes depressed, in 50 to 90 percent of cases studied the other twin will also show depression. Yet, environment is also important. Several factors, such as losing one's mother before the age of 11, have been shown to increase susceptibility to depression. To date there are almost more theories than facts regarding the cause or causes of depression!

Personality Disorders

Many people suffer from one of the numerous Personality Disorders. In such disorders the symptoms have often long been true of the individual. Thus, persons suffering a Personality Disorder may rationalize that it is "Just part of me." Changing their behavior therefore can be very difficult. The presence of two or more of the following symptoms is necessary to support this diagnosis: The symptoms include enduring patterns of inner experience and behavior, which are inflexible and markedly deviant from normal cultural expectations for the individual. These deviations are limited to the following. (1) Thought processes (how the self or other people or events are perceived and interpreted), (2) Emotional reactivity involving inappropriate responses in terms of their range, flexibility, and/or intensity, (3) hindrance of interpersonal functioning, and (4) poor control of impulses.

Such disorders include Paranoid Personality Disorder (being suspicious and mistrusting, but not delusional or psychotic), Schizoid Personality Disorder (being a loner), and Schizotypal Personality Disorder, which is similar to the schizoid disorder but more severe in showing thought abnormalities and perceptual and speech problems. In these conditions sufferers experience symptoms similar to but less severe than those of schizophrenia. Anyone experiencing such disorders will appear eccentric or odd.

A second cluster involves disorders that make people appear emotional, dramatic, or erratic. These disorders include the Antisocial Personality Disorder (a consistent pattern of violation of and disregard for the rights of others). Widely studied because of its public, social nature, someone experiencing an Antisocial Personality Disorder shows a lack of shame and remorse after committing a bad act. Such persons exhibit a seeming inability to learn from punishment and bad experiences. They suffer no anxiety, which may account for their failure to learn how to avoid punishment. Also included in this cluster are the Borderline Personality Disorder (unstable interpersonal relationships, impulsivity, and difficulty with affect and self-image), and the Histrionic Personality Disorder (a constant and excessive emotionality and exhibition of attention seeking). Some psychologists have claimed that the assumptions on which the DSM-IV is based are male oriented and thus lead to the diagnosis of an artificially large number of women as depressed or having a histrionic personality. Also included in this cluster is the Narcissistic Personality Disorder (having consistent feelings of self-importance and being unable to accept criticism).

The final cluster includes disorders making people appear overly fearful or anxious. These disorders include Avoidant Personality Disorder (experiencing social inhibition,

hypersensitivity, and feelings of inadequacy) and the Dependent Personality Disorder (which includes excessive dependency, fear of separation, and fawning, clinging submissiveness),. Also included among the personality disorders are the Obsessive-Compulsive Personality Disorder (aiming constantly for perfection) and the Passive-Aggressive Personality Disorder (showing indirect resistance to normal, acceptable demands at home or work, especially at work).

REVIEW

WHAT IS ABNORMAL?

1. What is the "Medical Student Syndrome," and how can you avoid it?
2. Who is usually the first to judge that someone's behavior is abnormal? On what basis is the judgment made?
3. Name three ways in which abnormality is defined and give an example of abnormality and normality according to each definition.
4. What are three signs that may indicate the need for professional help?

PROBLEMS OF DIAGNOSIS

1. What were the earliest modern systems of classifying mental illnesses?
2. Give some reasons for not using a specific label in identifying someone as abnormal.
3. What two procedures should be included in a full diagnosis of psychological problems?

ANXIETY-BASED DISORDERS

1. What are two characteristics of mild behavioral disorders?
2. In what ways are anxiety disorders and phobias "abnormal?"
3. What is meant by a somatoform disorder? Give three examples.
4. Describe the different types of dissociative disorders.

MAJOR DISORDERS INCLUDING SCHIZOPHRENIA

1. Why is it difficult to make a precise diagnosis of schizophrenia?
2. Explain what is meant by "mood disorders." List three specific types.
3. Name the different forms of schizophrenia and describe some symptoms shared by all those experiencing a

schizophrenia.
4. What are some suspected causes of schizophrenia?
5. Describe some of the personality disorders.
6. What are some characteristics of an antisocial personality?

ACTIVITIES

1. Dress for your classes in an unusual way for one day. For example, try wearing a suit, or perhaps sandals and white socks. Daring? Try wearing your underwear on the outside! In a brief essay, summarize people's reactions to the change in your clothing.

2. For one day, try changing the way you customarily greet people. For example, if you are usually quiet, give everyone a cheery hello. Describe any changes in the way people react to the new you.

3. Try another test of the effects of your behavior on others. When you're talking with a friend, stare at your friend's ear instead of looking him or her in the eye. Does this seem to make your friend nervous? What response do you get?

4. Choose a criminal whose crime made him or her nationally known (such as John Hinckley, who attempted to assassinate President Ronald Reagan) and who was subsequently diagnosed as mentally ill. In an essay, recount all you can find out about the behavior that brought about the diagnosis.

5. If your community has a psychiatric center, go interview a psychiatric nurse to learn of the types of behavior that require hospitalization and what criteria are used for diagnosis.

INTERESTED IN MORE?

ALDINE, V. M. (1976). *Dibs: In Search of Self*. New York, NY: Ballantine Books. A paperback describing the life of a seriously disturbed boy, his behavior, and how psychotherapy helps him.

CAMPBELL, R., et al. (1976). *The Enigma of the Mind*. New York, NY: Time-Life Books. Part of the "Human Behavior" series,

this paperback focuses on the environment, causes, and treatment of abnormal behavior.

COLEMAN, J. C. (1976). *Abnormal Psychology and Modern Life, 5th ed*. Scott, Foresman. Analyzes the factors -- biological, psychosocial, and sociocultural -- that cause mental illness. Assesses the methods used to treat abnormal behavior.

DAVISON, G. C. & NEALE, J. M. (1978). *Abnormal Psychology*. New York, NY: John Wiley and Sons. A well-written introduction to the basic issues and conditions surrounding abnormal behavior, including social problems. Includes a discussion of treatment.

FREUD, S. (1971). *Psychopathology of Everyday Life*. W. W. Norton and Co., Inc. You may be surprised to find that Freud is a delight to read. Here he analyzes everyday behavior (such as slips of the tongue and dreams) from the psychoanalytic perspective.

MEHR, J. (1983). *Abnormal Psychology*. Holt, Rinehart & Winston. A detailed, well-illustrated text that describes abnormal behaviors and how they relate to normal, everyday behavior.

SCHREIBER, R. F. (1973). *Sybil*. Henry Regnery. The story of a woman with multiple identities. Her problem is unusual, but the treatment is typical.

SIZEMORE, C. C. & PITTILLO, E. S. (1977). *I'm Eve*. Doubleday Books. The incredible life story of the woman about whom The Three Faces of Eve was written. Tells of other personalities she later experienced and their impact on her life.

STONE, S. & STONE, A. (1966). *Abnormal Personality Through Literature*. Upper Saddle River, NJ: Prentice-Hall. A paperback describing various mental illnesses, with examples from literature.

TRIGPEN, C. H. & CLECKLEY, H. M. (1957). *The Three Faces of Eve*. New York, NY: Doubleday Books. The book behind the movie. Focuses on "Eve's" early life and the problems of her triple personality.

ULLMAN, L. P. & KRASNER, L. (1975). *Psychological Approach to Abnormal Behavior, 2nd ed*. Upper Saddle River, NJ: Prentice-

Hall. This behavioral (learning-based) approach contrasts with Freud's Psychopathology. Shows how reinforcement and punishment can influence even severely abnormal behavior.

ZAX, M. & COWEN, E. L. (1976). *Abnormal Psychology: Changing Conceptions, 2nd ed*. Holt, Rinehart & Winston. Uses an historical approach to compare and contrast theories of abnormal behavior. Includes a discussion of electroshock treatment and mental health movements.