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Abnormal Psychology

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About the Chapter Opening Artists

We are pleased and privileged to offer as chapter opening illustrations creative works from Sistare, a nonprofit education institute, and from Creative Growth Art Center.

Sistare's first project was "Truth from Darkness," an exhibit of sculpture, prints, and paintings by artists with such mental disorders as schizophrenia, bipolar disorder, and obsessive-compulsive disorder. The exhibit opened in the Russell Senate Building Rotunda in Washington, D.C., in fall 1996 and traveled nationwide throughout the following year. The project was inspired by Susan Sistare Thorne, an artist who lost her battle with schizophrenia when she committed suicide in 1993. "The exhibit is committed to shedding light on the talents and intelligence of individuals who suffer from mental illnesses using fine art," says Sarah Thorne Mentock, president and founder of the namesake nonprofit organization. "It is simply one more avenue to bring the crisis of mental illness to the public, in hopes that awareness is raised and interest is heightened."

Creative Growth Art Center, a studio/gallery in the San Francisco Bay Area, provides creative art programs, educational and independent living training, counseling, and vocational opportunities for adults who are physically, mentally, and emotionally disabled. Yearly, over 4,000 people visit the Creative Growth Gallery, which was started with a National Endowment for the Arts grant as the first gallery of its kind in the country whose primary mission is to exhibit the art of people with disabilities. Creative Growth Art Center demonstrates that labels such as disability need not be barriers to high achievement and success in the arts.

To the Student

A Guided Tour of *Abnormal Psychology*

Welcome to one of the most fascinating courses you'll ever take! Fascinating as it may be, however, this is no tabloid treatment of the subject matter. The text you have opened is grounded in research and steeped in clinical experience. You can trust what you're about to read!

We know from experience with our own students that you'll be especially interested in coverage of clinical disorders—depression, schizophrenia, obsessive-compulsive disorder, and so on. So, after a basic introduction to the nature and diagnosis of abnormal behavior, we begin our coverage of disorders in Chapter 3—much earlier than most other texts do.

Because there is evidence that many disorders have their roots in childhood, so the first disorders chapters deal with disorders of infancy, childhood, and adolescence. These chapters will give you important developmental background material for understanding the later disorders chapters in the text.

Our coverage of all disorders is organized in relation to the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition *(DSM-IV),* published by the American Psychiatric Association. And, because prevention is quickly becoming as important in today's world as diagnosis and treatment, every disorders chapter includes a focus on how disorders might be prevented as well as treated.

Perhaps most important of all, you'll find the text peppered with real-life clinical stories of patients whom we and our colleagues have encountered.

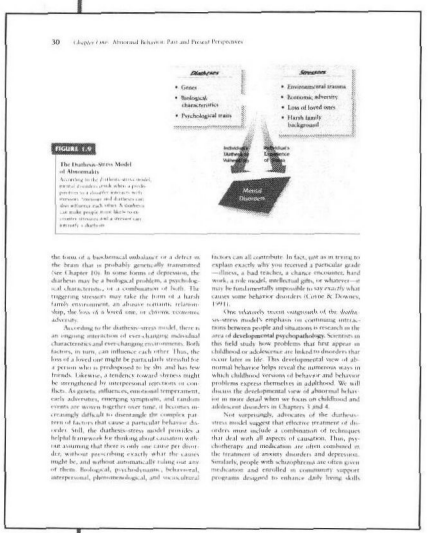
So that you'll make the most of all the material in the following pages and chapters, we've incorporated a number of helpful features and ancillary items in this textbook package.

An Integrated View of the Field

Roots of Disorders

Underscoring the developmental theme that appears early in the text and recurs throughout:

Connections tabs appear in every chapter, giving you cross-references to other interesting coverage elsewhere in the text. Rather than presenting abnormal psychology's varied topics as isolated bits of information, we will help you tie them together meaningfully at every opportunity.



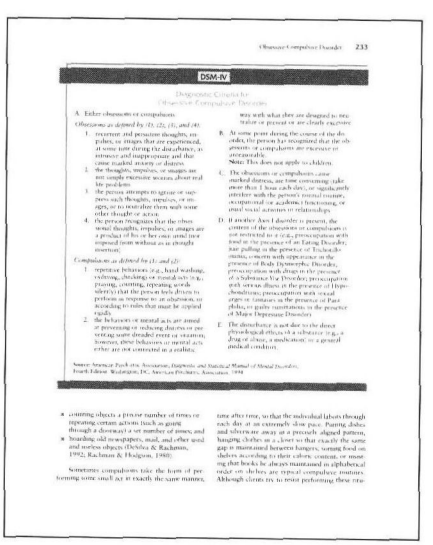
Diathesis–stress models are presented in carefully and consistently color-coded diagrams to show how the interaction of biological, psychological, and environmental factors can bring about disorders.

The Clinical and Research Base

Each chapter opens with **From the Case of . . . ,** a dramatic case history to which the chapter text refers and to which we return at the end of the chapter in **Revisiting the Case of . . . .** Among other cases, you'll be especially interested in the stories of

- Nelson McGrath, whose diary provides a haunting introduction to abnormality;
- former Green Bay Packers defensive end Lionel Aldridge, diagnosed with schizophrenia; and
- serial killer Ted Bundy's antisocial personality disorder.

Specially highlighted **brief case histories** appear throughout each chapter, further bringing the clinical world of abnormal psychology to life.



How should mental disorders be diagnosed? Find at-a-glance summaries of the official terminology, criteria, and categories in special **DSM tables.**

The research base truly comes to life, as today's leading authorities in the specialty areas of abnormal psychology speak with us in **A Talk with . . .** features within each chapter. Among others, hear the words of

- Lee Sechrest, on the science of abnormal psychology;
- Elizabeth Loftus, on repressed memory and dissociative disorders;
- Irving Gottesman, on schizophrenia; and
- David Orlinsky, on psychotherapy.


A Talk with Elizabeth Loftus

Repressed Memory and Dissociative Disorders

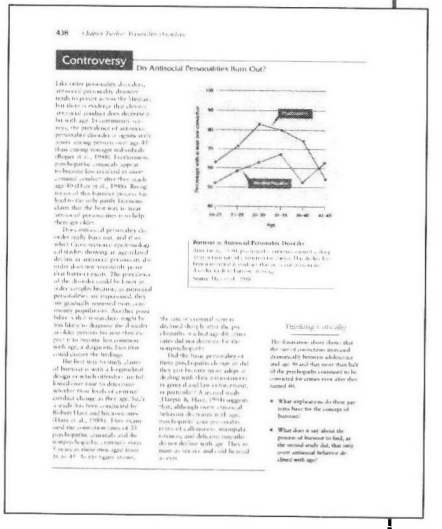

Prevention Improving Environments, Strengthening People

Prevention

How can mental disorders be prevented? Check out each disorders chapter's **Prevention** feature on such topics as

- adolescent suicide;
- the FAST track approach to derailing childhood conduct disorder;
- promoting community health; and
- adolescent drinking.

Holding Your Interest and Stretching Your Thinking


Controversy Do Antisocial Personalities Burn Out?

There is a special section in each chapter on a **Controversy** that is capturing current scholarly, popular, or clinical attention. A set of **Thinking Critically** questions at the end of each Controversy will deepen your understanding of the material. Among the Controversies are:

- What are the implications of genetic causes of abnormality?
- Are diagnoses gender biased?
- Is Ritalin a safe treatment for hyperactivity?
- Can violence be socially inherited?

Masterful Teaching and Effective Learning

In the Textbook . . .

Chapter Outlines help you preview and organize the material.

In Review at the end of most major sections, brief reviews provide you with summaries that help you along the way.

Chapter Summaries provide a paragraph of review for each of the chapter's main sections. You'll see the main headings from the chapter outline repeated here, for effective review and "chunking" of the material.

Key Terms All of the chapter's boldfaced glossary terms are gathered at the end of the chapter for you to test your recall of the chapter's terminology. If you're having trouble with a term, check the page reference provided.

And beyond . . .

A variety of student ancillary items are also available from your bookstore. Check with your instructor.

Practice Tests Multiple-choice tests, with answers, for all chapters, composed of real test items from the text's Test Bank, by Susan K. Fuhr of Weber State University, prepare you to take the real thing.

Study Guide By John Foust of Parkland College, applies the tried-and-tested learning technique—SQ3R—to a variety of exercises for each chapter.

Website Visit the Allyn & Bacon America Online home page (keyword: College Online) and this textbook's website (http://www.abacon.com/nietzel) for a wealth of information and assistance related to abnormal psychology. Interact with an online study guide, follow links to other useful sites, or just browse.

Casebook *Case Studies in Abnormal Behavior,* Third Edition by Robert G. Meyer and Yvonne Hardaway Osborne, provides a wealth of actual, recent cases, accompanied by introductions and discussions.

To the Instructor

This book arose from a vision that we shared about a more exciting organization for an abnormal psychology textbook, as well as a new set of emphases on how disorders develop and can be prevented. This vision was focused by our experiences teaching abnormal psychology courses, by talking with other instructors about their classes, and, most important, by talking with students about what they wanted in an abnormal psychology textbook. We believe we have translated this vision into a book that students will enjoy reading and that instructors will appreciate assigning in their classes.

An Innovative Organization

The traditional abnormal psychology textbook begins with four to six chapters on the history of psychology and abnormality, an overview of theoretical approaches to abnormal behavior, a survey of classification and assessment techniques, and often a primer on research methods. In many cases, one quarter to one third of the book is devoted to these topics. In our experience, such an organization creates several problems that we have tried to eliminate in this text. First, students routinely become bored with so much background material and grow impatient, as they often put it, "to get to the interesting stuff"—the disorders themselves. Instructors frequently respond by not assigning all of the opening chapters, but this can result in an incomplete introduction to the course, inadequately explained content later, or both.

In this text, we compress what we believe to be the necessary preparatory content into the first two chapters. In those chapters, we survey major historical periods and their associated worldviews, summarize various theoretical perspectives on abnormality, describe the basics of assessment and classification, and introduce the logic of the scientific method. We confine ourselves to the fundamentals of this material, but we return to all of these issues later in the text, by discussing them in the context of specific disorders. By the end of the book, students will have been exposed to all the basic historical, psychological, and scientific concepts in a way that we believe is more interesting and less artificial than the typical abnormal text's format.

A second major innovation in this text lies in its placement of chapters on infancy, childhood, and adolescence. In the typical text, these problems are discussed in the last third of the text, usually after all the major adult disorders have been described. This standard organization does nothing to help students understand the many important links between childhood experiences and adult problems. In this text, disorders of infancy, childhood, and adolescence, and developmental disorders, are covered before all others. This arrangement helps students learn how, in many individuals, childhood experiences are linked to adult disorders.

The unique organization of this text makes possible some special features and themes. One repeated theme is **developmental psychopathology,** a perspective on mental disorders that is gaining ever-greater prominence. The origins and signs of many adult disorders emerge in childhood and adolescence. Understanding how early developmental factors increase the risk of mental disorders is crucial, and the organization of this text provides a framework for achieving this understanding.

Special attention to developmental contributions to mental disorder is enhanced by an emphasis on **prevention.** Each disorders chapter contains a highlighted section devoted to a specific prevention topic. Does family violence produce aggressive children who then become antisocial adults? What role do early thinking patterns play in creating anxiety and mood disorders, and can these patterns be altered? Do we know enough about the genetics of mental disorders to offer genetic counseling to prospective parents? Although our current knowledge of psychopathology does not yet permit the design of effective prevention programs for all disorders, considerable progress has been made in several areas. Our book is intended to portray what is currently known about prevention and to help students understand the importance of research in this vital area.

Various theoretical models have attempted to explain mental disorders by invoking a large number of biological, psychological, and social factors. Our text surveys these models, but, for each disorder, we emphasize the causal model that we believe is best supported by existing data. For many disorders, this turns out to be a **diathesis–stress model,** which emphasizes an interaction between a vulnerability or predisposition to disorder (diathesis) and the stressors and other triggering events that translate diathesis into disorder. In order to highlight the importance of

the diathesis–stress model, we use carefully and consistently color-coded diagrams to depict the diatheses and stressors involved in specific disorders.

Why do men and women differ in the frequency with which they are diagnosed with certain disorders? What is the most effective form of treatment for a given disorder? Should we devote increased resources to preventing mental disorders or to treating them once they appear? For many of these questions, the answer remains unclear. Scholars often disagree about how to interpret empirical data about such questions or even about whether empirical data can resolve their disagreement. In order to acquaint students with these inevitable, and desirable, disputes, we have included a **Controversy** in each chapter that focuses on an unresolved diagnostic, causal, or treatment issue. The purpose of these Controversy sections is to point students toward some of the "big questions" that remain unanswered in the field of abnormal psychology while encouraging them to deepen their understanding of the issue by thinking critically about it. To this end, each Controversy concludes with **Thinking Critically** questions.

Just as childhood experiences are often linked to later problems, the symptoms, causes, and treatments of one type of disorder are often relevant to other conditions as well. Given the degree to which biological, psychological, and social factors interact with each other, this overlap should not be surprising. However, it is often overlooked. One key skill in learning about abnormal behavior is being able to see linkages between different disorders, causal factors, treatment methods, and outcomes. We attempt to promote this kind of insight in our readers by noting some of the connections between chapters. These **Connections** appear in the margins of the text and direct the reader to content on specific pages in other parts of the text that is related to the current topic under discussion.

Discoveries in abnormal psychology are unfolding at an astounding rate. New knowledge in the areas of diagnosis, causation, and treatment appears literally almost every day. To ensure that students are exposed to the most current and sophisticated thinking available, each chapter includes **A Talk with . . .**, an interview with a world-renowned expert on a topic covered in that chapter. These experts also suggest some of the most crucial questions in need of future study.

Promoting Interest and Learning

To promote students' interest in the material and aid their understanding, we have employed a number of other pedagogical devices in all chapters. In addition to brief case histories liberally distributed throughout the text, we begin each chapter with a lengthy case history entitled **From the Case of . . .**, which illustrates the clinical reality of a disorder discussed in that chapter. We return to these cases at the end of the chapter in **Revisiting the Case of . . .**, which summarizes the course and outcome of the individual's problem. These introductory and revisited cases were selected to show how general concepts of cause and treatment operate in individuals most of whom are known personally by the authors.

Students' studying of the text should be facilitated by our use of several other learning tools, including:

- **In Review** summaries that highlight the key points of major sections in each chapter.
- **Chapter Summaries,** which identify and integrate the most important subject matter for chapters.
- **Key Terms,** which are boldfaced in the chapter, listed at the end of each chapter with page references, and defined in the book's Glossary.

Ancillaries for Instructors

No major college textbook today would be complete without a full complement of teaching materials to help make the instructor's job easier. Ours is no exception. We are pleased to offer:

- An **Instructor's Manual,** by Peggy Nash of Broward Community College, featuring chapter overviews, outlines, lecture makers, transparency lists, and various other helpful resources.
- A **Test Bank** of over 2,500 items, by Susan K. Fuhr of Weber State University, available in both hard copy and computerized form for DOS, Windows, and Macintosh computers.
- A **website** specifically for this textbook, which offers both students and instructors the opportunity to browse to other sites relevant to specific topics in this textbook, to chat with one another on our message boards, and to participate in an on-line study guide.
- **Transparencies,** in full color, of key figures from the textbook and other sources.
- A variety of video resources for you to choose from, including:
  - —A 90-minute **case video,** featuring (1) Devon, an autistic boy, whose mother is interviewed by pediatric psychologist Sandra

D'Angelo; and (2) Lionel Aldridge, former Green Bay Packers defensive end, diagnosed with paranoid schizophrenia, interviewed by Mike Nietzel. Each case also provides a description of the disorder, as well as treatments each individual received.

—A series of videos from **American Psychiatric Press, Inc.**, on diagnostic issues and treatments for a variety of disorders.

Acknowledgments

We gratefully acknowledge the contributions of two colleagues who provided valuable assistance in the creation of this book:

Dr. Ronald Kleinknecht, of Western Washington University, wrote the initial drafts of Chapters 7 (Anxiety Disorders), 10 (Schizophrenia), and 15 (Biological Treatment of Mental Disorders);

Dr. Arthur Nonneman, of Asbury College, wrote the initial draft of Chapter 11 (Cognitive Disorders) and assisted with other sections of the text concerned with neuroanatomy and brain functioning.

In addition, we were fortunate to be able to interview and share the wisdom of the following leaders in the field of abnormal psychology. We thank them deeply.

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Geraldine Dawson, University of Washington
David L. Dunner, University of Washington Medical School
Irving Gottesman, University of Virginia
Constance Hammen, University of California, Los Angeles
Robert Hodapp, University of California, Los Angeles
Danny Kaloupek, Boston Veterans' Administration Medical Center
Terrence Keane, Boston Veterans' Administration Medical Center
Elizabeth Loftus, University of Washington
William R. Markesbery, University of Kentucky
Alan Marlatt, University of Washington
Karen Matthews, University of Pittsburgh
David Orlinsky, University of Chicago
James Pennebaker, Southern Methodist University
Ron Roesch, Simon Fraser University, Vancouver, British Columbia
Lee Sechrest, University of Arizona
Tom Widiger, University of Kentucky
Melvin Wilson, University of Virginia

We also want to thank several other colleagues who provided extremely valuable advice and assistance at several points throughout this project. Whether we asked for a review of an initial draft, help with references, clarification of controversies in the field, opinions about treatments, or information that would fill gaps in our own knowledge, the following people were always generous with their time and their expertise. We owe them a lot.

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Tom Widiger

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Logan Wright, *University of Oklahoma*
Eric A. Zillmer, Drexel University

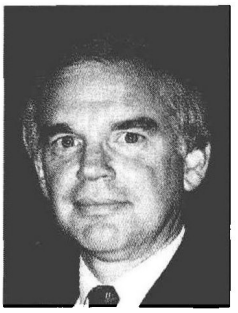
The completion and coordination of this manuscript would have been impossible without the heroic efforts of Mike Nietzel's assistant, Shirley Jacobs, who, in this project as in many previous ones, proved to be efficient, tireless, tactful, patient, and dedicated. In short, Shirley was her usual indispensable self, the miracle worker of Kastle Hall.

We also want to thank the many individuals at Allyn and Bacon, who teamed up to help us write this book. Special praise must go to our developmental editor, Kathy Field, who was a wonderful source of advice, examples, teaching, and wisdom, and to Sue Gleason, senior developmental editor, who provided an abundance of suggestions, encouragement, and organizational skill to keep us on track. They both listened to our gripes, helped us out of tight spots, pushed us when they had to, and bolstered our confidence. To the extent that this text is successful, Kathy and Sue deserve much of the credit.

Our deep thanks also go to several others at Allyn and Bacon, including Sean Wakely, vice president and editor in chief, for his leadership and belief in our project; Sandi Kirshner, editorial director, and Bill Barke, president, for their support and confidence; Joyce Nilsen, director of field marketing, for her marketing insights and instincts; Susan McIntyre, senior production administrator, for her attention to all the details in bringing the manuscript together; Marjorie Payne, freelance production editor, for her meticulous reading of and corrections to the manuscript; Jay Alexander, graphic artist, for his knowledgeable preparation of the figures; and Laurie Frankenthaler, photo researcher, for her inspired eye in finding just the right photographs.

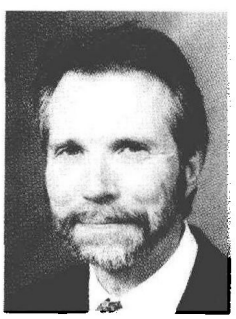
Finally, a word about some of the people who are closest to us. Writing this book meant there were many nights when we neglected our families, numerous weekends when we isolated ourselves from them, and countless times when we were distracted, curt, or downright boring. Writing a book is tough on families and loved ones. We want to thank ours for making it go more easily than we had any right to expect. So, to Sandy, Aaron, Katy, Matt, and Emory, our apologies for the inconveniences and absences, and our thanks for your tolerance and understanding.

About the Authors



MICHAEL T. NIETZEL earned his Ph.D. in clinical psychology at the University of Illinois at Urbana-Champaign in 1973. He joined the faculty at the University of Kentucky that same year. He is currently professor of psychology and chair of the department of psychology at the University of Kentucky. Throughout most of the 1980s, he served as the director of the clinical psychology program at the University of Kentucky. Mike's research and teaching interests are focused on abnormal psychology, psychotherapy, forensic psychology, origins of criminal behavior, the assessment of therapeutic outcomes, and the relationship of personality to mental disorders. He is a frequent consultant to law enforcement agencies and correctional facilities. Mike is the coauthor of leading textbooks on clinical psychology and psychology and the law.

Among Mike's favorite pastimes are playing golf, listening to jazz, following the Chicago Cubs, watching his son Aaron play hockey, and observing his wife Sandy unsuccessfully attempt to train their two Labrador retrievers, Axel and Bella.



MATTHEW SPELTZ received a B.S. in psychology from the University of Illinois and an M.S. in psychology from Western Washington University. He earned his Ph.D. in clinical psychology at the University of Missouri-Columbia in 1980. Matt then completed a postdoctoral fellowship in child clinical psychology at the University of Washington. He is currently the chief of child psychiatry outpatient services at Seattle's Children's Hospital and Medical Center, and associate professor of psychiatry and behavioral sciences at the University of Washington School of Medicine. Matt has taught introductory psychology to undergraduates and developmental psychopathology to graduate students in child clinical psychology. He also teaches clinical psychology interns and psychiatry residents about clinical work with children and families. Matt has published research on the early development of children with conduct problems, the assessment of children's risk for injury, and the psychosocial development of infants with craniofacial birth defects.

In his spare time, Matt enjoys skiing and hiking in the Cascade Mountains in Washington state, playing basketball with friends, and watching Puget Sound sunsets with wife, Katy, and cat, George.

ELIZABETH A. MCCAULEY completed her undergraduate studies at the University of Wisconsin at Madison and her Ph.D. at the State University of New York at Buffalo. She is currently an associate professor in the department of psychiatry and behavioral sciences, with an adjunct appointment in the department of psychology, at the University of Washington in Seattle. Elizabeth is the clinical director of the Inpatient and Partial Psychiatry Hospitalization Programs at the Children's Hospital and Medical Center and the psychology head for the University of Washington's Adolescent Health Training Program. She teaches and provides clinical supervision in the department of psychiatry and behavioral sciences. Elizabeth also lectures on adolescent development and psychopathology to pediatric residents and psychology students. Her research has focused on mood disorders in children and adolescents, and on the behavioral aspects of endocrine and sex chromosome anomalies. She is currently working on a federally funded study of a preventive intervention for at-risk high school students.

In her spare time, Elizabeth enjoys reading, gardening, and hiking. She and her husband are landscaping their back yard—bit by bit. She goes on a yearly backpacking trip into the wilds of the Pacific Northwest with a group of women and is planning a trip to Tanzania with Habitat for Humanity. She has enjoyed raising and coparenting three children—two stepdaughters, and a son—all of whom have now left home to explore the world of college and work.

DOUGLAS A. BERNSTEIN received his Ph.D. in clinical psychology frm Northwestern University in 1968. In that same year, he joined the faculty at the University of Illinois at Urbana-Champaign, where he is currently professor of psychology. His teaching responsibilities have included undergraduate courses in introductory psychology, abnormal psychology, clinical psychology, and behavior modification, as well as graduate courses in research methods and psychotherapy. He has won the University of Illinois Psychology Graduate Student Organization's teaching award, as well as the department's Mabel Kirkpatrick Hohenboken Memorial Teaching Award. Doug's research interests have centered on anxiety assessment and treatment (including programs to alleviate fear of dentistry), and the modification of smoking behavior. In recent years, he has focused most of his energies on directing the introductory psychology program at Illinois, on coauthoring textbooks in introductory and clinical psychology, and on promoting excellence in the teaching of psychology through his leadership of the National Institute on the Teaching of Psychology (now in its 20th year) and his founding, in 1994, of the APS Preconvention Institute on the Teaching of Psychology.

Doug enjoys travel, dancing, listening to classical and country music, and keeping a blinding shine on his car. He also loves to teach and has made a minor hobby out of collecting odd excuses from students. His only regret in life is his inability to teach Mike Nietzel how to train his dogs.

dom employed and, if they do hold jobs, their incomes average less than $5,000 a year. Beyond all this, they suffer almost daily rejection by members of the general public who both pity and fear them (Federal Task Force on Homelessness and Severe Mental Illness, 1992). The policy of confining these people in state mental hospitals was obviously not the answer, but at least it usually assured them a minimum level of safety and shelter. Today, with public mental hospitals a less-ready refuge, there is a continuing struggle to provide the broad range of services these individuals need.

Should they all be put back in hospitals? The problem of mental illness among the homeless is too complex and profound to be solved through any single program or idea. The National Institutes of Mental Health Task Force on Homelessness and Severe Mental Illness has proposed creation of an integrated system of care with three main components (see Figure 18.2). The first would be its *assertive outreach orientation,* meaning that service providers would seek out and bring treatment to the homeless mentally ill on the streets and in shelters rather than waiting for these clients to ask for help. Service providers would also offer *integrated case management,* helping clients obtain necessary health and welfare benefits, arranging appointments with health care providers, and making sure they are receiving appropriate services.

The second major component of this system would be to provide adequate housing. Many of the homeless mentally ill need *safe havens* from their confusing and frightening lives on the street or in mass shelters. These facilities would provide semiprivate living conditions and basic services (such as food, showers, and clothing) for small groups of people whose mental illness has kept them out of larger shelters. Safe havens would provide temporary help until more permanent housing could be found in a special-residence hotel, halfway house, group home, foster home, nursing home, board-and-care home, or apartment.

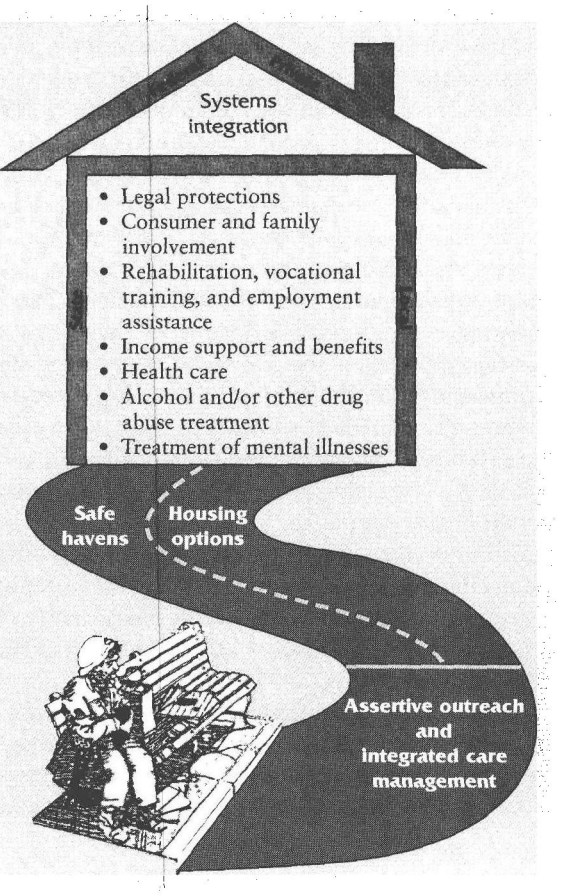


FIGURE 18.2

An Integrated System of Care for the Mentally Ill Who Are Homeless

Connections

Do services such as psychosocial rehabilitation successfully maintain patients in the community? See Chapter 17, pp. 602–604.

The final component in this integrated system of care would consist of a collection of income support, health care, psychosocial rehabilitation, mental health and substance abuse treatment, education, and vocational services. The specific package of services offered would depend on the particular needs of a given client, as assessed by a case manager. Because some severely mentally ill persons resist or avoid psychiatric treatment, one strategy would be to "bundle" services so that mental health treatment and rehabilitation are always paired with necessities such as food and shelter. Proponents of bundled services see them as a reasonable, efficient way to reach an often-inaccessible population; opponents view bundling as coercing people into treatment that they may not want and should be free to refuse. The debate highlights again the enduring conflict in the United States between personal autonomy and the rights of society at large.

The Mentally Ill in the Criminal Justice System. The process of deinstitutionalization has placed ever-greater responsibility for supervising the severely mentally ill on police and the criminal justice system.

Police officers have wide discretion in their response to disruptive people who may also be mentally ill. They can arrest them or force them into a hospital. They can attempt on-the-spot counseling, refer them to a mental health agency, or return them to the care of friends or relatives. Research suggests that the police are reluctant to arrest or hospitalize mentally ill people unless they create an obvious public danger (Bittner, 1967). This reluctance is part of a general tendency for police to avoid arrests in minor encounters unless the suspect is disrespectful or a complainant insists on pressing charges. Consider, for example, the research of Linda Teplin (1984), a sociologist at Northwestern University, who trained a team of psychology graduate students to observe police–citizen interactions over a 14-month period in two Chicago precincts. Using a symptom checklist and a global rating of mental disorders, the researchers studied more than 800 police–citizen encounters. In these encounters, over 500 citizens were considered suspects eligible for arrest, but only 29.4 percent of them were actually arrested. However, of the 30 suspects rated by the observers as mentally ill, 46.7 percent were arrested, a significantly higher rate than for suspects who did not appear to display a mental disorder. Similar results have been reported in other cities.

In other words, when something must be done about a disruptive mentally ill person, police officers may prefer arrest over hospitalization, partly because arrest often involves less red tape, and also because hospitals often refuse to accept these people because they are too dangerous, not dangerous enough, or suffer a disorder that the hospital does not treat. Thus, the homeless mentally ill are being "criminalized" to a certain extent because society does not know what else to do with them. They are often treated like petty criminals and, for many, local jails have become their major source of shelter, food, medical treatment, detoxification, remedial education, and other services. Not surprisingly, rates of severe mental disorders and substance abuse are now alarmingly high among jail populations (Abram & Teplin, 1991). Commenting on this situation as it affects Black youngsters, the Reverend Jesse Jackson noted that, for many teenagers, "Jail is a step up; once they are jailed, they are no longer homeless . . . they have balanced meals . . . they will no longer be hit by drive-by shootings."

By the 1980s, it was apparent to most thoughtful observers that an exclusive concern for protecting the rights of mentally disordered patients often meant ignoring their needs for adequate care, housing, and treatment. Ironically, the legislative reforms of the 1970s inadvertently helped create a situation in which it was too hard to get mentally ill people into a hospital for needed treatment and too easy for them to be released before they were ready to cope effectively with the outside world. These people had been protected from hospitalization only to be relegated to the streets, jails, or "psychiatric slums" that offered neither treatment nor protection from hunger, crime, disease, and other dangers. Had adequate attention been given to providing community-based services to deinstitutionalized patients, the results

Partly as a result of laws that make it harder to hospitalize the mentally ill against their will, increasing numbers of individuals with mental disorders are being detained in local jails where they can be observed for a day or two to determine whether a hospital commitment is justified. One jailer, commenting on individuals who are repeatedly arrested for this reason, said "it is as if they are serving a life sentence a few days at a time."

might have been different. But the fact is that most communities have not assured the services that a proper deinstitutionalization program requires.

As activism by mental health professionals and patients' families awakened interest in these concerns, the social policy pendulum began to swing back toward making it a bit easier to commit people to a hospital without their permission. Many states altered their laws to permit involuntary commitment, not only of people whose mental illnesses poses a danger to themselves or others, but also of people who are *gravely disabled* by their disorder or are in danger of *deteriorating* if they are not hospitalized. These revised laws recognized that a small percentage of people may be so severely incapacitated by mental illness that, although they pose no real danger to others, they will be unable to survive for long unless they receive custodial care and protection.

Even before legislators began to pass these revised state laws, clinicians and judges had informally started to use commitment criteria that anticipated them. Their decisions were based on a commonsense model of commitment that did not "place rights above suffering" (Applebaum, 1994). Sometimes called the "thank-you theory" of commitment, this model assumed that patients whose disorders render them unable to make reasonable decisions about their lives will ultimately be grateful for the treatment that a mental health professional or judge insists they receive. This practice amounted to an informal return to the *parens patriae* logic for commitment.

Types of Commitment in Use Today. Most state laws now permit three types of involuntary commitment of mentally ill persons: (1) commitment without a court order, (2) commitment by court order, and (3) outpatient commitment.

Commitment without a court order is allowed under emergency circumstances. Because most commitments arise in emergency situations, this is the most frequent means by which patients are committed to hospitals. Family members, police officers, mental health professionals, or, sometimes, just concerned citizens can initiate this type of commitment by alerting law enforcement officials when people appear mentally disturbed and about to harm themselves or others. This was the basis for the commitment of Wilson, whose case opened this chapter. A few states require approval by a judge before allowing an emergency commitment but, in most cases, the decision is left up to a mental health professional at the hospital to which the person is taken by the police. Upon being committed, the person is read a list of legal rights pertaining to commitment. Patients are told, for example, that they can be detained in the hospital for only a limited time—usually from 24 hours to a few days—before a court hearing must be conducted to determine whether more extended confinement is necessary.

Commitment with a court order requires that a family member, police officer, or other concerned party petition a court to have the allegedly mentally ill person examined by a mental health professional. A court hearing is then conducted to determine whether the criteria for commitment are satisfied. The person whose commitment is being sought has the right to be represented at this hearing by an attorney who can call and cross-examine witnesses. The judge or a jury then decides whether the commitment criteria have been met. Although "dangerousness" is the standard discussed as the formal basis for most involuntary commitments, proof of "grave disability" is actually the criterion that usually determines the court's decision (Turkheimer & Parry, 1992). Regardless of the formal criteria, if the judge or jury thinks a person is mentally ill and in obvious need of care, commitment is usually ordered.

Outpatient commitment is a procedure allowed in most states, but, until recently, it has not been used very often. It allows the state to commit a patient to mandatory treatment in an outpatient setting—a community mental health center, or day center, for example. Outpatient commitment often occurs when patients are given conditional release from a mental hospital: they are ordered to continue to receive medication or other treatment in the community and, if they fail to do so, they can be returned to an inpatient institution.

Although outpatient commitment appears to be an attractive alternative for treating some severely mentally ill persons, it carries several complications. For example, are therapists liable for any dangerous acts performed by patients while on outpatient commitment? Is effective, community-based treatment readily available? Finally, the vast majority of outpatient commitments require that patients continue to take prescribed medication. Can patients be forced to take these medications? This last question, the thorniest of all, involves patients' right to refuse treatment.

The Right to Refuse Treatment

Several fundamental questions about patients' rights are raised when a patient does not want to take medication that a physician believes would be beneficial. Should society "help" patients by giving them treatment against their will? Does the need for treatment outweigh patients' rights to protection against inva-

sion of privacy and against interference with decisions about what goes into their bodies? Does it make sense to commit people to an institution and then allow them to refuse the very treatment that may be necessary for them to regain their freedom?

For many years the treatment of medical patients has been governed by rules that require patients to give informed consent before receiving medication, surgery, or other procedures. The rules of **informed consent** presume that medical patients are competent to decide whether they want to receive a treatment after being told about its potential benefits and risks and the alternative treatments available (see Figure 18.3 on page 626). For many decades, however, informed consent rules were not usually applied in the treatment of the seriously mentally ill because it was assumed that their disorders made them incompetent to render such decisions. In short, the mentally ill were expected to simply follow doctors' orders.

By the late 1970s, however, courts in Massachusetts (*Rogers* v. *Okin,* 1979) and New Jersey (*Rennie* v. *Klein,* 1978), among others, had decided that committed mental patients should not be automatically presumed incompetent and that they therefore retained the right to refuse medication, even if it were likely to be beneficial. Still, the right to refuse treatment is not recognized in all states; some state courts have decided that committed patients can be ordered to comply with treatment that a professional has deemed necessary.

Indeed, the U.S. Supreme Court has never held that the mentally ill have a constitutional right to refuse all treatment. Instead, it has mostly followed the principle of deferring to the professional judgment of physicians who are treating a patient. For example, in the 1982 case of *Youngberg* v. *Romeo,* which involved a profoundly retarded young man who was involuntarily committed, the court held that honoring the rights of patients cannot unnecessarily restrict the judgment of the treating professionals. Likewise, in *Washington* v. *Harper,* a 1990 case involving a mentally ill prisoner, the court stated that the prisoner could not be medicated against his will *unless* treating professionals concluded that medication was necessary to ensure the safety of the prisoner or others. The Supreme Court reached a similar decision in the 1992 case of *Riggins* v. *Nevada,* when it ruled that it was unconstitutional to force a defendant on trial for murder to be medicated *unless* it could be shown that such medication was necessary to ensure the defendant's safety (or the safety of others) or that the trial could not be conducted unless the defendant were medicated.

Even in states that recognize a patient's right to refuse treatment, that right is not absolute. A patient's refusal can be overridden if the patient is behaving dangerously and medication is likely to lessen the emergency, or if the patient is judged to be incompetent to make a decision about treatment. In the latter instance, a judge or a panel of clinicians and citizens can give "substituted" consent on the patient's behalf if they conclude that the patient would have consented to treatment had he or she been mentally competent to do so.

Despite these exceptions, many mental health professionals were alarmed about the implications of allowing patients even limited rights to refuse treatment, especially psychoactive medications. They predicted that, because the mentally ill often deny their problems, few of them would consent to treatment and that mental hospitals would thus not be able to do their job. They warned that hordes of unmedicated patients would make hospital wards increasingly chaotic, violent, and dangerous, and they suggested that the nearly constant hearings required to determine the competency of each nonconsenting patient would place a substantial drain on their time and money.

In fact, these predictions have generally not come true. Formal refusals of treatment are surprisingly infrequent. On average, in jurisdictions recognizing the right to refuse treatment, only about 10 percent of patients actually do so (Appelbaum, 1994). Even fewer refuse medication for very long, and those who do almost always have their refusal overridden eventually by a judge or review panel (Appelbaum & Hoge, 1986). And while states that allow patients to refuse treatment have seen some increases in aggression in hospital wards, these increases have been less than feared.

Predictions about increased costs *have* come true. Taking into consideration the clinicians' time, judicial and court costs, waiting periods, and review panel obligations, it is clear that allowing patients to refuse treatment is an expensive process. However, these costs must be viewed in light of their benefits in giving patients a feeling of control over their lives. Typically, a patient's refusal of treatment comes as an initial *objection* to treatment. Then, the patient and physician usually begin to negotiate (Appelbaum, 1994). If the patient refuses one drug, the clinician may prescribe a different one. If the patient refuses medication because of feared side effects, the clinician may prescribe a lower dose. In some cases, patient and therapist come to an understanding and the therapist may agree to suspend medication for a while in order to see how well the patient functions. If symptoms return, the patient agrees to go back on the medicine. If the symptoms do not return, the doctor does not insist on continued treatment.