Eighth Edition

An Outline of Psychiatry

Clarence J. Rowe, M.D.

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wcb
Wm. C. Brown Publishers
Dubuque, Iowa

To the clan:

Patricia
Padraic
Barbara
Rory
Carol and
Kelly Michael

They've kept the wind at their backs!

And to:

Burtrum C. Schiele, M.D., who started it all.

Library of Congress Catalog Card Number: 83–71874

ISBN 0–697–06590–1

Printed in the United States of America
10 9 8 7 6 5 4 3

Introduction to the Eighth Edition

The publication of the eighth edition marks the thirtieth year the *OUTLINE* has been in print. As in the past, the book is written primarily for students of various professions who want an understandable entry-level text of psychiatry. Again, no claim to uniqueness is made. The contents reflect my clinical experience in practice, consulting, and teaching. Selective references are listed at the end of each chapter.

The classifications of mental disorders follow the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* 3rd ed., 1980 (*DSM*-III).

A *Psychiatric Glossary,* 5th ed. (Washington, D.C.: American Psychiatric Association, 1980), and *Psychiatric Dictionary,* 5th ed., by Robert J. Campbell, M.D. (New York: Oxford University Press, 1981) have been useful in formulating some of the definitions.

My collaborators, Dr. Shirley H. Mink and Dr. Walter D. Mink, have offered critical comments and helpful suggestions throughout the book.

Sharon Weitzel, once again, skillfully and patiently prepared the manuscript.

Clarence J. Rowe, M.D.

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The mind of men is a mystery; and, like the plant, each one of us naturally appropriates and assimilates that about him which responds to that which is within him.

Joseph Roux:
"Prelude," *Meditations of a Parish Priest* (1886)

Etiology of Mental Disorders

I. Introduction

A. Definition

Webster's Third New International Dictionary (1971) defines etiology as—

1. A science or doctrine of causation or the demonstration of causes.
2. A branch of science dealing with the causes of particular phenomena.
3. All the factors that contribute to the occurrence of a disease or abnormal condition; cause; origin.

B. Actually, the essential causes of many mental disorders are unknown or incompletely understood. It is thus necessary for us to consider all the factors that could play a role in the development of any particular mental disorder.

C. One view is that mental disorder results from the interaction of the person (personality) with predisposing and precipitating factors. Subsumed in this view are the following:

1. Predisposing factors are those that render the personality susceptible or vulnerable and are present over a long period of time (subclinical).
2. Precipitating factors are events that precede the clinical onset of the disorder.
3. The severity of the predisposing factors determines the person's vulnerability or susceptibility to precipitating factors.
4. Precipitating factors of varying severity may produce disorder in mildly predisposed persons. For example:
   a. A loosely disorganized schizophrenic may be inordinately upset by a mild social rebuff.
   b. A well-integrated person may develop a mild anxiety reaction to a catastrophe, such as a fire or a flood.
5. Predisposing factors endure throughout the life of the individual. They may be cumulative or connected. Precipitating factors occur intermittently throughout the individual's lifetime. They may be related to special developmental tasks (see p. 5).

D. As a matter of fact, human behavior at any time is determined by the individual's mental status and his or her capacity, at that moment, to adapt to the immediate environment.

E. In the past, two major hypotheses have been advanced to account for mental illness: the psychogenic theory and the somatogenic theory.

1. Proponents of *psychogenic hypothesis* regard mental disorder as an inefficient and unsuccessful compromise to the conflict between the demands of the real world and the individual's desires.
2. Proponents of *somatogenic hypothesis* regard mental illness as resulting from the malfunction of the central nervous system. Such malfunction may be genetically transmitted.

F. The psychogenic and somatogenic hypotheses have been viewed as conflicting alternatives. This view is unnecessarily dualistic. All factors interact, whether they are categorized as "psychosocial" or "organic." It is the *interaction* of the factors that must be considered in any etiology.

G. One way of ranking factors is to separate those that contribute to vulnerability or susceptibility to stress (predisposing) from those that are stressors (the precipitating factors or psychosocial stressors as listed in *DSM*-III). A partial listing of predisposing factors and precipitating factors that are frequently considered in etiological studies is contained in the following sections.

II. Predisposing factors

A. Vulnerability

Vulnerability is a function of predisposing factors, which include the following:

1. Genetics

a. In the diasthesis-stress theory it is assumed that certain genes or combinations of genes give rise to a predisposition (diasthesis) to a particular disorder, which will then be manifested as a result of certain kinds of environmental stress. There is some evidence to support this theory:

(1) The incidence of schizophrenic disorders is much higher in the offspring of schizophrenics than in the general population. The onset of the illness might be related to a particular stress during the person's development.

(2) The incidence of bi-polar disorder (previously called manic-depressive disease) is higher among the offspring of bi-polar depressive parents than in the general population.

(3) Many kinds of dementia (organic loss of intellectual function) seem to be hereditary. Two are noted below.

(a) Huntington's chorea (a degenerative disease of the basal ganglia and cerebral cortex).

(b) Porphyria (an episodic metabolic disorder characterized by the excretion of porphyrins in the urine and accompanied by attacks of abdominal pain, peripheral neuropathy, and a variety of mental symptoms).

b. However, it should be kept in mind that pathological emotional states may be transmitted by parents to their offspring by the parents' pathological behavior rather than through the germ plasm. Such illnesses are familial rather than hereditary.

2. Age

a. Certain periods of life are considered periods of special stress, not only because of the physical changes that occur but also

because of specific psychological stresses that are encountered during such periods.

b. Adolescence, middle life (sometimes called the involutional period), and the senium (the geriatric age, the period of old age) are many times thought of as periods of special stress.

B. Gender

1. More women than men with emotional problems consult physicians.
2. Affective disorders are more common among women.
3. Alcoholism is much more frequent among men.
4. More attempts at suicide are made by women in the United States, but more men are successful.
5. It is difficult to separate factors that are role related from those that are constitutional or dimorphic.

III. Precipitating factors

A. Environment

Environment includes the emotional as well as the physical milieu. Among environmental factors are the following:

1. Various family interactions (engagement, marriage, discord, separation, death, becoming a parent, conflict with a child, illness in a child).
2. Other interpersonal relationships (difficulties with friends, neighbors, or associates).
3. Living circumstances (change in residence, immigration).
4. Financial affairs (inadequate finances, financial reverses).
5. Legal affairs (being arrested, suing, being sued).
6. Occupation
   a. Stress related to the job (e.g., conflict with a supervisor, competition for promotion, but *not* overwork, which is usually a symptom rather than a cause of an emotional problem).
   b. Special occupational hazards (e.g., environmental hazards, such as asbestos, coal dust).
   c. Women's occupations in which they have to contend with sexist attitudes, including less pay, difficulty in moving into certain roles, and expected stereotypic feminine behavior in certain positions.
7. Poverty

B. Physical illness

Physical illness may pose both practical and emotional problems. Among these are the following:

1. Personal (pain, discomfort, enforced idleness).
2. Financial (cost of treatment, inability to make a living).
3. Emotional (reactivation of repressed conflicts, especially those related to feelings of dependency).
4. Body image (mutilative surgery, e.g., breast amputation, may cause certain disturbances of body image).

5. Endocrinal (e.g., hyperthyroidism may lead to tension and anxiety; hypothyroidism may lead to apathy and lethargy).

C. Physical handicaps

Physical handicaps may or may not give rise to emotional disturbances.

1. They may serve as a focus of inferiority feelings and result in such undesirable defenses as overcompensation (see chapter, "Adaptations to Anxiety").
2. However, many persons with physical handicaps do not manifest any significant emotional problems.

D. Exogenous factors

Exogenous factors include drugs, chemicals, infections, and trauma.

1. Drugs and chemicals (alcohol, sedatives, narcotics, and industrial toxins, for example) cause organic mental disorder, or organic brain syndrome, or otherwise affect the individual's adaptive response (see chapter, "Organic Mental Disorders").
2. Certain infectious diseases may lead to delirium. Syphilis may produce changes in the central nervous system with or without mental disease.
3. Trauma may lead to reversible or irreversible changes, with accompanying personality disorders, or to post-traumatic disorders.

E. Deprivations and deficiencies

1. Starvation, for example, may lead to personality changes (meanness, suspiciousness, withdrawal).
2. Sensory deprivation, of sight, for example, may lead to delirium with hallucinations (following cataract extraction when the eyes are kept covered postoperatively or the hallucinations described by lone explorers or sailors).
3. Deprivation of sleep may lead to mental and personality changes (inability to concentrate, restlessness, apathy).

IV. Stages in development

A. Although development is a continuum, it is often divided into stages for convenience of description and discussion.

B. The developmental stages can serve as a background against which to consider any developmental sources of stresses and tasks whose resolution may contribute to vulnerability.

C. Stages of cognitive development (according to Jean Piaget (1896–)

1. Sensorimotor stage, from birth to 18 months (preverbal).
2. Preoperational stage, 18 months to 7 or 8 years, with the beginnings of organized language.
3. Stage of concrete operations, 7 to 8 years through 11 to 12 years.
4. Formal operation stage, from 11 to 12 years to adulthood (capacity for abstract throught develops).

D. Arnold Gesell has outlined developmental milestones in the normally developing child from 2 weeks to 6 years.
   1. An infant smiles at 1 to 2 weeks.
   2. An infant follows an object with his or her eyes at 2 to 4 weeks.
   3. The infant smiles meaningfully at a person (social smiling) at 4 to 8 weeks.
   4. The infant vocalizes at 16 to 18 weeks.
   5. The infant sits by 6 to 8 months.
   6. The infant stands by 9 to 12 months, and by 12 to 15 months walks and talks.

E. Following is an outline of Erik Erikson's psychosocial stages of life as elaborated by Lawrence R. Allman and Dennis T. Jaffee.*

Life State	Approximate Age Period	Developmental Tasks
Infancy	0 – 2	Social attachment; object permanence; sensorimotor intelligence; maturation of motor functions
Toddlerhood	2 – 4	Self-control; language development; fantasy and play
Early childhood	5 – 7	Sex role identification; early moral development; group play
Middle childhood	8 – 12	Social cooperation; self-evaluation; skill learning; team play
Early adolescence	13 – 17	Peer group membership; heterosexual relationships
Later adolescence	18 – 22	Autonomy from parents; sex role identity; career choice values
Early adulthood	23 – 30	Marriage, childbearing, work, life style
Middle adulthood	31 – 40	Management of household and career; child raising
Middle life	40 – 55	Coming to terms with achievements; career revision; consolidation of identity.
Aging	55 +	Redirection of energy to diminishing role; perspective of death; acceptance of own life

*Abridged and adapted from table 2.1 "Expanded outline of Erik Erikson's psychosocial stages of life" (p. 32) in *Abnormal Psychology in the Life Cycle* by Lawrence R. Allman and Dennis T. Jaffe. General Editor Phillip Whitten. Copyright © 1978 by Lawrence R. Allman and Dennis T. Jaffe and Phillip Whitten. By permission of Harper & Row, Publishers, Inc.

F. Adult development
   1. Influenced particularly by the ideas of Erikson, considerable attention has been paid in the past decade to stages of adult development (for a popular account, see *Passages* by Gail Sheehy).
   2. Accounts of adult development generally agree on the following issues:
      a. Adulthood is not static but in a state of change toward greater self-definition and organization of functions in a pattern of life.
      b. Adult development is continuous with childhood development.
      c. Adult development displays the interaction of individual needs and the requirements and opportunities of a natural and social environment.
      d. Adults must come to terms with the limitations of their span of life and their individual mortality.
   3. An example of current approaches to the study of adult development can be found in the work of Daniel Levinson and associates. (It should be noted that this approach is based on a study of men.)
      a. The life cycle consists of a series of roughly 20-year eras: preadulthood (0–20), early adulthood (20–40), middle adulthood (40–60), late adulthood (60–80), and late, late adulthood (80+).
      b. Each era includes transition stages and periods of relative stability which display the development of, and commitment to, a *life structure,* a patterning of key choices, goals, and values.
      c. Transition stages, which occur at the beginning of each adult era and at the beginning of the middle decade as well (around 30 and 50), are times for assessment and modification of life structures.
      d. The transition periods of evaluation may also be for some persons, periods of crisis (e.g., the "mid-life crisis" in the early 40s).

G. For additional developmental perspectives see the chapter, "Psychodynamic Concepts."

V. Etiology of mental disorders

A. The etiology of emotional disorders should be regarded as a complex and complicated interaction of genetic, psychosocial, and physical factors.
   1. Some of these factors are probably inborn, some develop so early that they become an integral part of the "basic" personality structure, and others come into play later on.
   2. These statements can be represented schematically, but first let us define our terms again.