Understanding Mental Illness

TYPES OF PSYCHIATRIC ILLNESS

Nancy C. Andreasen M.D., Ph.D.

Types of Psychiatric Illness

Nancy G Andreasen

e-Book 2015 International Psychotherapy Institute

From *Understanding Mental Illness* by Nancy G Andreasen

Table of Contents

Types of Psychiatric Illness

O the mind, mind has mountains;

cliffs of fall

Frightful, sheer,

no-man-fathomed.

Hold them cheap

May who ne'er hung there.

POEMS, GERARD MANLEY HOPKINS

Information about the types of psychiatric illness has been kept in a closet, hidden away like a frightening skeleton, for too long. Intelligent people who are familiar with the symptoms of diabetes mellitus or multiple sclerosis usually do not have an equal understanding of psychiatric disorders such as schizophrenia or even anxiety neurosis. In part, this is due to the nature of the history of psychiatry, a relatively young field in medicine. When Freud was a medical student or an apprentice neurologist-psychiatrist, the various psychiatric illnesses had not been well differentiated from one another. Our diagnoses still lack some precision today, but, nevertheless, a number of discrete illnesses have been delineated, and the layman, particularly someone who must deal with mental illness in

a family member, will usually benefit from knowing psychiatric terminology.

Doctors are sometimes hesitant to give out information concerning a diagnosis to patients or family members. If the doctor is asked directly and avoids giving a specific answer, you are certainly entitled to inquire further as to why he is hesitant. But if he persists in hesitating, he has probably made a decision that it would be contrary to the patient's welfare for him or his family member to know the diagnosis. Even if he will not give a specific diagnosis, he will probably be willing to talk openly concerning course and outcome of the illness involved. In some cases, too, doctors are hesitant to give a specific diagnosis because they are not certain as to which diagnosis is appropriate and they feel it would worry the patient or his family unduly. Neurologists who suspect multiple sclerosis are also usually hesitant to make a definite diagnosis before they are certain, as are surgeons who suspect cancer, or pediatricians who suspect mental retardation. If you have a fearful fantasy that you or a relative may have a specific illness, do bring it up and discuss it with your doctor, for usually people suspect that the illness they have is much worse than it actually is.

This chapter is designed as a brief introduction to psychiatric

terminology. In the following pages, the major psychiatric illnesses that afflict humanity are described briefly. In general, the descriptions tend to follow the diagnostic terminology agreed on by the American Psychiatric Association, the professional group to which most American psychiatrists belong.

Schizophrenia

Schizophrenia is the most serious and crippling of all psychiatric illnesses. Some individuals with schizophrenia are fortunate and experience episodes of being ill which last for several months and then go into partial remission, usually with the help of medications. Some have a single episode which clears completely without leaving any deficit. Current thinking in psychiatry, however, is tending to suggest that illnesses which remit fully may not be true schizophrenia, although this is a matter of some debate. Most people who suffer from schizophrenia have a chronic illness and show at least some of its symptoms throughout most of their lives. Unfortunately, in spite of its seriousness, schizophrenia is not uncommon. One in a hundred individuals suffers from schizophrenia, and its distribution appears to be the same worldwide.

The word "schizophrenia" is of Greek origin and literally

translates "split mind." Popularly, this has been taken to refer to a "split personality." The movie "The Three Faces of Eve" is believed by many people to represent what schizophrenia is like. Most schizophrenics in fact do not have split personalities at all. The Dr. Jekyll and Mr. Hyde personality change is not in any sense characteristic of schizophrenia. The name was coined in the 19th century by a Swiss psychiatrist named Bleuler, a contemporary of Sigmund Freud, who together with Freud is one of the founding fathers of modern psychiatry, although he has received much less recognition than his Austrian colleague by the general public. Bleuler coined the term in an attempt to describe the schizophrenic's characteristic "splitting of the fabric of his thoughts," to quote Bleuler himself. A typical schizophrenic usually displays a remarkable lack of connection between his thoughts and feelings.

Schizophrenia usually begins in a young person, typically during late adolescence, but it may also occur without prior symptoms in middle-aged adults. Its onset may be acute and sudden or slow and chronic. Individuals who follow a chronic course usually have a basically shy personality and are described as having been loners with few friends during childhood and particularly during their teenage years. These patients are usually described by relatives as becoming steadily more withdrawn, slowly losing interest in things they used to

enjoy, and cutting down their already limited social contact to none at all. Sometimes such patients are brought in to see a psychiatrist because relatives have noticed that they do practically nothing but sit in their rooms and stare at the walls all day long, perhaps occasionally muttering to themselves. They may also become uninterested in personal hygiene and careless about their personal appearance.

Patients who have an acute onset more typically have outgoing personalities before the beginning of their illness. Like the patients with a more chronic course, they may become withdrawn, but they may also be quite anxious and agitated with strange or bizarre behavior. One young man who developed acute schizophrenia was a B student in college with a number of friends when he suddenly became ill. He began to believe that people were intentionally tormenting him, became very anxious and hostile, and indulged in magical rituals to protect himself, such as painting his shoes different colors and wearing three layers of clothing. He improved markedly after about one month of treatment.

The typical symptoms of schizophrenia may be divided into those which characterize the patient's emotional life, his thinking, and his social adjustment. The emotional symptoms are especially striking. Often the schizophrenic's emotional responses are quite

inappropriate. For example, he may giggle in a foolish manner when talking about the death of a loved one. Psychiatrists call this "inappropriate affect" (affect being synonymous with emotion) and consider it a distinctive characteristic of schizophrenia. Alternately the emotions may simply be dulled rather than inappropriate. Psychiatrists call this "flattening of affect." A schizophrenic may show little or no emotion when talking about subjects which for most people would be emotion-laden. For example, he may speak calmly and matter-of-factly about the death of a loved one and exhibit no grief or sense of loss. Patients who exhibit this dulling of emotion seem to have lost the sparks of feeling that most of us have.

A second typical symptom of schizophrenia is disturbance of thinking. This, too, may take one of several forms. Sometimes schizophrenics have hallucinations. Typically the hallucinations take the form of voices, which may call them names or predict that something dreadful is going to happen. Other schizophrenics may have delusions, which are fixed false beliefs that they continue to hold persistently in the face of contradictory evidence. A schizophrenic may believe, for example, that someone is poisoning his food, controlling his body with electricity or radioactivity, or surreptitiously writing about him in newspapers. Sometimes the disturbance of thinking is not this clearly bizarre or flagrant. The schizophrenic's thought may

simply seem disjointed: he jumps from one idea to another while talking without apparent connection. Observers will simply note that sometimes he does not “make sense.” Sometimes schizophrenics exhibit a symptom known as "blocking.” They will talk quite fluently and then stop and stare blankly, as if they had somehow lost their train of thought. These symptoms represent the “splitting of the fabric of thought” that Bleuler thought most characteristic and used to give schizophrenia its name.

A third way schizophrenics exhibit symptoms is in their social behavior. They usually have few friends and little interest in making contacts with other people. Often they are quite fearful of other people, especially members of the opposite sex. They rarely date and usually do not marry if their symptoms begin during adolescence. They have difficulty holding jobs because of their loss of interest in most things and their inability to persist in a task. They tend to show poor judgment about practical matters. Directions tend to be taken quite concretely and literally. One young man lost a job with a lumberyard, for example, when he was told to deliver an order rapidly and transported an uncovered load of valuable lumber through a rain storm so that it arrived at its destination quickly but also totally ruined. A young woman, when asked by her therapist to write down a recipe for hamburgers, wrote: “Get out a frying pan. Put the frying pan

on the stove, turn on the stove. Get out the hamburger. Take off the wrapper ..." This simple list of tasks persisted at length because she did not seem to have enough judgment to distinguish between what was important and what was simply to be taken for granted.

Some schizophrenics also exhibit paranoia. Paranoid individuals tend to be suspicious, aloof, withdrawn, hostile, and to consider themselves superior to others. They usually have a well-developed delusional system. Typically they believe that there is some complex plot going on propagated by some important agency such as the Federal Government or the FBI, which has a goal of somehow injuring or destroying them. Paranoids tend to have better judgment than other schizophrenics. Often they learn to avoid talking about their delusions and may appear normal most of the time. Usually the paranoid is dependable and has a good work history, but simply seems a little unusual and a bit of a loner.

Affective Disorder

Affective disorder is a form of psychiatric illness in which symptoms are limited primarily to the patient's mood or emotional states. Mania and depression are the two major forms of affective disorder, and these sometimes occur in alternation in the type of

patient known as the manic-depressive. Patients who exhibit both mania and depression are called bipolar, while those who show depression only are unipolar.

Affective disorder is even more common than schizophrenia. Approximately two individuals out of a hundred have severe symptoms of affective disorder at some time in their lives. If milder depressions are also included, the prevalence may be as high as eight out of every hundred people. While it should be taken seriously, affective disorder is basically a less serious illness than schizophrenia. People who suffer from this illness may have many episodes of mania and depression throughout their lives or they may have only one attack. In either case, they are typically well between episodes and able to lead quite normal lives. Many famous and successful people have suffered from affective disorder, including Abraham Lincoln, Woodrow Wilson, and Samuel Johnson.

Everyone experiences mood swings from time to time. Duration and severity of symptoms distinguish a significant psychiatric illness from a simple downward mood swing. Symptoms of depression include loss of appetite, weight loss, loss of interest, chronic fatigue, decreased sex drive, diminished energy, difficulty falling asleep or early morning awakening, guilt feelings, feelings of worthlessness, and

hopelessness about the future. Psychiatrists usually consider an individual who describes himself as feeling blue or depressed and admits to four or five of these symptoms for more than three to four weeks as suffering from depression. These symptoms also occur in a person suffering grief from loss of a loved one, but in this situation they are considered to represent a "normal grief reaction" rather than depression. The suffering of a depressed person is usually intense and his misery is so severe that often he contemplates suicide. Suicidal thoughts or threats in a depressed person should never be taken lightly, for most suicides occur in individuals suffering from depression. If untreated, depressive symptoms may last from several months to as much as a year, but even if untreated the depression usually goes slowly away and the individual is able to return to normal functioning. Occasionally a depressed person may feel that he is being persecuted or hear accusatory voices, but ordinarily bizarre or unusual thinking is rare in depression, and the depressed person seems quite normal except for his extreme sadness.

Depression may occur at any age. Perhaps the most typical ages for depression are in the late twenties for women and the mid-forties for men. Sometimes childbirth precipitates depression in women. Sometimes the first depression occurs in the sixties. Depression which occurs in later years (called "involutional depression" by psychiatrists)

is the most difficult to treat. People suffering from involutional depression may be particularly agitated—pacing, wringing their hands, and complaining of strange and unusual pains in their body—or they may become extremely withdrawn and apathetic, refusing to eat or care for themselves in other simple ways.

At the opposite pole from depression is a condition known as mania. Some people who suffer from affective disorder experience depression only, while in others episodes of depression alternate with episodes of mania. Depression alone is quite common, but mania alone is very rare. In either case people who suffer from affective disorder have an episodic illness and are normal between episodes, although sometimes they may seem a bit more moody than the average individual.

A person in the midst of a manic attack has an exaggeration of many traits which are often considered desirable. An attack usually comes on suddenly. Uncle Bill, normally a competent, friendly, and easy-going man, will suddenly display enormous amounts of energy. He will stay up very late at night working on a project and waken refreshed at 5:00 A.M. after retiring at 1:00 A.M., getting by with little sleep without apparent fatigue. He may be too busy to have any interest in food, but he also may notice a sudden increase in appetite

and eat voraciously. In spite of his furious energy, which may be directed into either a constructive or a grandiose project, his sex drive is also heightened and he may wish to have intercourse once or twice a day instead of his usual once or twice a week. When he becomes manic, Uncle Bill will become unusually jolly and seem quite euphoric. He will talk more than usual, speak very rapidly, and jump from one idea to another. His jolliness will disappear quite quickly if his plans or desires are blocked, however, and he then may become irritable, hostile, and disagreeable.

Most of the traits just described seem relatively harmless, and indeed a typical manic feels that he is on top of the world. It can be very difficult to persuade Uncle Bill that he has a psychiatric illness. Unfortunately, however, a person in the midst of a manic attack tends to have very poor judgment. For example, one manic suffering from his first episode had been a successful real estate dealer and insurance salesman in a small mid-western city. When he became manic he decided to expand the business to Hawaii. He purchased a plane, hired four pilots to fly it, took all his employees with him to explore the area, wrote a series of bad checks and ended up deeply in debt. Early recognition of his symptoms of mania and prompt treatment might have averted this disaster. Although he had no insight at the time of his illness, when asked afterwards if he really needed four pilots, he

replied, “Heavens no, I didn't need any pilots. I didn’t even need a plane.” Other manics may become grandiose with religious delusions. One patient, for example, felt that he was in direct communication with God and he would carry on conversations with him intermittently while also talking with his psychiatrist. He was admitted to the hospital at his wife’s request because God had told him to take a plane to Miami, where he would meet Jackie Kennedy and be crowned the King of Nations while she would be his Queen of Nations.

Mania may seem normal in mild forms, and a person who is simply good natured and has large amounts of energy would not be considered manic. Poor judgment and impaired ability to function in normal life distinguish the manic from the energetic person without psychiatric illness. Mania should be considered a serious illness, but usually it responds quite well to treatment. The use of lithium carbonate, a simple alkali metal salt similar in chemical structure to ordinary table salt, has been a recent significant breakthrough in the treatment of mania. Prior to the development of modern drug therapy, mania could be a life-threatening illness, since manics would sometimes die from starvation or exhaustion.

Organic Brain Syndrome

As the name implies, an organic brain syndrome occurs when brain function is impaired by some type of physical insult. The term "organic" means that the cause of this type of disorder is physical rather than emotional. Intoxication with alcohol or drugs, personality changes secondary to brain tumor, or the impaired intellectual functioning often associated with old age are all examples of organic brain syndrome. Organic brain syndromes are usually divided into two groups, acute and chronic, because they are quite different in cause and outcome, and sometimes in symptoms as well.

An acute brain syndrome usually comes on suddenly. Some people experience their first example of an organic brain syndrome when they become seriously ill. A person who has a high fever with a serious infectious illness such as pneumonia, who has experienced a sudden debilitating illness such as a heart attack, or has suffered a massive injury such as a severe burn will often develop delirium. Symptoms of delirium are familiar to parents in a mild form if they have ever had a child who has been quite ill with a high fever. An older person who is delirious begins to behave in puzzling ways. He is not himself, he becomes confused, and sometimes he doesn't know where he is or perhaps even who he is. He may shout, become violent, and swear. Alternately he may become stuporous and lethargic. From time to time he will seem to recover from this delirium, become friendly

and cooperative, recognize relatives, converse normally, seem like himself again, only to relapse into delirium much to the despair of his loved ones. The first frightening thought that comes to them is, “He’s losing his mind and he’ll never be the same again.”

It is important that the relatives of a person with an acute organic brain syndrome realize that this state is almost always reversible. Its cure is to cure the original illness. When the high fever drops, the heart muscle functions in a more normal fashion, or the burns heal, the delirium also disappears and the patient completely recovers his normal mental and emotional functioning. It is also important for people dealing with the delirious person to recognize its fluctuating nature. The patient cannot control these fluctuations, and their cause is unknown. Relatives and friends of an individual suffering from delirium should be as calm and reassuring as possible. When the patient’s doctor and the hospital permit it, a single close relative, such as a wife or child, can help the delirious patient (who also recognizes part of the time that he is confused and fears that he is losing his mind) by remaining with him as much as possible so that he is continually reoriented by a familiar face. Many of the violent or frightened responses of a delirious person arise from misinterpretation of unfamiliar surroundings such as the noises of a respirator, the beeps of monitors in a coronary care unit, or the hushed voices and movements

of white-clothed individuals passing by.

A chronic organic brain syndrome, unlike an acute one, usually develops slowly, so slowly that a person in continual close contact will scarcely notice the change. This form of illness is most familiar in the elderly person who is sometimes described as senile. Usually this common form occurs because blood flow (and therefore nourishment with oxygen and nutrients) to the brain has decreased through narrowing of the vessels, diminished pumping capacity of the heart, or actual occlusion of vessels leading to the brain as in a stroke. When blood flow is diminished, the brain functions much less efficiently.

As grandfather develops a mild organic brain syndrome he will show decreased memory, often forgetting where he has put his keys or pipe or that he should zip his fly. His memory for things in the distant past will be much better than his memory for recent things, and therefore the elderly individual prefers to reminisce about his childhood because that is easier for him than discussing current events. He will find it difficult to adapt to new surroundings, and he therefore may become quite unhappy, confused, or restless if he leaves the home where he has lived for 30 years and takes a plane to California to visit his grandchildren. He will have a tendency to repeat himself and may tire the impatient by telling the same stories over and

over. He may become unexpectedly tearful or unexpectedly angry even though he was once a very even-tempered person. Sometimes he may have difficulty getting to sleep at night or staying asleep and may rise in the middle of the night and wander around the house not quite knowing what to do. In an elderly person decreased hearing and vision often worsen the situation. When poor hearing and sight are added to already mildly impaired brain function, he may misinterpret his surroundings or become quite suspicious. He may even accuse loved ones of plotting against him or playing tricks on him. In the most severe forms of this illness, the person may become demented. He will not know where he is, lose control of his bowels or bladder, and make inappropriate remarks.

This type of chronic organic brain syndrome is usually irreversible. It may remain mild and not particularly troubling to friends and relatives, or it may become steadily worse. The relatives of an elderly person with this syndrome are often presented with a challenge. The impaired memory is best handled with love and patience. Grandfather's reminiscences should be listened to with attention and interest even if they have been heard many times before. The elderly person with relatively severe impairment of memory, particularly if hearing and sight is decreased too, should be spared long trips to unfamiliar surroundings. Or if trips are taken, every effort

should be made to surround grandfather with familiar possessions and explain the environment and events which are occurring with a running commentary in order to decrease or prevent confusion. The elderly person who is emotionally unstable should never be taken personally. Crying spells or angry outbursts by grandfather do not mean that he has suddenly turned against his loved ones and forgotten the many happy years they have spent together. Paranoid suspiciousness is particularly difficult for loved ones to accept, but this, like the emotional instability, must be understood and accepted as due to changing brain function secondary to aging.

Sometimes the organic brain syndrome becomes so severe, either due to marked paranoia or to dementia, that relatives of an elderly person must consider placing him in a nursing home or hospital. Grandfather may, for example, refuse to eat any food prepared by family members because he suspects they are trying to poison him to get his money; or he may be confined to a bed, repeatedly soiling himself and the bedclothes and unable to recognize people who come to talk with him. Such situations are difficult for an elderly wife or husband or for the child who assumes responsibility for their care. Ultimately, placing such a severely handicapped elderly person in a hospital or nursing home is an individual decision. It must be made taking into account the welfare of everyone involved,

including not only the handicapped person, but also the other living relatives such as the elderly wife or the children and grandchildren.

Most of the symptoms described above are characteristic of the chronic brain syndrome which develops during the course of old age, and they may be regarded as the natural results of the aging process in some individuals. But a warning should be added. Symptoms similar to those described may also occur in other illnesses. Brain tumor, excessive use of drugs such as sleeping pills, or excessive use of alcohol by a middle aged or elderly person may produce similar symptoms, as may a condition known as "pre-senile dementia" which comes on in the forties or fifties. It is quite important that any person who evidences symptoms of an organic brain syndrome be taken to see a physician as soon as possible and given a thorough evaluation, particularly if these symptoms occur in the forties, fifties, or sixties. A brain tumor or drug abuse, for example, are treatable illnesses, and the symptoms may be completely reversed if they are noticed and treated early enough.

Neurosis

The group of illnesses called neuroses differ dramatically from those previously discussed. In the first place, schizophrenia, affective

disorder, and organic brain syndrome are probably all caused by some sort of physical factor. Neurosis, on the other hand, is generally thought to be caused by psychological factors, although this has not been definitely proved. Neurotic illness is the type Freud was most interested in, most frequently treated, and wrote most of his books about. Consequently, Freudian theory pervades the way many psychiatrists conceptualize and treat neurotic illnesses. The psychological factor causing neurosis is usually considered to be some conflict, typically arising from a childhood problem which was not completely resolved. The adult with neurotic traits thus carries with him this unresolved problem, which affects the way he relates to other people in his everyday life. Unlike the illnesses previously discussed, neuroses are usually treated on an outpatient basis and do not require hospitalization unless severe. They may be handicapping but typically are not incapacitating. Further, neurosis is universal in the sense that all of us have some. Every adult human being has neurotic conflicts and neurotic methods of handling them. Most of us do not need treatment for our mild neuroses. The descriptions which follow indicate the way in which "normal" neurosis differs from that which needs treatment.

OBSESSIVE-COMPULSIVE NEUROSIS. The mildest form of obsessive-compulsive neurosis appears in the individual usually

described as having a compulsive personality. This type of person is conscientious, hard-working, punctual, tidy, perfectionistic, and often quite intellectual. The housewife whose house is never messed up and who always has well-planned meals prepared promptly for breakfast, lunch or dinner is a familiar example of this type of personality. So, too, is the hard-working businessman who is a stickler for details. Usually compulsive traits work for the benefit of the individual possessing them and often for his associates, though compulsive people are sometimes difficult to be around. The tidy housewife may nag her husband and children excessively about dirtying ashtrays or messing up the house while playing, and the detail-oriented businessman may irritate his associates with complaints which seem petty.

The compulsive can be quite contemplative, worry a great deal, and have trouble making decisions. In spite of his superficial orderliness, he usually has one area of his life where he is extremely uncompulsive and messy. Psychiatrists summarize this with the saying, “Scratch a compulsive and you’ll find dirty underwear.” The compulsive has trouble showing, recognizing, and expressing anger. Consequently, he is unusually pleasant to have around and seems quite mild mannered. Unable to “blow his stack,” he may irritate others by continually nagging or picking at them.

The compulsive personality was usually brought up by parents similar to himself. They too were conscientious and perfectionistic and encouraged the development of these traits in their offspring. Freud thought that compulsive personalities were often produced by excessively harsh toilet training, but this is probably an oversimplification. The compulsive is usually a successful person who rarely needs or seeks psychiatric treatment. This is perhaps the one form of neurosis which tends to promote successful adjustment in our achievement-oriented society. The chief hazard a compulsive faces is the development of depression when his ability to achieve his ideals is frustrated, either through personal limitations or through being blocked by some external force. For example, a compulsive individual finds it difficult to bear physical illness, because most of his life is organized around keeping busy and performing tasks. If he makes a serious error, he tends to develop guilt feelings out of proportion to the actual act. Thus on these occasions his conscientiousness and perfectionism may get in his way and he may develop a depression of sufficiently significant proportion to need psychiatric treatment.

A full-blown obsessive-compulsive neurosis differs from the compulsive personality just described by being much more severe. Instead of being simply perfectionistic, these people find their entire lives governed by obsessions and compulsions. Bill, a Ph.D. chemist,

was an obsessive-compulsive neurotic who found himself in need of treatment. He possessed the typical underlying compulsive personality. He was a minister's son, strictly reared, who when only 20 married a widow several years older with a small child. After they had been married for about five years, he found himself growing gradually incapacitated by a compulsion to wash his hands repeatedly when he was under severe professional stress at work and financial stress at home. The problem was brought most sharply in focus by his compulsive need to wash his hands after playing with his stepson. He sought treatment when both the boy and the mother indicated how distressing they found this behavior. He improved after three or four months of psychotherapy, in which he explored his inability to express his feelings, his excessive conscientiousness, and his considerable (but previously unrecognized) anger toward authority figures.

A few obsessive-compulsives have a very severe form of this illness. These people are so handicapped by their obsessive thoughts and their compulsive rituals that they are literally unable to accomplish anything. They may spend hours after getting up in the morning buttoning and unbuttoning and rebuttoning their clothes in order to get it done just right. Fortunately, such severe forms of this illness are rare.

ANXIETY NEUROSIS. Anxiety neurosis too may range from mild to severe. The tense, nervous individual who is a continual worrier is the prototype of the mild form of this problem. Like the compulsive, he usually functions quite successfully because his neurotic tensions and fear of failure drive him on to achievement. The mildly anxious individual rarely needs or seeks treatment, although he probably suffers more personal discomfort than the mildly compulsive individual, for his is a problem of irrational fear, which is subjectively unpleasant. Freud thought that the person suffering from anxiety neurosis actually experienced some overwhelmingly fearful event in childhood which he then forgot or repressed because it was so painful. Yet the memory of this fearful event lurks in his unconscious and haunts him.

The anxious individual only needs and seeks treatment when he finds his anxiety handicapping. Often the stimulus to seek treatment is an experience which psychiatrists call an "anxiety attack." This consists of a subjective experience of an irrational fear or panic, feelings of impending doom, accompanied by physical sensations such as shortness of breath, pounding heart, sweaty palms, and queasiness in the stomach. These symptoms may be brought on by a realistically fear-provoking situation, such as when a student is called on in class, when a person is unable to perform satisfactorily sexually, or when a

man is called on the carpet by his boss. But severe anxiety attacks frequently occur without any precipitating stimulus and, therefore, are irrational in nature. Treatment usually consists of tranquilizing drugs, psychotherapy which aims at helping the individual understand the sources of his anxiety, or a combination of both.

PHOBIC NEUROSIS. Phobic neurosis (Greek, *phobos,* or fear) is related to anxiety in that it too is based on a crippling sense of fear. In Freudian theory, phobic neurosis is caused by the same sort of primal overwhelmingly fearful experience as anxiety neurosis. Most of us have some mild phobias. Another psychiatric truism is that "every person is entitled to have one or two phobias." Some common relatively normal phobias are fear of high places, fear of being trapped in an elevator, or fear of animals such as snakes or spiders.

A phobia should only be considered troubling when it handicaps an individual's ability to function. Mr. Mason sought treatment, for example, when he found his fear of traveling too far from home kept him from enjoying forms of recreation which he valued highly. He was a successful retired businessman who enjoyed fishing and hunting. His mother died when he was only eight, and he witnessed her death. He was again orphaned at sixteen when an older sister who had been caring for him died. He worked hard, invested wisely, and eventually

built up a substantial fortune. He married in his late thirties and had no children. He had an extremely close relationship with his wife and first began to experience his fear of leaving home after he retired in his early sixties. His retirement had been precipitated by having a heart attack from which he recovered fully, but which led him to the decision to spend the remainder of his life enjoying himself. As he talked more and more about his phobia, it emerged that his primary fear was of death, particularly of death while separated from his wife. He evolved the magical belief that he would not die as long as he was close enough to get back to her and have her hold his hand. In this particular case, helping him understand that his fear of dying alone probably was based on his prior abandonment by two important mother figures in his life was of little help. Neither was the Roman Catholic faith in which he had been raised. This particular case responded well to behavior therapy—simply separating him from his wife and encouraging him to travel farther and farther from home, which eventually led him to realize that nothing drastic would happen if he were in fact separated from her by long distances and long periods of time.

HYSTERIA. Hippocrates, the father of modern medicine, coined the term hysteria to describe emotional disorders which he observed primarily in women. Their primary symptom was difficulty speaking or swallowing. He hypothesized that their uterus (Greek, *hysterikos)*

had been displaced and wandered up to block their throat. In fact, the disorder occurs, although more rarely, in men as well.

Hysteria sometimes appears in a milder form, usually called a personality disorder rather than a neurosis by psychiatrists. A person who has a hysterical personality is rather immature, emotionally unstable, and tends to describe his or her experience in a rather dramatic and flamboyant way. Hysterics have difficulty forming deep and lasting emotional relationships with others and place a great emphasis on appearances. They often complain of multiple physical ailments for which no cause can be found.

The disorder which Hippocrates described is the more severe form, hysterical neurosis. Psychiatrists divide this into two types, the dissociative form and the conversion form. Dissociative neurosis occurs when the person experiences a severe and sudden personality change, similar to the split personality popularized in film and fiction. The person is in a dreamlike state and performs acts he is unaware of. In the conversion form the person suddenly suffers from a dramatic physical symptom such as seizures, paralysis, inability to speak or swallow, or severe abdominal pains. The symptoms appear so severe and convincing that the disorders are often treated either medically or by surgery, but in fact on careful study no physical basis can be found.

"Anna Peterson" illustrates both the dissociative and the conversion form of this illness. She was a very attractive young woman, apparently happily married to an artist husband and the mother of three small children. Because her husband had chosen not to work for a year in order to have more time to devote to his painting, she began to work evenings as a waitress for dinner parties at the local country club. One night while serving for a poolside party she slipped, fell, and struck her head on the edge of the pool. She lost consciousness for several minutes but, although stunned thereafter for an hour or two, she seemed to have recovered fully by the next day. Several months later she began to suffer from a seizure disorder in which she would cry out and then shake with her entire body. A complete neurologic workup demonstrated no cause for the disorder and no relationship to the fall. She was placed on medication but the seizures worsened. She also began to have dissociative episodes in which she would disappear for a day or two at a time, taking the family car and suddenly coming to herself hundreds of miles from home. She began to go from neurologist to neurologist to find the cause for these ailments, and when repeatedly none could be found she was eventually hospitalized in a psychiatric institution. There hypnosis was used as a means of treatment, and eventually material was uncovered which indicated that she felt unresolved anger toward her husband for

requiring her to work and raise her children, and also unresolved sexual feelings toward her father. When this material was lived through in hypnosis and brought to a conscious level afterwards, she eventually recovered fully.

Hysteria is the most dramatic of the neuroses, as the case of Anna illustrates. Freud earned his living by treating wealthy Viennese women suffering from this ailment. It was through working with them that he developed his theories of the unconscious, the "talk it through" therapy that eventually became psychoanalysis, and his theories about infantile sexuality, fixation, regression, and the Oedipus complex. Most of the women he treated described sexual feelings for their fathers and actual rape by them. Initially Freud believed these stories, but when they began to occur repeatedly his stolid middle-class temperament finally led him to doubt their truth and he recognized that in fact the stories represented wish fulfilling fantasies. For some reason such severe forms of hysteria are relatively rare today. Further, not all hysterics neatly fulfill Freud's theory that hysteria results from unresolved feelings of love toward the father.

Alcoholism and Drug Abuse

ALCOHOLISM. Alcohol is one of the world's oldest drugs.

Through the centuries it has been used as a tranquilizer, an antidepressant, an anesthetic for labor pains or minor surgery, and a liquid sleeping pill. Use of alcohol is very widespread and many physicians follow St. Paul and suggest taking a little wine as a means of enhancing the appetite and calming the nerves. Conditions encompassed by the general term alcoholism range from what might be called "problem drinking" to a severe condition which involves physical dependence on alcohol and physical and mental deterioration secondary to excessive use.

When should one begin to worry that use of alcohol may be excessive? Perhaps a sensible guideline is that someone who takes more than two drinks on a daily basis is potentially headed for a problem. The individual who abstains during the week but habitually drinks himself blind on the weekends is also potentially headed for a problem.

Psychiatrists decide that the problem has become real rather than potential on the basis of a number of indicators. One of these is physical symptoms. People who use alcohol to excess often develop physical problems such as abdominal pains due to gastritis or ulcers, blackouts, delirium tremens, or cirrhosis of the liver. Perhaps the most severe complication is a condition known as Wernicke-Korsakoff

syndrome in which the individual becomes uncoordinated, has paralysis of his eye muscles, suffers from poor memory, and is unable to learn new material. Another indicator that problems with alcohol are becoming severe is a variety of behavioral manifestations—missing work, becoming quarrelsome under the influence of alcohol, making suicide attempts while drinking, having marital difficulties, being arrested for drunken driving, or having a car accident while intoxicated. The third indicator is certain drinking patterns such as an inability to stop drinking once started, drinking before noon, and drinking while at work.

A person who has been drinking excessively usually develops a physical dependence on alcohol and has withdrawal symptoms when he is no longer able to drink. Symptoms of withdrawal from alcohol can be serious and life-threatening, for in addition to tremor, fever, sweating, subjective discomfort, seizures and severe changes in blood pressure may occur. For this reason a person physically dependent on alcohol should always be truthful about his alcoholic intake when placed under circumstances when he may be deprived of alcohol. For example, a businessman who drinks heavily and is admitted to the hospital for routine surgery such as hernia repair may develop symptoms of alcoholic withdrawal if he attempts to hide his dependence on it. Withdrawal symptoms can be prevented or reduced

if the physician is aware of the dependence and prescribes tranquilizers.

Living with an alcoholic can be difficult and heartrending. Furthermore, alcoholism is one of the most difficult forms of psychiatric illness to treat. Nevertheless, a variety of options are open. One of these is Alcoholics Anonymous. AA stresses total abstinence and uses regular group meetings in which members provide mutual support for one another as a means of maintaining this total abstinence. AA is not helpful for everyone, however, for its evangelical emphasis on recognizing one's error and reminding oneself of it continually is distasteful to some people. But it is perhaps the single most effective means of handling alcoholism.

Another resource for the alcoholic is the general physician. He may help in the supervision of medical problems which arise secondary to alcoholism and by prescribing medications which may help control the drive to drink. Tranquilizers are often prescribed for alcoholics to substitute for the tranquilizing effects of alcohol. Antabuse (disulfiram) is a drug which alcoholics take voluntarily, knowing that if they drink within five days after they have taken an antabuse tablet they will become physically ill with extremely unpleasant symptoms. Antabuse can be helpful to highly motivated

alcoholics in preventing impulsive drinking binges. Rarely, alcoholics may wish to visit psychiatrists. A psychiatrist can help an alcoholic examine his reasons for drinking, prescribe antabuse or tranquilizers like the general physician, and provide individual support and encouragement for abstinence.

DRUG ABUSE. Although more attention is focused on drug abuse among young people, drug abuse is in fact a significant problem among young and old alike. Each age group has its characteristic drugs which it abuses. Those of the young include marijuana, LSD, "uppers," and "downers." Heroin also tends to be a problem among the young rather than the old simply because heroin addicts rarely live to be old. In addition to alcohol, the drugs which older people abuse include diet pills, tranquilizers, and sleeping pills.

Many parents wonder how they can recognize signs of drug abuse in their children. Perhaps the single most suggestive sign is a dramatic personality change, especially withdrawal and loss of interest in activities previously enjoyed. A youngster using "uppers" and "downers" may have periods of excessive sleepiness and excessive energy in alternation. Marijuana users often have red watery eyes and appear mildly sedated. Very obvious signs include finding drug paraphernalia such as foul-smelling pipes or hypodermic syringes,

pills of any kind, or needle tracts on the arm. A parent who notices indicators such as these should simply confront his child directly and kindly. If the suspicion of drug use turns out to be correct, then the youngster should be evaluated by a professional if his drug problem seems to be severe.

What constitutes a severe drug problem? Which drugs are dangerous? LSD is still in use, although its vogue appears to be passing as more and more people have become aware of the hazards involved in LSD use. LSD can produce acute psychotic episodes in which the user becomes panic-stricken and terrified. The death of Art Linkletter's daughter while on such a "bad trip" brought the hazards of LSD usage to widespread popular attention a few years ago. Occasionally young people who have used LSD repeatedly may also suffer from a residual state similar to schizophrenia. Generally speaking, LSD should never be used, for it cannot be predicted when an individual is going to have a bad trip. Furthermore, what is often sold as LSD may contain other dangerous substances such as strychnine.

Amphetamines or "speed" are another potentially dangerous drug, for repeated use can produce a state known as "amphetamine psychosis." The symptoms of amphetamine psychosis include difficulty

sleeping, a preoccupied repetition of simple tasks, paranoid suspicion, and unexpected outbursts of anger. Clinically, amphetamine psychosis is also similar to schizophrenia.

The dangers of heroin can simply not be overestimated. The drug is so pleasurable that using it even one time may lead to addiction. Repeated heroin usage, in addition to demanding that the user pay for his habit with criminal behavior because it is so costly, also inevitably leads to physical illness such as hepatitis or other infections. Many heroin addicts die of accidental overdoses.

Marijuana, in contrast, is probably most dangerous simply because it is illegal. Chronic marijuana usage does not lead to addiction, although it may produce a mild psychological dependence. It is probably no worse in this respect than alcohol, and the physical and emotional problems associated with marijuana usage may actually be less than with alcohol. Nevertheless, laws against marijuana remain on the books at present and consequently few parents will want their children to become involved with it.

Older people can also have drug problems, although they are more prone to ignore them. Amphetamine usage is perhaps a more serious problem among middle-aged housewives than it is among

young people. The older person takes amphetamines for different reasons than the young person. He usually conceives of them as diet pills rather than speed and uses them both to keep his weight down and to increase his pep and energy. Until quite recently, diet pills were abundantly available to this age group, which had the economic power to pay for them. Consequently, there has actually been more risk of dependence and amphetamine psychosis in the middle-aged than in the young.

The second group of drugs which older people abuse most commonly are barbiturates and tranquilizers. Often these are prescribed for a person who has mild anxiety and some difficulty sleeping. The sleeping pills are very helpful at first, but then a phenomenon known as tolerance begins to occur. The person's body becomes accustomed to the drug, and increasing doses are required to get the same effect. The average dose prescribed to produce sleep with a barbiturate is about 100 mg. Middle-aged people will appear in psychiatric hospitals on dosages as high as 1000 or 1500 mg., having gradually increased the dosage in order to counteract their insomnia and anxiety. Often they have gotten their pills from a variety of physicians who were not aware of the person’s dependence. Signs suggestive of dependence on barbiturates or tranquilizers are slurred speech, impaired balance, staggering, falling, or car accidents.

The hazards of tranquilizers are similar to barbiturates but they are likely to be milder because these drugs are less habit-forming and tolerance is developed less quickly. As in the case of physical dependence on alcohol, sudden withdrawal from barbiturates or tranquilizers can be a serious matter, and again such physical dependence should never be hidden from a physician. Sudden withdrawal of barbiturates can produce seizures, brain damage, and acute psychosis. If the drug is withdrawn slowly, depression often follows afterwards. People who have been taking large amounts of drugs such as LSD, amphetamines, heroin, or barbiturates and tranquilizers will ordinarily require hospitalization.

Disorders in Children

THE HYPERACTIVE CHILD. The syndrome known as hyperactivity is quite common, occurring in approximately four percent of school age children. It is much more common in boys than girls. In the past it has been labeled with other names such as "minimal cerebral dysfunction" or "minimal brain damage." These terms are best avoided, since the causes of hyperactivity are not known definitely, and many children suffer severe assault to their self-esteem when they are made to feel that their brain is damaged by being given such labels. The syndrome of hyperactivity has no specific relationship

with intelligence, and it can occur in the very bright as well as children with intelligence below normal. Hyperactive children are sometimes the product of a difficult pregnancy, a prolonged labor, or a difficult birth, and sometimes it is associated with neurological problems such as clumsiness, perceptual reversals, or left-right confusion. This has led some psychiatrists to suspect that there may in fact have been some minimal cerebral trauma, but if so it is a type of trauma which probably affects behavior rather than intellectual ability.

The classic symptoms of the hyperactive child are restlessness, excitability, distractibility, and impulsiveness. In school, teachers notice that the child has difficulty sitting still for long periods of time, cannot pay attention to tedious tasks, and is prone to clown to get the attention of other children. Often children are first brought in for treatment when they enter kindergarten because their restless behavior and short attention span make them difficult to manage in the classroom situation.

Usually the child's mother has noticed long before that Johnny is difficult to manage. He gave up his nap early, usually before two years, and during his waking hours was restless, curious, and often destructive. He was difficult to get to bed at night and seemed to require very little sleep. Sometimes hyperactive children have more

difficulty achieving bowel training than bladder training, and they have a tendency toward constipation. The abundance of energy and curiosity which normal children have is magnified many times in the hyperactive child, and he can move from pouring oatmeal on the floor to unraveling all the toilet paper to emptying out all the wastepaper baskets with astonishing rapidity. He shows little "common sense" and will impulsively run out in the street without looking or jump into deep water when he does not know how to swim. He tends to ignore painful stimuli, and often spankings are of little help in disciplining him and may make him worse.

When he finally does get to sleep at night, he is a restless sleeper who tosses and turns and whose bed is difficult to make in the morning because of the tangled sheets. He sweats a lot and may awaken in the middle of the night with night terrors—a state different from nightmares in which the child shouts out and appears frightened but remains in a dreamlike state and cannot recall what happened after awakening. Hyperactive children are also more likely to be sleepwalkers than other children. They often have rather poor coordination and are slower to learn to swim or ride a bike than their peers. Because of their restless and often destructive behavior, their emotionality, and their attention-seeking behavior, they often have trouble getting along with children their own age.

The treatment of hyperactivity is often double-barreled if the problem is severe. The hyperactive youngster should be evaluated by a physician who may recommend the use of cerebral stimulants such as Ritalin or Dexedrine. Paradoxically, these medications which are so stimulating to adults have a tranquilizing or sedative effect on the hyperactive youngster. They are quite effective in increasing his attention span and diminishing his distractibility, and therefore they are particularly useful when he is in the classroom.

The second mode of treating hyperactive children is through good disciplining and parenting at home. All children need firmness, consistency, and affection, but the hyperactive child needs these in more abundance than most. Because his emotional and destructive behavior tends to alienate others, the hyperactive child often suffers from a poor self-image and low self-esteem. He comes to feel that he is unpopular, a "dummy," and a "bad kid." Firm rule setting is necessary for these children, and rules should be enforced with absolute consistency. Perhaps the most effective form of punishment for a hyperactive child is isolation rather than spanking. Sending him to his room for fifteen minutes or a half hour will cut down the stimuli which have "cranked him up" and led him to misbehave, and he will usually emerge calmed down.

LEARNING DISABILITIES. Learning disabilities are often associated with hyperactivity, but either problem can also occur in isolation from the other. Learning disabilities are also not related to intelligence. By definition, a learning disability occurs when a child is more than two years behind the level appropriate to his mental age (not chronological age) in a specific subject. If Johnny has a normal IQ (a mental age of ten years when he has a chronological age of ten years) and is reading at a level appropriate to an eight year old, then he probably has a specific learning disability in reading.

Like hyperactivity, learning disabilities are more common in boys than in girls. Often they tend to run in families, suggesting that there may be a heredity factor. One often hears that grandfather never learned to read and that uncle Jim only succeeded in learning after much difficulty. Now little Johnny is coming in for an evaluation in the first grade because his teacher has noticed that at the end of the first semester he has fallen markedly behind the other children. If Johnny is indeed brought in in first grade, one should rejoice. Learning disabilities are best handled when they are caught early and appropriate teaching methods initiated before the child gets too far behind.

We still have much to learn about learning disability. The

youngster who is having difficulty learning should probably be evaluated with testing of his vision and his hearing to rule out some specific physical cause. As yet we know of no way to change the defect if one is present. Instead it must be worked with and compensated for. The child will ordinarily be placed in a special program which will help him handle his specific problems. For example, he may need more drilling on fundamentals. Or he may have already developed such severe feelings of frustration and failure that he will need to be given his assignment in small “dosages” which he feels more able to handle; whereas children in a regular program may get fifty problems on one page, the child with difficulties in math may be given ten problems on five pages.

Parents can provide considerable help for the child with learning disabilities. Most importantly, they can prevent further losses of self-esteem. They should help him look for an area where he genuinely excels, such as sports or artistic skills, and then give him enthusiastic praise for his success in these areas. They can often supplement schoolwork by providing amusing ways to work on fundamentals such as phonics or mathematical facts at home. This can help the child increase his vocabulary by teaching him new words at home, improve his ability to abstract by playing games like "animal, vegetable, or mineral,” or have him make up stories or describe things he sees. A

child with difficulty in mathematics can be given a few addition or multiplication problems to solve at the dinner table, beginning at first with simple ones that he is able to do well. The child should be given lots of positive reinforcement in the form of praise for his success, and the problems should be gradually increased in difficulty.