CASE STUDIES IN ABNORMAL BEHAVIOR

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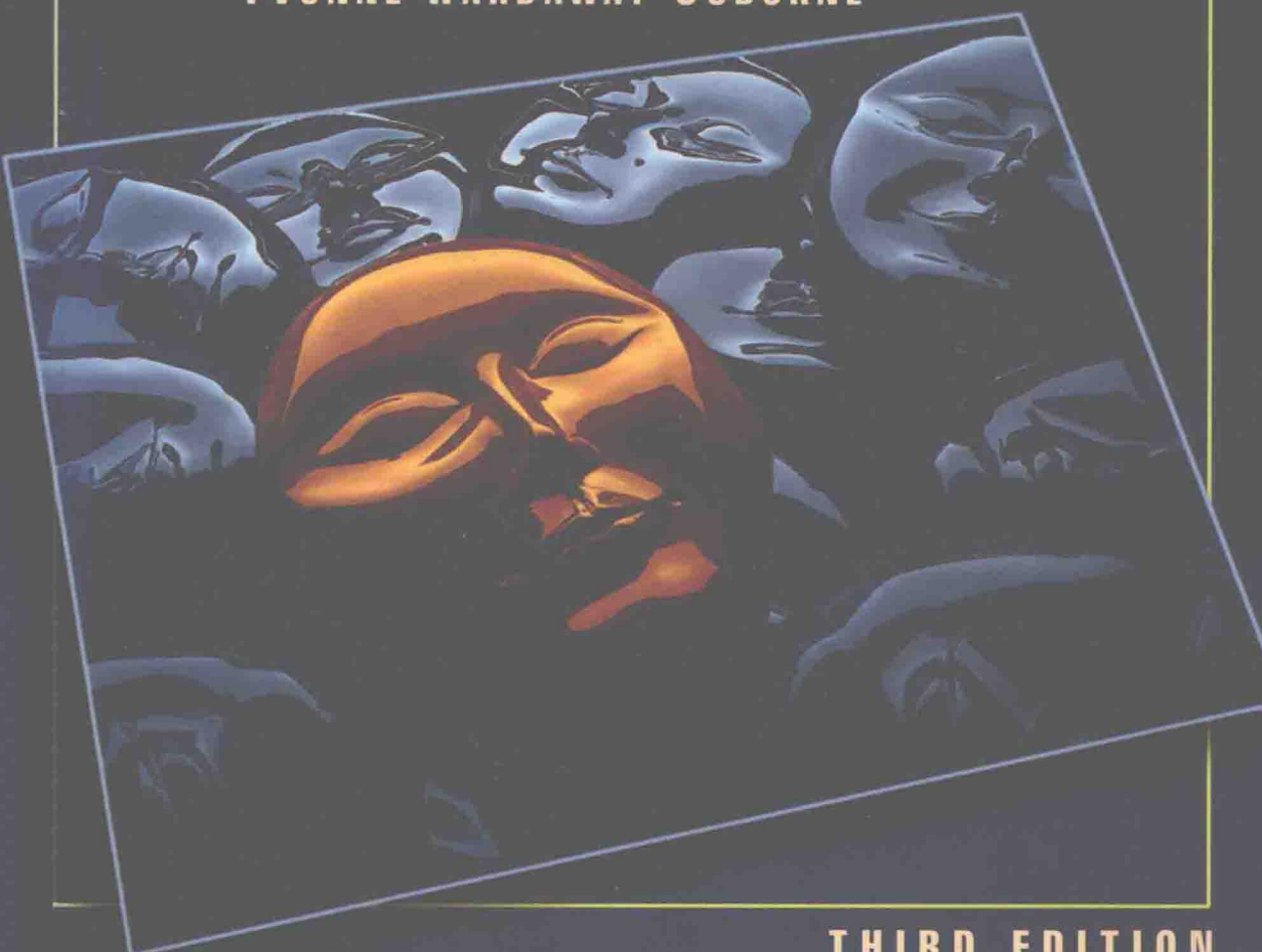

THIRD EDITION

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

PREFACE

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

The cases presented in *Case Studies in Abnormal Behavior* are based on actual, typical 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 originate in the experience of the author; a few were donated by other clinicians who have substantial experience or special expertise with a particular disorder. For example, Dr. Paul Salmon, a psychologist at the University of Louisville who also works with children, was kind enough to provide a couple of the organic mental disorder and childhood disorder cases. I have also included a couple of cases published in journals. These cases either make an original point or demonstrate a particular point of view, as in the case of Anna O. in Chapter 4.

Readers will note that cases that are provided by the author and that are not reprints from journals are assigned names with a logical or mnemonic (i.e., sounds like) relationship to the syndrome being studied; for example, Agnes—Agoraphobia, and Al—Alzheimer's disease. While this may at times sound a bit 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, since such data give the reader clearer ideas about how specific behavior patterns were generated and maintained. A few of the case studies have little background data, such as in the case of Harry, in 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. In cases such as Harry's, I present more detailed information regarding 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 Mylan Jaixen, 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 by Sandy Garcia, Donna Smith, Georgetta Moore, and Suzanne Paris.

R.G.M.

INTRODUCTION

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, Bleiberg, and Weissman, 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 and more specifically, behavior therapy were coming into bloom in the 1950s and '60s (Wolpe, 1958; Ayllon and Azrin, 1968) and then merging with the cognitive therapies in the '80s and '90s, 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 (Schwartz et al., 1995; Silverman and Weinberger, 1985). Behavior therapy, meanwhile, (1) was becoming 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, Freeman, and Associates, 1990), (3) was developing into a broader perspective on environmental variables under the social learning theorists (Bandura and Walters, 1963; Mischel, 1969), and in general (4) 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 inter-

esting that the "sphere of relevance" of an approach is most closely centered on the original group that was studied or treated when the approach came into being.

Freud's specific theories became less relevant as society lost some of the repressions of the Victorian era (possibly only to take on repressions in other dimensions). Carl Jung's treatment techniques, which focus on uncovering "spiritual" yearnings and on creating a sense of meaning, arose primarily in the therapy of middle-aged males who had "made it big" financially and in their careers but who lived the feelings expressed in 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 multi-modal 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 Chapter 2 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 in general, 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 offers 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."

1865: Gregor Mendel publishes his influential theories of genetics.

Enlightenment (1700–1800): More humane care becomes more 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.

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 was 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, published 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, was published.

1921: The first description of the Rorschach Test was published. Hermann Rorschach, a Swiss psychiatrist, had noticed while riding in the countryside 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 was opened in Wlliamsburg, Virginia.

Late 1700s: "Moral therapy" becomes popular.

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

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

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).

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

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

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

1913: John Watson, sometimes referred to as the "father of behaviorism," 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.

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 is 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. (DSM-IV, the fourth edition, is published in 1994.)

1950s and 1960s: The humanistic and cognitive models increase influence; and the advent of a new class of psychotropic drugs, the phenothiazines, e.g., chlorpromazine (Thorazine) for the first time allows 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–1990s: This decade saw 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.

DSM-IV

The general framework for this book is in the diagnostic terminology of the DSM-IV (American Psychiatric Association, 1994). Even though there are valid criticisms of the DSM, it 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 (American Psychiatric Association). Indeed, the simple listing of changes took up twenty-eight pages in the DSM-IV book. A concise list of 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."

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, clearly highlights the social, legal, and political issues inherent in defining abnormality and subsequently applying that label to an individual. The second chapter, on theories and techniques, first presents the case of Danielle, who manifests a most common problem, a persistent though not constant moderate level of anxiety, several simple phobias, and some allied mild depression. After Danielle's case is detailed, there is an analysis of the etiology and treatment that could be expected from the six major overall theoretical viewpoints: psychoanalytic-psychodynamic, behavioral, cognitive, information processing and systems theory, humanistic-existential, and biological. The chapter closes 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, post-traumatic stress disorder, which is considered as an anxiety disorder.

Chapter 4 presents both the dissociative disorders and sleep disorders, since 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 sleep–wake cycle with insomnia. Chapter 5 looks at the psychogenic pain disorder, a commonly observed subtype 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 the functioning has especially deteriorated. These two forms are then compared with the nonpsychotic paranoid personality disorder pattern. The other category of very severe disorders, the affective disorders,

are detailed in Chapter 7 in cases of major depressive disorder (the case of Joseph Westbecker—a workplace violence case that was also the first major civil trial focusing on the drug Prozac) and bipolar disorder (the case of Virginia Woolf, a famous writer and a pioneer in the women's movement); 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), 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 (the case of Betty Ford), prescription drug abuse (the case of Elvis Presley), and nicotine dependence (the case of Dr. S.).

Complementing the discussion of a personality disorder pattern (paranoid) found in Chapter 6, 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 features two of the more important personality disorders: the histrionic and antisocial patterns. This latter diagnosis is discussed in the case of Theodore Bundy. This complements the discussion of the paranoid personality disorder in Chapter 6 and the borderline personality disorder in Chapter 12. Somewhat related issues are then found in the disorders of impulse control, seen in cases of a borderline personality disorder associated with rape, pathological gambling, and kleptomania. Violence patterns are found in several cases throughout this book, for example, in the cases of O.J. Simpson (Chapter 1), Jeffrey Dahmer (Chapter 8), Bret (Chapter 12), 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 the 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 of identity and independence that are often a concern in middle childhood and adolescence.

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

Chapter 16 is concerned with the interaction of psychological disorder and legal issues. Providing a transition from the prior chapter, the first case discusses legal incompetence as a result of brain dysfunction from aging and alcohol. In the second case, the case of The Wound That Never Heals, the focus is on the important issue of how to discriminate true disorder from malingering and from the unique and related factitious disorder. The last case, that of John Hinckley, who attempted to assassinate President Reagan, examines the legal concepts of insan-

ity, incompetence (to stand trial), and involuntary civil commitment as it relates to predicting dangerousness. The last chapter focuses on the development of positive mental health.

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

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