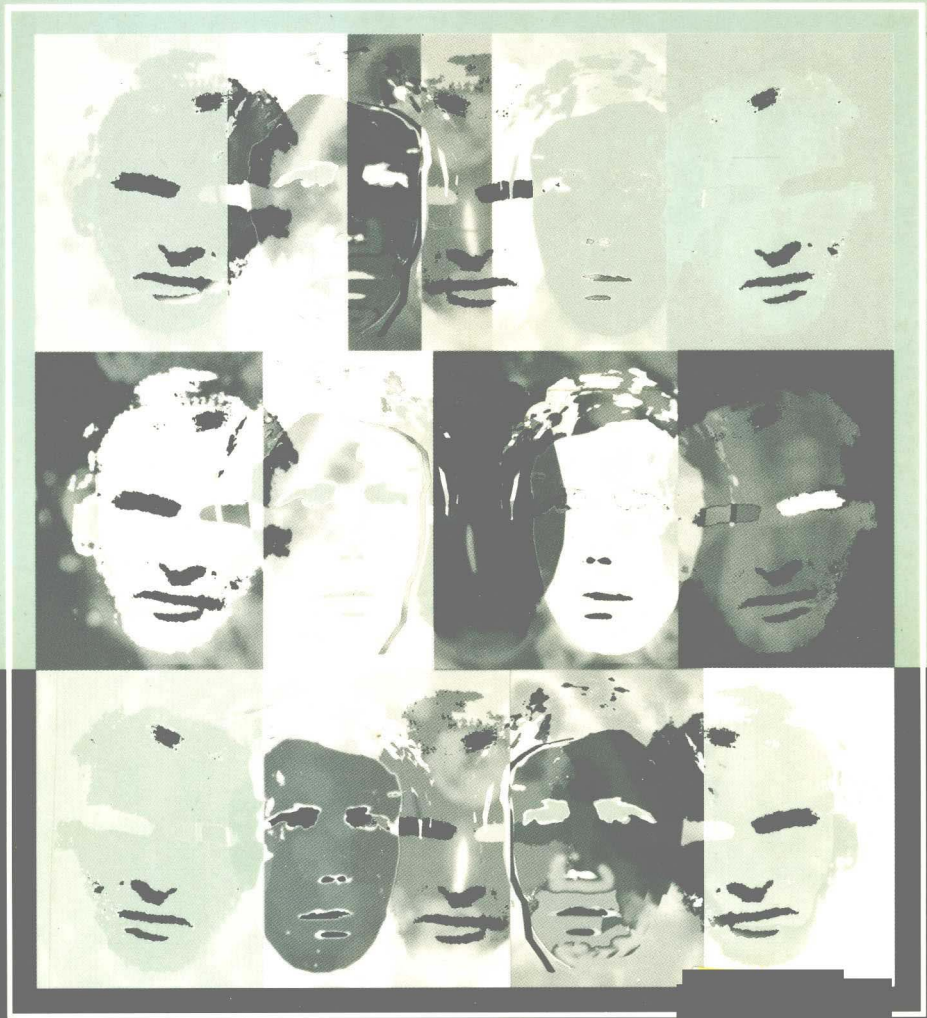


Case Studies in ABNORMAL BEHAVIOR



SIXTH EDITION

ROBERT G. MEYER

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Robert G. Meyer

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*To Monika Meyer Hubbard:
Still quite a case and still delightful*

PREFACE

Research articles in abnormal psychology necessarily focus on specific theories and experiments; texts in this area are concerned with integrating a vast array of literature on historical, descriptive, research, diagnostic, and treatment issues. Some texts do a good job of bringing in “chunks” of case material to demonstrate particular points. However, textbooks cannot do justice to their other goals if they provide any significant number of cases in depth. *Case Studies in Abnormal Behavior* fills this niche. This book helps the reader regain a sense of how the whole person experiences and reacts to the diverse factors studied in abnormal psychology. The abstract and conflicting concepts of this field can thus be seen in the context that eventually counts—the totality of an actual person who has the disorder.

Many of the cases in this book are of people who are well known for one reason or another (e.g., Princess Diana and Presidents Reagan and Clinton) or who played an important role in the evolution of the field of psychology (e.g., Anna O.). A number of these and other cases presented are based on actual, recent cases, though not in the public record. Identifying details have, of course, been changed to protect people from even a small chance that they would be recognized. Aside from those in the public record, most cases originated from my own experiences or were donated by colleagues. I have also included several classic cases originally published in journals or early manuscripts. These cases either make an original point or demonstrate a particular point of view (e.g., as in the Cases of the Three Little Fellows, Hans, Albert, and Peter, in Chapter 3).

Readers will note that cases that are provided by me and that are not reprints from other journals are assigned names with a logical or mnemonic (i.e., sounds like) relationship to the syndrome being studied—for example, Agnes Agoraphobia. Granted, though this may at times sound a bit corny, I have nevertheless found it to be a helpful technique for most readers. Students have found this to be a useful device, since it adds clarity to classroom discussion and it enhances the remembrance of the cases if needed during a test.

Readers might also note the high number of case studies in this book. Feedback from my students and from other professors and their students indicated that case studies in most other books were too long and included irrelevant detail (and in a couple of cases, much too short). The cases in this book contain the full details of background material that are relevant to etiological, diagnostic, and therapeutic considerations, and yet, hopefully, they are not overly long. This allows me to provide a full spectrum of case studies, perhaps more than in any previous case study book. It also allows me to detail cases from all categories of the *Diagnostic and Statistical Manual (DSM-IV)* of the American Psychiatric Association, to provide contrast cases within the major categories, and to present some other cases that deal with other important patterns. Also, new material from the Text Revision version (2000) of the *DSM*—that is, the *DSM-IV-TR*—is included as well.

Relevant and detailed family and social history data are presented in almost all of these case studies, since such data give the reader clearer ideas about how specific behavior patterns were generated and maintained. A few of the case studies have little background data, such as in the case of Harry (in Chapter 15), in which an abrupt organic trauma is the

focus of disorder. In cases such as Harry's, I present more detailed information regarding present behavior and the responses in psychological evaluations. Other cases have less background data if it seems less important for some other reason—for example, when it seems clear that genetic factors dominate the development of the disorder, as in the case of Virginia Woolf (Chapter 7). All cases go through to a natural conclusion, even though it may not always be termed a success. As in most experiences, much can be learned from failure.

I thank those individuals who have helped with this book. Much appreciation is extended to Rebecca Pascal, my Allyn and Bacon editor, for her support and advice. I would also like to acknowledge the help in writing some of these cases, as denoted in prior editions, and in this edition from Chris Weaver (mental retardation), Susan Knight (gender identity disorder), Luciano Tristan (post-traumatic stress disorder), Julie Oliver (school shooting), and Tracey Fintel (Munchausen by Proxy). I also appreciate the extensive help from my wife, Peggy, in organizing this edition.

INTRODUCTION AND MAJOR HISTORICAL DEVELOPMENTS

*If you always think the way you always thought,
you'll always get what you always got.*

—Anonymous

The field of abnormal psychology has evolved through many theoretical orientations. In the first half of the twentieth century, the Freudian psychoanalytic model, already developing a more broad-spectrum *psychodynamic* orientation (Kohut, 1977; Schwartz et al., 1996; Weston, 1998), was clearly dominating the study of abnormal psychology in North America. At the same time, the seminal behavioral studies of John Watson and Mary Cover Jones established behaviorism as an important influence in the study of abnormal behavior. Behaviorism, and more specifically, behavior therapy, was coming into bloom in the 1950s and 1960s (Ayllon & Azrin, 1968; Wolpe, 1958), and then merged with the cognitive therapies in the 1980s and 1990s (McCullough, 2002). Concurrently, a “third force” also was emerging, marked by diverse theories, many new psychotherapies (Garfield, 1981; Piper et al., 2002), and a varying and differing interest in diagnosis and etiology. At the same time, psychodynamic theory was further diversifying and showing a renewed concern for experimental verification (Silverman & Weinberger, 1985; Wachtel, 1997; Weston, 1998). Behavior therapy, meanwhile, was (1) becoming less wedded to theory (Lazarus, 1971), (2) expanding its concern back to at least some aspects of the mind under the influence of the cognitive-behavior modifiers (Beck, Freeman, et al., 1990; McCullough, 2002; Meichenbaum, 1977), (3) developing into a broader perspective on environmental variables under the social learning theorists (Bandura & Walters, 1963; Mischel, 1969), (4) being forced by the pressure of managed care and national health insurance issues into an emphasis on shorter-term and more focused therapies (Piper et al., 2002), and (5) facilitating the overall trend in the mental health field toward a greater emphasis on the experimental verification of assessment and intervention techniques (Meyer & Deitsch, 1996).

Teachers and practitioners alike have reflected the increasing sophistication that is inherent in this maturing and diversification process. Very few would now argue that any one technique or theoretical approach answers all or even most of the diagnostic, etiological, and treatment questions that arise. Certain theories and techniques have more relevance to certain disorders. In this vein, it is interesting that the “sphere of relevance” of an approach is most closely centered on the original group that was studied or treated when the approach came into being.

Freud’s specific theories became less relevant as society lost some of the repressions of the Victorian era (possibly only to take on repressions in other dimensions). Carl Jung’s treatment techniques, which focus on uncovering “spiritual” yearnings and on creating a

sense of meaning, arose primarily in the therapy of middle-aged males who had “made it big” financially and in their careers, but who lived the feelings expressed in the songstress Peggy Lee’s classic refrain, “Is that all there is to that?” Just as the client-centered therapy techniques of Carl Rogers seem most appropriate to bright “psychologically minded,” and introspective clients (similar to the graduate ministerial and psychology students he first worked with), the behavior therapist’s “token economy” is most effective when dealing with clients who are institutionalized and who show marked deficits in basic social and interpersonal skills.

Concomitant with this growing awareness that no one theory or technique holds all the answers is the concept that a number of diverse techniques may be necessary to handle any one case most efficiently. This *multimodal* approach, first thoroughly developed as a concept by Arnold Lazarus, is an underlying assumption in this book.

The eclecticism inherent in the ideas stated here is another assumption in this book. Hopefully, this allows a broad-based acceptance of many cause-paths to disorder, as well as a more comfortable melding with most specific theories and an absence of an “in-group” language.

In order to put some of the prior comments in perspective, and to provide a historical framework for the book in general, following the quote is a synopsis of those important historical developments related to mental disorder.

The only reason I have dabbled in psychology here is to demonstrate to you that you can use it to arrive at whatever conclusions suit you best. It all depends on who uses it. Psychology tempts even the most responsible and serious people to create fictions, and they cannot really be blamed for that.

—Defense Attorney Fetyukovich’s closing argument
from Fyodor Dostoyevsky’s novel, *Brothers Karamazof*

Major Historical Developments Related to Mental Disorder

Western Society

Early Greeks—Hippocrates (460–377 B.C.)—(a) Provides a focus on the brain as the site of disorder, (b) emphasizes life stressors.

Romans—Galen (2nd century A.D.)—(a) Conceptualizes the hospital as a treatment center, (b) the first thorough classification of disorders.

Age of Crusades—(a) Physicians obtain higher-status social class and greater intellectual influence, (b) the rediscovery of Greek and Roman texts, as well as contact with Near Eastern and Oriental influences, offer new perspectives on abnormal behavior.

1347—From this year to the end of the fourteenth century, the Black Death ravages Europe, destroying not only lives but also the “medieval period” in its primary reliance on theological explanations of everyday behavior.

Renaissance (1500–1650)—(a) There is a beginning rejection of witchcraft, (b) naturalistic explanations of emotional disorder attain wider acceptance, (c) in the late fifteenth and early sixteenth centuries former leprosariums are converted into the first asylums or “madhouses.”

Enlightenment (1700–1800)—(a) More humane care, (b) keeping of case histories and rudimentary statistics.

Late 1700s—Jean-Baptiste Pussin and then Phillipe Pinel free mental patients from their chains at LaBicetre, a hospital in Paris.

1810—Friedrich Koenig, a German working in London, harnesses steam power to produce the “fast” printing press (i.e., to power a cylinder over a paper sheet lying on a bed of inked type, instead of hand pressing a flat weight on it as was done when Gutenberg invented the first printing press in approximately 1450). Koenig’s discovery allows for a much faster dissemination of ideas nationally and internationally.

1865—Gregor Mendel publishes his influential theories of genetics.

1879—Wilhelm Wundt, a professor of physiology at the University of Leipzig, in Germany, establishes the first laboratory for the experimental study of psychology.

1883—Emil Kraepelin’s influential textbook on psychiatry likens mental disorder to physical disease.

1891—The first description of psychosurgery is published by Dr. Gottlieb Burckhardt, director of a Swiss asylum. This approach was later popularized by Dr. Egas Moniz, a Portuguese psychiatrist, whose 1936 monograph first described the lobotomy. Moniz was awarded the Nobel Prize in medicine in 1949 for this work.

1893—Sigmund Freud, with Josef Breuer, publish the first chapters of *Studien uber Hysterie*. Hypnosis is used to produce spontaneous verbalizations that are theorized to break down psychological repressions, leading to catharsis, and “cure.” These concepts parallel the earlier theories of Johann Christian Heinroth (1773–1843), who asserted that mental illness springs from the conflict between unacceptable wishes and the guilt generated by these wishes.

1905—The first publication of a true IQ scale, the Binet-Simon Scale.

1921—The first publication describing the Rorschach Test. Hermann Rorschach, a Swiss psychiatrist, while riding in the country, had noticed that what his children saw in the clouds reflected their personalities.

United States

Early colonial period—there is a regression to witchcraft and demonology.

1693—The peak of the witch-hunting trials in Salem, Massachusetts.

1773—The first hospital specifically for mental patients—in Williamsburg, Virginia.

Late 1700s—“Moral therapy” becomes popular.

1812—Benjamin Rush, a signer of the Declaration of Independence and the “father of American psychiatry,” writes the first American textbook on psychiatry. He also invents the “tranquilizing chair,” a kind of immobile straitjacket.

1842—Dorothy Dix takes a position as a school teacher in a prison. The conditions she encounters stimulate her to become the major reformer of the mental health movement in the nineteenth century.

Circa 1850—Hospital reform movement begins to generate provision of more humane treatment.

Late 1800s—Medical model increases its influence.

1892—The first meeting of the American Psychological Association (APA). In 1925, APA incorporates (and eventually adopts its first formal ethics code in 1953).

1892—Responding to an invitation from William James to direct the psychological laboratory at Harvard, Hugo Munsterberg, who had been a student of Wilhelm Wundt, engages in activities that arguably allow him the title “Father of Forensic Psychology,” including his 1908 book, *On the Witness Stand*. Munsterberg is also considered the “father of industrial psychology.”

1896—Lightner Witmer, often called the “father of clinical psychology,” establishes the first psychological clinic in the United States, at the University of Pennsylvania.

Circa 1900—Morton Prince pioneers the use of hypnosis in reintegrating (i.e., “fusion”) a multiple personality in his case of “Miss Beauchamp.”

Early 1900s—Freudian model increases its influence, especially stimulated by Freud’s lectures delivered at Clark University in 1912.

1907—Clifford Beers writes *A Mind That Found Itself*, the story of his long-term struggle with his own mental illness and the treatments he encountered. The widespread popular response to his book furthered the reform movement inherited from the efforts of Dorothy Dix.

1913—John Watson publishes his influential manifesto, “Psychology as a Behaviorist Views It.” Sometimes referred to as the “father of behaviorism,” he argues that psychology should abandon the study of consciousness, laying the groundwork for the behavior therapists and for later theorists such as B. F. Skinner. In about 1920, Watson goes to work for an advertising agency and helps to develop advertisement that encourages women to smoke cigarettes.

Early to mid-1900s—Behavioral model increases its influence.

1923—In *Frye v. United States* (295 F.1013(D.C. Cir.)), a federal appeals court establishes the standard of “scientific acceptance” for the admission of information-based opinions from an expert witness (from all fields, not just psychology) into trial testimony. This remains the standard until 1993, when the Supreme Court, in *Daubert v. Merrill Dow Pharmaceuticals*, appeared to allow a much less stringent “helpfulness” (to the court, e.g., the jury) standard in federal trials, an influential though not compelling standard on state courts as well.

1936—The first psychosurgery in the United States, a frontal lobotomy, by Dr. James Watts and Dr. Walter Freeman, in Washington, DC.

1939—The first publication of the Wechsler-Bellevue Intelligence Scale, the predecessor of the various Wechsler measures of intelligence, the most popular forms of the IQ test.

1943—The first published version of the Minnesota Multiphasic Personality Test (MMPI), devised by Starke Hathaway and Jovian McKinley. It is revised as MMPI-2 in 1989.

1946—The first true computer, developed by John Mauchly and J. Presper Eckert, ENIAC (Electronic Numerical Integrator and Computer) is demonstrated at the University of Pennsylvania. In the 1970s, in a patent dispute, a court held that the

Atansooff-Berry computer, built at Iowa State University, was first. But since that ABC computer was only designed to solve parts of linear equations, experts agree that ENIAC deserves the title because of its general applicability. Two essential concepts evolved out of ENIAC: the idea of “stored programs” and the programming tool known as an “if statement.” When it was fully operational, ENIAC filled a 30- by 50-foot room, but a \$30 calculator today has more computing power.

1951—The first nationwide television broadcast, by Edward R. Murrow.

1952—The first edition of the *Diagnostic and Statistical Manual of Mental Disorders* is published by the American Psychiatric Association. *DSM-IV*, the fourth edition, is published in 1994, and a text revision form (*DSM-IV-TR*) is published in 2000.

1950s and 1960s—Humanistic and cognitive models increase influence; and the advent of a new class of psychotropic drugs, the phenothiazines (e.g., chlorpromazine [Thorazine]), for the first time allow chemical control of psychotic behavior.

Early 1960s—Community Health Act of 1963 and the mental health centers that are subsequently developed change care delivery structure; the related “deinstitutionalization” of patients generates an exodus from the centralized state hospital systems.

2000—Francis Collins, leader of the Human Genome Project, and J. Craig Venter of Celera Genomics independently, yet with some collaboration, complete the first analysis of the human genetic code. The code consists of 3.15 billion letters that provide the instructions for all human genes. Although the code varies among individuals by only about 1 percent, these differences are crucial to the development, and hopefully the control of, many of the physical and mental disease processes in humans.

1980s–present—“Corporatization” of mental health care delivery and the advent of “managed care.” Those who pay for services (or their administrators, such as health maintenance organizations [HMOs] and preferred provider organizations [PPOs]) capture the system from those who deliver the services. There is a continuing interest in universal health care, but likely with only modest coverage for mental health.

America is one of the few places where the failure to promote oneself is widely regarded as arrogance.

—Gary Trudeau, Cartoonist Author of *Doonesbury*

An Outline of the Cases

The first chapter’s case in this book, that of O. J. Simpson, clearly highlights the social, legal, and political issues inherent in defining abnormality and subsequently applying that label to an individual. The second chapter, on theories and techniques, first presents the case of Danielle, who manifests a most common problem—a persistent though not constant moderate level of anxiety, several simple phobias, and some allied mild depression. After Danielle’s case is detailed, there is an analysis of the etiology and treatment that could be expected from the six major overall theoretical viewpoints: Psychoanalytic-psychodynamic, Behavioral, Cognitive, Information Processing and Systems Theory, Humanistic-existential, and Biological. The chapter closes with a multimodal treatment approach,

wherein techniques from a variety of theoretical perspectives are blended together to treat a case of exhibitionism.

The third chapter, but the first to focus on a specific syndrome, is concerned with anxiety disorders. After a discussion of those three little fellows (Hans, Albert, and Peter) who are classic, early cases in the psychodynamic and behavioral traditions, more severe cases are presented—specifically, Agoraphobia and Obsessive-Compulsive Disorder. This chapter closes with a relatively recent, though now often-used, addition to the *DSM*: Post-traumatic Stress Disorder, which is considered an Anxiety Disorder.

Chapter 4 combines Dissociative Disorders and Sleep Disorders, since the altered state of consciousness in each provides some interesting contrasts. Dissociative Disorders are exemplified by the case of Anna O., considered the first case in the psychoanalytical tradition, and here seen not so much as a case of hysteria but as a case of multiple personality. Sleep Disorders are exemplified first by a sleepwalking case and then one that combines a disturbance of the sleep-wake cycle with insomnia. Chapter 5 looks at Somatization Disorder (in the case of Empress Alexandra Fedorovna, the wife of the last Czar of Russia, at the time of the communist revolution) and Psychogenic Pain Disorder, commonly observed subtypes of the Somatoform Disorders.

Chapter 6 is concerned with severely disruptive syndromes: Schizophrenic and Paranoid Disorders, as seen in cases of Undifferentiated Schizophrenia, Paranoid Schizophrenia (here exemplified in Freud's classic case of Daniel Paul Schreber), and Paranoid Personality Disorder. Schizophrenia is a subgroup within the overall conceptual category of "psychosis," which essentially designates a loss of reality contact. The two schizophrenia cases allow a contrast between Paranoid Schizophrenia, the most well-integrated form, and Undifferentiated Schizophrenia, in which the functioning has especially deteriorated. These two forms are then compared with the nonpsychotic Paranoid Personality Disorder pattern also discussed here. The other category of very severe disorders, the Affective Disorders, are detailed in Chapter 7 in cases of Major Depressive Disorder (the case of Joseph Westbecker—a workplace violence case that was also the first major civil trial focusing on the drug Prozac) and Bipolar Disorder (the case of Virginia Woolf, a famous writer and a pioneer in the women's movement), and again both of these are often psychotic-level disorders.

In combination with the case of exhibitionism from Chapter 2, the full spectrum of Psychosexual Disorders is seen in Chapter 8. In addition to a case of sexual addiction (the case of William Clinton), a classic general paraphiliac (the case of Jeffrey Dahmer), and a pedophile (the case of Jesse Timmendequas), cases of both male and female sexual dysfunction are noted, as well as a case of Gender Identity Disorder. Then, Chapter 9 (Addictive Disorders) discusses three of the most common disorder patterns in society: Alcohol Dependence (in the case of Betty Ford), Prescription Drug Abuse (in the case of Elvis Presley), and Nicotine Dependence (in the case of Dr. S.).

Complementing the discussion of addictive patterns in Chapter 9, Chapter 10 discusses eating disorders, with the case of Karen Carpenter focusing on anorexia nervosa, and that of Princess Diana on bulimia nervosa. Chapter 11 has three of the more important personality disorders: the Histrionic, Antisocial, and Schizoid patterns. Ted Kaczynski, known more popularly as the Unabomber, illustrates the Schizoid Personality Disorder. The antisocial diagnosis is discussed in the case of Theodore Bundy. This complements the discussion of Paranoid Personality Disorder in Chapter 6 and Borderline Personality disorder in

Chapter 17. Somewhat related issues are then found in Chapter 12 (Disorders of Impulse Control), seen in cases of a Borderline Personality Disorder Associated with Rape, Pathological Gambling, and Kleptomania.

Violence patterns are found in several cases throughout this book (e.g., in the cases of O. J. Simpson [Chapter 1], Jeffrey Dahmer [Chapter 8], and others). In Chapter 13, the issue of violence and its causes is specifically addressed in the case of Jack Ruby, and then two cases of family violence. In Chapter 14, the cases of Developmental Language Disorder, Attention Deficit Disorder with Hyperactivity, and Early Infantile Autism point to three of the most critical disorders that emerge in childhood. The Oppositional Disorder and Separation Anxiety Disorder (associated with School Phobia) cases then document two common maladaptive channels for the strivings of identity and independence that are often a concern in middle childhood and adolescence. Another case focuses on the recent epidemic of school shooting. The last case focuses directly on the identity crises and identity disorder.

Chapter 15 offers three cases in which a clearly defined organic factor has caused psychological symptomatology. The first case documents a person's disorder and then virtually complete recovery of psychological functioning subsequent to having an entire half of the brain surgically removed. The second case shows how depression can result from organic trauma, and the third case here focuses on Alzheimer's disease.

Chapter 16 is concerned with the interaction of psychological disorder and legal issues. Providing a transition from the prior chapter, discussion focuses on the all-important issue of how to discriminate true disorder from malingering, and how to differentiate the unique and related Factitious Disorder from Munchausen by Proxy. The last case, that of John Hinckley, who attempted to assassinate President Reagan, examines the legal concepts of insanity, incompetency (to stand trial), and involuntary civil commitment as it relates to predicting dangerousness. The last chapter focuses on the development of positive mental health.

The full spectrum of cases provided by this book should develop an awareness of the diversity inherent in the modern study of abnormal psychology.

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