CASE STUDIES IN

Abnormal Behavior



ourth Edition

Robert G. Meyer

FOURTH EDITION

CASE STUDIES IN ABNORMAL BEHAVIOR

Robert G. Meyer University of Louisville

Allyn and Bacon

Boston London Toronto Sydney Tokyo Singapore

Series editorial assistant: Jessica Barnard Manufacturing buyer: Suzanne Lareau



Copyright © 1999, 1996, 1987, 1983 by Allyn & Bacon A Viacom Company Needham Heights, Massachusetts 02194

Internet: www.abacon.com

All rights reserved. No part of the material protected by this copyright notice may be reproduced or utilized in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without written permission from the copyright owner.

Library of Congress Cataloging-in-Publication Data

Meyer, Robert G.

Case studies in abnormal behavior / Robert G. Meyer. — 4th ed.

p. cm.

Includes bibliographical references and index.

ISBN 0-205-28624-0

1. Mental illness—Case studies.

RC465.M44 1998

616.89'09—dc21

95-4459

CIP

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.

Some of the cases are people who are well known for one reason or another, like Princess Diana, or who have played an important role in the evolution of the field of psychology, like Anna O. A number of these and other cases presented here are based on actual, recent cases, although in those cases 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 in the experience of the author or were donated by colleagues. I have also included a couple of cases published in journals, which either make an original point or demonstrate a particular point of view, as in the cases of Hans, Albert, and Peter in Chapter 3.

Readers will note that cases that are provided by the author and that are not public cases or reprints from journals are assigned names with a logical or mnemonic relationship to the syndrome being studied; for example, Agnes—Agoraphobia. While this may seem corny, I have found it to be a helpful technique for most readers. Students have said this device adds clarity to classroom discussion and enhances the remembrance of the cases if needed during a test.

The reader may 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 some cases were 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 (I hope) 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.

Relevant and detailed family and social history data are presented in almost all of these case studies, to give the reader a clearer idea 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, or if it seems highly probable that genetic factors dominated the development of the disorder, as in the case of Virginia Woolf (Chapter 7). In cases such as Harry's, I present more detailed information on present behavior and the responses in psychological evaluations.

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.

The author wishes to thank those who helped with this book. Much appreciation is extended to Sean Wakely, my Allyn and Bacon editor, for his support and advice. I would also like to acknowledge the very helpful input from Susan Leavenworth in writing some of these cases, and also input from Lisa Thomas in the cases of Betty Ford and Elvis Presley, as well as the extensive help in organizing and typing this book provided primarily by Georgette Moore and Sandy Garcia.

R.G.M.

INTRODUCTION AND HISTORY

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 this century the Freudian psychoanalytic model, already developing a more broad-spectrum psychodynamic orientation (Schwartz et al., 1995; Kohut, 1977), clearly dominated 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. While behaviorism-more specifically, behavior therapy—was coming into bloom in the 1950s and 1960s (Wolpe, 1958; Ayllon and Azrin, 1968) and then merging with the cognitive therapies in the 1980s and 1990s, a third force also was emerging, marked by diverse theories, many new psychotherapies (Garfield, 1981), 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 (Wachtel, 1997; Schwartz et al., 1995; Silverman and Weinberger, 1985). Behavior therapy meanwhile was becoming (1) less wedded to theory (Lazarus, 1971), (2) was also expanding its concern back to at least some aspects of the mind under the influence of the cognitive behavior modifiers (Meichenbaum, 1977; Beck et al., 1990), (3) was developing into a broader perspective on environmental variables under the social learning theorists (Bandura and Walters, 1963; Mischel, 1969), (4) was forced by the pressure of managed care and national health insurance issues into an emphasis on shorter-term and more focused therapies, and (5) helped facilitate the overall trend in the mental health field toward a greater emphasis on the experimental verification of assessment and intervention techniques (Meyer and 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-age 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?" 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 Rogers 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; it is dramatically emphasized in the case of Roger, discussed in the upcoming section on theories and techniques.

The eclecticism inherent in the ideas stated here is another assumption in this book. Optimally, this allows a broad-based acceptance of many causal 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 these comments in perspective and to provide a historical framework for the book, a synopsis of important historical developments related to mental disorder is offered next.

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

1. Western Society

Early Greeks: Hippocrates (460–377 BC) provides a focus on the brain as the site of disorder and emphasizes life stressors.

Romans: Galen (second century AD) conceptualizes the hospital as a treatment center and posits the first thorough classification of disorders.

Age of Crusades: Physicians obtain higher-status social class and greater intellectual influence; Greek and Roman texts are rediscovered; and 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): There is a beginning rejection of witchcraft; naturalistic explanations of emotional disorder attain wider acceptance; and in the late fifteenth and early sixteenth centuries former leprosariums are converted into the first asylums or "madhouses."

Enlightenment (1700–1800): More humane care becomes prevalent, as well as 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.

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 Kraeplin'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. His techniques were popularized in the 1930s by Dr. Egas Moniz, a Portuguese psychiatrist.

1893: Sigmund Freud, with Josef Breuer, publishes the first chapters of *Studien uber hysterie*. Hypnosis is used to produce spontaneous verbalizations, which 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 true IQ scale, the Binet-Simon Scale, is published.

1921: The first description of the Rorschach Test is published. Hermann Rorschach, a Swiss psychiatrist, had noticed while riding in the country that what his children saw in the clouds reflected their personalities.

2. United States

Early colonial period: There is a regression to witchcraft and demonology.

1693: This was the peak of the witch-hunting trials in Salem, Massachusetts.

1773: The first hospital specifically for mental patients is opened 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 schoolteacher in a prison. The conditions she encounters prompt her to become the major reformer of the mental health movement in the nineteenth century.

Approximately 1850: The hospital reform movement begins to generate more humane treatment.

Late 1800s: The medical model increases its influence.

1892: The first meeting of the American Psychological Association (APA) is held. The APA incorporates in 1925 (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 earn him the title "Father of Forensic Psychology" in the United States. Although controversial and self-promoting, he makes some worthwhile contributions in the areas of experimental and forensic psychology, including his 1908 book *On the Witness Stand*.

1896: Lightner Witmer establishes the first psychological clinic in the United States at the University of Pennsylvania.

Ca. 1900: Morton Prince pioneers the use of hypnosis in reintegrating (i.e., "fusing") a multiple personality in his case of "Miss Beauchamp."

Early 1900s: The Freudian model increases its influence, 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." Watson argues that psychology should abandon the study of consciousness, laying the groundwork for the behavior therapists and for later theorists like B. F. Skinner.

Early to mid 1900s: The 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 into trial testimony. (This will remain the standard until 1993, when the Supreme Court, in *Daubert* v. *Merrill Dow Pharmaceuticals*, allows a much less stringent "helpfulness" standard in federal trials.)

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

1939: The Wechsler-Bellevue Intelligence Scale is published, the predecessor of the various Wechsler measures of intelligence, the most popular forms of the IQ test.

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

1952: The first edition of the *Diagnostic and Statistical Manual of Mental Disorders* is published by the American Psychiatric Association.

1950s and 1960s: The humanistic and cognitive models increase influence; and the advent of a new class of psychotropic drugs, the phenothiazines, for example, chlorpromazine (Thorazine) for the first time allow chemical control of psychotic behavior.

Early 1960s: The 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.

1980s–2000: These decades give rise to the "corporatization" of mental health care delivery and the advent of "managed care." Those who pay for services (or their administrators—e.g., health maintenance organizations [HMOs] and preferred provider organizations [PPOs]) capture the system from those who deliver the services. There is movement toward universal health care, with 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, that of O. J. Simpson, 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 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 by describing a multi-modal treatment approach, wherein techniques from a variety of theoretical perspectives are blended together to treat a case of exhibitionism.

The third chapter, (the first to focus on a specific syndrome) is concerned with the 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 the obsessive-compulsive disorder. This chapter closes with a relatively recent but often used addition to the *DSM*, posttraumatic stress disorder, which is considered as an anxiety disorder.

Chapter 4 presents both the dissociative disorders and sleep disorders, as the altered state of consciousness in each provides some interesting contrasts. The 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. The sleep disorders are represented first by a sleepwalking case and then one that combines a disturbance of the sleepwake cycle with insomnia. Chapter 5 looks at the somatization disorder (in the case of Empress Alexandra Fedorovna) and the psychogenic pain disorder, commonly observed subtypes of the somatoform disorders.

Chapter 6 is concerned with severely disruptive syndromes: the 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 the 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 functioning has deteriorated. These two forms are then compared with the nonpsychotic paranoid personality disorder pattern. The other category of very severe disorders, the affective disorders, is 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); again, both of these are often psychotic-level disorders.

In combination with the case of exhibitionism from Chapter 2, the spectrum of the psychosexual disorders is seen in Chapter 8. In addition to a classic paraphiliac (the case of Jeffrey Dahmer) and a pedophile (Jesse Timmendequas), cases of both male and female sexual dysfunction are noted, as well as a case of transvestism. Then Chapter 9 (Addictive Disorders) discusses three of the most common disorder patterns in our 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 the 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 the paranoid personality disorder in Chapter 6. Somewhat related issues are then found in Chapter 12 in the disorders of impulse control, seen in cases of pathological gambling, and kleptomania. Violence patterns are found in several cases throughout this book, for example, 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 in two cases of family violence. In Chapter 14, cases of developmental language disorder, attention-deficit disorder with hyperactivity, and early infantile autism illustrate 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 for identity and independence that are often a concern in middle childhood and adolescence. The last case focuses directly on the identity crises and identity disorder.

Chapter 15 offers two 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 focuses on Alzheimer's disease, illustrated by the plight of former president Ronald Reagan.

Chapter 16 is concerned with the interaction of psychological disorder and legal issues. Providing a transition from the prior chapter, the first case discusses the evaluation of an elderly woman's legal competence to handle her affairs. The second 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. Chapter 17 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.

CONTENTS

	Preface Introduction and History	ix xi
1.	Concepts of Abnormality	1
	The DSMs	
	Rates of Mental Disorders	2
	A Presumably Normal Person Potentially Viewed as	5
	Pathological: O. J. Simpson	4
2.	Theories and Techniques	14
	Multiple Theoretical Views on Moderate Anxiety, Depression,	
	and Simple Phobias: Danielle	14
	The Various Mental Health Professionals	25
	A Multi-Modal Treatment Program	28
3.	The Anxiety Disorders	34
	A Study on Anxiety	35
	Agoraphobia: Agnes	39
	Obsessive-Compulsive Disorder: Bess	45
	Posttraumatic Stress Disorder: Ryan the "Postman"	53
4.	Dissociative and Sleep Disorders	61
	Multiple Personality Disorder: "Anna O"	62
	Sleep Disorders: Ilse	68
5.	The Somatoform Disorders	75
	Somatoform Disorder Subcategories	75
	ATTACH THE PROPERTY AND ADDRESS AND ADDRES	

	Somatization Disorder: "Alix"—Empress Alexandra Fedorovna Psychogenic Pain Disorder: Pam	78 82
6.	The Schizophrenic and Delusional (or Paranoid) Disorders Undifferentiated Schizophrenia: Sally Paranoid Schizophrenia: Daniel Paul Schreber Paranoid Personality Disorder: Lloyd	88 90 98 103
7.	The Affective (or Mood) Disorders and Suicide Major Depressive Disorder Associated with a Suicide Attempt: Joseph Westbecker	107
	Seasonal Affective Disorder Bipolar Disorder (Manic-Depressive Psychosis): Virginia Woolf	115 120
8.	The Psychosexual Disorders	128
	Paraphilias: Jeffrey Dahmer Pedophilia: Jesse Timmendequas (and Megan's Law) Transvestism: Randy	128 136 140
	Sexual Dysfunction (Impotence): <i>Tim</i> Female Psychosexual Dysfunction: <i>Virginia</i>	144 150
9.	The Substance Use Disorders	156
	Alcohol Dependence and Abuse: Betty Ford	158
	Prescription Drug Abuse: Elvis Presley	168 168
	Polysubstance Dependence Nicotine Dependence: <i>Dr. S.</i>	172
10.	The Eating Disorders	176
	Anorexia Nervosa: Karen Carpenter Bulimia Nervosa: Princess Diana	176 183
11.	The Personality Disorders	191
	Personality Types and Their Potential Disorders	192
	Histrionic Personality Disorder: Hilde	193
	Antisocial Personality Disorder: Theodore Bundy	199
	The Schizoid Personality Disorder: Theodore Kaczynski	208
12.	Disorders of Impulse Control	216
	Pathological Gambling: Greg	217
	Kleptomania: Clare	221
13.	Disorders with Violence	227
	Causes of Violence: <i>Jack Ruby</i> Family Violence—Physical and Sexual Abuse of	227
	Children and Spouses: Charles and Abby	224

14.	Disorders of Childhood and Adolescence	243
	Developmental Language Disorder: Delano	244
	Attention-Deficit Hyperactivity Disorder: Matt	248
	Autistic Disorder: Audrey	253
	Separation Anxiety Associated with School Refusal: Julie	257
	Oppositional Defiant Disorder: Phyllis	263
	Identity Development Crisis or Disorder: Mr. E.	268
15.	Organic Mental Disorders and Mental Retardation	271
	Recovery of Functions Following Removal of Dominant	
	Brain Hemisphere: Harry	271
	Alzheimer's Disease: Ronald Reagan	275
	Mental Retardation	280
16.	Legal Issues and Psychological Practice	282
	Central Nervous System Dysfunction and Legal Incompetence	
	from Aging and/or Alcohol: Ingrid	282
	Criminal Responsibility, Competency to Stand Trial,	
	and Dangerousness: John Hinckley	289
17.	Postscript: Positive Mental Health	297
	References	301
	Index	309
	HUCX	

/ 1

Concepts of Abnormality

Adultery: Consensual non-monogamy.

Corrupt: Morally challenged. Looters: Nontraditional shoppers.

Drug addicts/alcoholics: People of stupor.

Sadomasochists: The differently pleasured.

—A few entries from The Official Politically

Correct Dictionary and Handbook,
by Henry Beard and Christopher Cerf

The first case in this book, that of O. J. Simpson, dramatically highlights some of the problems inherent merely in defining abnormal behavior. A traditional method of defining abnormal behavior has been to use statistical norms. However, this only establishes extremes and does not per se discriminate between positive and negative patterns or characteristics. Also, some widespread patterns, for example, drunk driving, anxiety, may be labeled as normal because of their commonness.

Defining abnormality as the absence of optimal or ideal characteristics is another possibility. The problem is then simply shifted, what is "optimal," and who decides? Also, most normal individuals are not that close to "ideal."

In any case, most people will generally agree that abnormal behavior is behavior that significantly differs from some consensually agreed upon norm and which is in some way harmful to the differently behaving person or to others. More specifically, components of a judgment of abnormality often include the following descriptors: deviant Deviant refers to behavior that differs markedly from

socially accepted standards of conduct. In many cases the

word has negative connotations.

different Different also suggests behavior that varies significantly, at

least statistically, from the accepted norm, but it does not

usually have negative connotations.

disordered Disordered implies a lack of integration in behaviors; the

result may be impairment of a person's ability to cope in

various situations.

bizarre Bizarre suggests behavior that differs extremely from

socially accepted norms. In addition, it connotes inadequate coping patterns and disintegration of behavioral patterns.

If we like a man's dream, we call him a reformer; if we don't like his dream, we call him a crank.

-William Dean Howells, Writer (1837-1920)

The DSM's

The general framework for this book is in the diagnostic terminology of DSM-IV (American Psychiatric Association, 1994). Even though there are valid criticisms of the DSM approach, the manual is the official document of the American Psychiatric Association, is approved by the American Psychological Association, and is well respected by all varieties of mental health workers, both nationally and internationally. The first DSM was published in 1952, DSM-II in 1968, DSM-III in 1980, and DSM-III-Revised in 1987. There were numerous changes from DSM-III-R to DSM-IV, published in 1994. Indeed, the simple listing of changes took up twenty-eight pages in the DSM-IV book. Concisely, some of the more important changes are as follows: only the Personality Disorders and Mental Retardation remain on Axis II; Rett's Disorder, Childhood Disintegrative Disorder, and Asperger's Disorder have been added as Childhood Disorders; there is no separate category of Attention Deficit Disorder, it is subsumed under ADHD; there is now a separate overall category of Eating Disorders; there are now two separate Bipolar Disorders, with Bipolar Disorder II referring to the traditional, severe form, where both recurrent manic and depressive patterns are observed; the phrase "outside the range of normal human experience" has been deleted as a criteria for PTSD, and the related category of Acute Stress Disorder has been added; the term Multiple Personality Disorder has been changed to Dissociative Identity Disorder; Passive-Aggressive Personality Disorder has been deleted as an Axis II Personality Disorder but has been retained in revised form as a "Criteria Set... for further study"; two new patterns in "other conditions that may be a focus of clinical attention" are "Religious or Spiritual Problem" and "Acculturation Problem."