FIRST RESPONDER’S GUIDE
TO ABNORMAL PSYCHOLOGY

Applications for Police, Firefighters
and Rescue Personnel
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TO

Phyllis, Karen, Aaron, Will, Zack and Eric

Karen & Steven, Max, Benjamin, and Oliver; Michael & Roberta,
Micaela and Maya, Sara, Laura & Andrew,
Jacob, Anne, and Jonathan

AND TO

All the First Responders who make their world a safer
place in which to live
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The devastating events of September 11, 2001 crystallized in the national consciousness the critical role of our police, firefighters and emergency medical personnel in dealing with emotional as well as physical trauma. These First Responders played central roles in addressing the overwhelming medical and psychological needs of massive numbers of victims and brought continuous attention to these dedicated public servants over a period of several months. As a result of this crisis, our country has developed a renewed appreciation for the contributions these First Responders make on a daily basis. In particular, we have come to appreciate more fully the important functions these personnel serve in evaluating and intervening with individuals suffering from chronic psychological and psychiatric impairments as well as traumatic stress resulting from accidents, domestic violence, natural disasters and other life threatening emergencies—all in addition to the more highly publicized disaster. While the psychological literature supporting the educational and training needs of emergency personnel is voluminous, there is relatively little published that is geared to the needs of First Responders covering the range of psychiatric and psychological disorders with which they must deal. We have written First Responder’s Guide to Abnormal Psychology to address their needs and those of students who aspire to fill those roles.

First Responders, personnel who are often first on the scene when an emergency occurs, are police officers on their daily beat, detectives trying to solve a murder case, firefighters responding to a conflagration, or air marshals protecting passengers on a flight. They are transportation safety workers, probation officers, FBI agents seeking to identify terrorists, detention center staff, wardens and deputy workers in our jails and prisons as well as military police keeping order after a bomb explodes. Few of these individuals will have had training in understanding people’s emotional responses to stress and trauma or the signs and symptoms of psychological illness. We have written this book to address these critical issues.
The book has been organized so that professors who are teaching courses in criminal justice, psychology, social work, or emergency services can easily adapt material to their syllabi. We offer current information in clinical and forensic psychology, as well as crisis and trauma theory employing real life examples of the principles discussed in the text, and concise tables summarizing the cardinal features of the various mental disorders that First Responders encounter. We have chosen to eliminate references to research literature in the text that are so common in traditional psychology textbooks written for professional mental health workers or psychology majors. Rather, we have attempted to enhance readability by emphasizing the clinical and practical nature of the issues we describe, adding source material at the end of each chapter for those who wish to explore any topic more fully.

The text includes chapters covering the major psychological and psychiatric impairments, including cognitive disorders; schizophrenia; depression and bipolar disorder; anxiety, somatoform, and dissociative disorders; substance use disorders and personality disorders. Another chapter summarizes the most relevant information on disorders common in children and adolescents including discussions of child abuse, domestic violence, and juvenile justice. Finally, specialized chapters address crisis, terrorism and trauma theories, and intervention strategies useful for First Responders, in addition to the role of therapeutic justice that includes sections on drug, mental health and domestic violence courts, involuntary commitment, and the insanity defense.

The National Institute of Mental Health reported in 2006 that mental disorders are the leading cause of disability in the United States and Canada for ages 15 to 44, with an estimated 26.2% of Americans these ages and older—about one in four adults—suffering from a diagnosable mental disorder in a given year. The Department of Justice claims that over 60% of all inmates in jails and prisons in the United States have experienced a mental illness at some time of their lives. We hope that our book will enable our readers to perform their critical jobs more effectively, more sensitively, and with a fuller appreciation of the very debilitating role stress, trauma, and mental illness play in the lives of citizens they serve.

We want to express our appreciation to our editors especially Sharon Panulla at Springer for their support and patience as we developed this text. We offer very special thanks to Dr. Rosemary Timoney who carefully reviewed and edited preliminary drafts of the manuscript. Our text became more readable under her thoughtful and sensitive direction.

William I. Dorfman
Lenore E.A. Walker
Ft. Lauderdale, FL
January 2007
WHO ARE FIRST RESPONDERS?

The term “first responders” became publicized during the aftermath of the terrorist attack on the World Trade Towers and Pentagon on September 11, 2001. First Responders are trained persons who respond to an emergency or crisis call. They may be police officers, fire fighters, emergency medical technicians, mental health counselors and psychologists, medical staff and doctors, crime scene technicians, child protective services workers, security guards, first-line soldiers in combat, and in some cases, office managers and school teachers.

First Responders rarely know what they will find when answering a call. Police are trained to intervene in a home invasion but if either the perpetrator or the victim has a mental health problem, his or her behavior may well be unpredictable, putting everyone in danger. Firefighters are trained to save a burning building, but how to persuade a mentally ill person that it is safe to leave may require another set of skills. A child protective services worker may have to make a home visit in a building being “guarded” by a paranoid schizophrenic who sees the worker as the enemy. Security guards may find disheveled and disorientated people, but may have no training in how to deal with them.

We all became aware of the firefighters who lost their lives on September 11 in NYC when, unaware that the buildings were about to collapse, they ran into the World Trade Towers to save people trapped inside. Many New Yorkers became First Responders that day, trying to help their friends, family, or even strangers standing next to them deal with the magnitude of the tragedy that unfolded before them. Strangers talked to each other, trying to make sense out of what had just transpired. Stories of heroes that day emerged; the woman train dispatcher who stopped the NJ Transit trains from going towards the station under the World Trade buildings, the office workers who helped colleagues down the stairs when they became afraid to continue, the people in the
fourth airplane destined for the White House who went down with the plane rather than comply with the hijackers’ demands, and other brave people just like them. The Red Cross sent hundreds of volunteers to the scene over the next several months. Many learned that providing a listening ear, a blanket, and warm cup of cocoa was critically important. Later, psychologists and other mental health workers provided crisis counseling for these First Responders to prevent them from developing more serious trauma reactions themselves.

We learned during this mass catastrophe what others who were trained to respond in an emergency knew when they first arrived at a disaster scene; caring people make a difference in saving lives and preventing further psychological injuries. But what about those whose mental status is not very stable even before tragedy strikes? Or those whose mental illness seems to propel them into the criminal justice system repeatedly? In the following chapters, we attempt to explain what we know about mental illness both before an emergency strikes as well as afterwards. We will describe the impact of crisis situations on individuals, how the brain and nervous system control human behavior; and how mental health professionals use their skills to diagnose, evaluate and treat psychological dysfunction. We believe that First Responders need this knowledge in order to deal more effectively with patients and victims who may suffer both physical and psychological trauma [Box 1.1].

WHAT KINDS OF PEOPLE WILL FIRST RESPONDERS DEAL WITH?

Trauma Victims

The first responder who answers a crisis call may find people who are traumatized by the current situation or those who were mentally ill previously and then became retraumatized by what they had just experienced. Again, September 11 provides good examples. Many people who observed the planes hit the buildings, watched people jumping out windows to their death, climbed down smoke-filled staircases to save their own lives or watched the buildings collapse in front of their own eyes developed acute and chronic traumatic stress reactions. Some of them developed the more chronic Post Traumatic Stress Disorder (PTSD). Many who watched the images on television over and over again were traumatized. Those who lost family and close friends in the buildings also developed these reactions. Police and fire-fighters developed traumatic stress as well. In some cases, these reactions lasted for months and years afterwards. Others were shaken by the experience but moved on with their lives, rarely showing any emotional impact. What was it that motivated people to respond in such widely different ways to the same experience?
It is believed that those who have experienced prior traumatic events may be at a higher risk to develop PTSD from a new event, while those for whom this is the first exposure to a traumatic event may have more emotional resilience to handle it. Some even suggest that there are different genetic vulnerabilities in response to stress and trauma. Studies have shown that people who have a more positive outlook on life—that is, those who believe that “a glass is half full rather than half empty”—may have more resilience in handling trauma. Some people learn to shut off their painful emotions so they may not feel emotional pain during a crisis or trauma situation. Others may have developed a very distinct

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**Other Victims of 9/11: Therapists, Social Workers**  
*By Alison McCook*

NEW YORK (Reuters Health)—Social workers who counseled large numbers of patients traumatized by the September 11 attacks in New York appear to be at risk of developing the same nightmares and flashbacks as their patients, a new study reports.

Study author Dr. Joseph A. Boscarino explained that this phenomenon, known as secondary trauma, likely results when therapists or social workers hear descriptions of traumatic events from patients, then picture those events and become traumatized themselves.

“As a therapist, you can be at risk from treating these people,” he said.

However, he noted that social workers who said they had a supportive work environment—meaning, for instance, that their boss was sensitive to their needs, or they received a lot of time off to de-stress—appeared to be protected from secondary trauma.

For social workers and other therapists who have already developed secondary trauma, “there’s every reason to believe they should have counseling themselves,” Boscarino noted. “Just like a victim who directly experienced (the trauma).”

In an interview, Boscarino, who is based at the New York Academy of Medicine in New York City, explained that previous research has shown that spouses and therapists of Vietnam veterans who have post-traumatic stress disorder often develop the same disorder themselves.

To investigate whether this phenomenon occurred among social workers who offered their services during the September 11, 2001 attacks, Boscarino and his colleagues mailed questionnaires in May 2003, to 600 social workers who had addresses in New York City.

Overall, 236 social workers returned the questionnaires. More than 80 percent said they counseled people during the days following the attacks.

The investigators found that the more social workers had involved themselves in the recovery from the attacks, the more likely they were to have developed secondary trauma. However, the more social workers rated their work environment as being supportive, the less likely they were to develop secondary trauma.

These findings, reported in the International Journal of Emergency Mental Health, reinforce the importance of creating a good work environment for people exposed to traumatized patients on a regular basis, Boscarino noted.

He added that although the September 11 attacks were a unique event, social workers, psychologists and psychiatrists who regularly counsel abused women, for instance, may also be at risk of secondary trauma.

“This could be an occupational hazard that needs to be looked at,” he said.


*Reuters, July 1, 2004.*
coping style that permits them to go on. In this last group there may be those who escaped from terrorism in their native country. However, there are some theories that suggest a loss of resilience each time another trauma event is experienced.

The one most important factor found, however, in studies that looked at survival techniques was the presence of a support system made up of caring people. The more support a person perceived he or she had, the less emotional impact from the current trauma, no matter what kind of trauma it was. This is also true for crisis intervention when a non-traumatic but emotionally distressing crisis occurs. Although emotionally painful when experiencing them, crisis periods can be considered positive for personal growth afterwards. For example, the death of a parent may be a very painful event when it occurs, but the sense of relief that a loved one is no longer suffering and the ability to reclaim one's own life can be very positive outcomes for those who were caretakers. We more fully describe the techniques recommended in dealing with crisis and trauma in Chapter Ten.

**Seriously Mentally Ill**

What about the police officer who responds to a call at an apartment house and discovers that the door is locked? He or she knocks loudly and calls out for someone. Nothing is heard at first. Then slowly the door opens slightly with the woman inside peering out. There is enough space for the officer to slam open the door, but that could traumatize the family. The right choice is to stand or sit there talking quietly to the person to avoid getting him or her more upset. Once the person seems calmer, it may be possible to persuade him or her to open the door and leave peacefully. Police officers trained in dealing with the mentally ill or in hostage negotiation techniques have far fewer deaths or serious injuries because of their ability to “talk down” someone who is suffering from severe mental illness.

Some mentally ill people become aggressive when confronted with a legal situation. Many police departments are beginning to carry laser guns to protect themselves when responding to a crisis call with someone they know has been diagnosed as mentally ill. Look at this description of the taser in Box 1.2 and imagine what it feels like getting stunned by it.

Adults who are seriously mentally ill may react inappropriately to a fire fighter or emergency medical technician who has come to help them. If the person is responding to his or her own internal mental stimuli, the mentally ill adult may be confused by the identity of the First Responder and may respond in a disorganized or even aggressive manner. This behavior is likely when severely mentally ill persons stop taking their anti-psychotic medication and are out of touch with reality. As with Stacey who described in Box 1.3, the risk for the First Responder...
is to exacerbate the situation by setting off a violent attack by the person who otherwise would not be aggressive. It is important for the First Responder to learn how to recognize the difference between a mentally ill or substance abusing person and one who is purposefully dangerous or behaving aggressively.

We describe the major mental illnesses and the role of First Responders in dealing with them in Chapters Five (psychotic behavior), Six (mood disorders), and Seven (anxiety disorders), in addition to the personality disorders in Chapter Eight and the substance use disorders in Chapter Nine.

**Children**

Children who have mental problems pose a difficult problem for First Responders. Those children with limited intellectual resources may be easily tricked into giving a statement if the interviewer asks questions that can be answered by yes or no. The problems associated with mental

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**BOX 1.2**

**Taser Guns Growing in Popularity**

Firing 50,000 volts of electricity into a person’s body is an extreme measure, but at least it’s better than a bullet. That may be the ultimate lesson to draw from the experiences of police departments that have issued to their officers.

The number of people killed by police in Seattle, Miami, Phoenix, and other cities has fallen dramatically, in part, it seems, because officers in those cities have been relying on Taser guns when, in the past, they might have used deadly force.

But as the Taser spreads rapidly, it is raising questions about whether the weapon, which can also be applied directly to the skin as a stun gun, could be abused by the police. The Taser zaps suspects with 50,000 volts of electricity, disabling them for five seconds at a time. Critics say the weapon is ripe for abuse because the shock leaves no obvious mark, other than what looks like a small bee sting. Human rights groups in the United States and abroad have called Tasers potential instruments of torture.

Incidents of abuse are not unknown. A man in Las Vegas died last month after being shot with a Taser four or five times. Here’s what his cousin saw:

“He was on the ground,” Ms. Bell said in a telephone interview. “He had two pairs of handcuffs on him, and I didn’t know the Taser was being used until I heard him screaming. He kept screaming and screaming, saying, ‘Oh God, Jesus, please no.’ He was screaming in pain, he was hurt and he didn’t resist.”

The long term effects of being zapped with 50,000 volts are unknown, and the possible lethality of the weapon is open to debate. Still, if the alternative is the use of a gun that will almost certainly cause serious injury or death, police departments should seriously consider training officers in the use of a Taser.

Police departments should vigilantly guard against the abusive use of Taser guns, just as they should guard against abuse of any kind. Policies limiting the use of Taser guns should be strictly enforced, so that officers are held accountable if they resort to a Taser gun when safer and less painful methods can safely be used to obtain an offender’s compliance.

by TChris

*Posted Sunday: March 07, 2004*

*Taser Guns*
retardation are chronic and they will not go away with a quick fix. Those who have emotional problems also need special handling by the First Responder. In the above case (see Box 1.3), a girl who had been raped one year earlier and then was stopped by the police for being out after curfew, could have had a different ending had the first responder here been more sensitive to her mental condition at the time.

Was Stacey just behaving like a typical teenager when she wanted her money and lipstick preserved? Could the police officer have known that Stacey had recently been raped and had such a reaction to being touched as a result? No, but she could have known that this was one possible reason for Stacey’s frantic behavior as the officer approached her. We discuss various ways to approach teens and avoid exacerbating trauma reactions that had left scars previously, as well techniques to deal with those teens with serious mental disorders in Chapter Twelve.

A child protective worker was called to the house by a neighbor who feared that a child was being harmed. Box 1.4 describes the situation that a CPS worker found when she entered Linda’s home. It became clear rapidly that Linda had a serious mental illness. It took longer to recognize that there was no baby to protect.

Other cases involve police officers who are about to make an arrest. It is important here to interact with mentally disturbed individuals, both children and adults, in a way that does not exacerbate their...
illnesses. Law enforcement officers in various jurisdictions are getting training in making decisions about the mentally ill based on assessing and observing behavior, emotions, false beliefs, appearance, speech and thinking. They are trained to quickly identify hallucinations, delusions, suicidal and homicidal thoughts and behavior. Police officers who attend these programs around the country find them very helpful in their work.


The U.S. Department of Justice has become aware of the burgeoning numbers of mentally ill who are in the justice system. Jails and prisons estimate that close to 60% of their inmates have mental health problems. Close to 50% may have serious alcohol and other drug addictions that need attention to prevent recidivism. These numbers are substantially higher for women detainees and prisoners. We discuss the new therapeutic or problem-solving courts such as mental health courts, drug courts and domestic violence courts where restorative justice is the norm in Chapter Eleven. In Box 1.5 the interview with Judge Ginger Lerner-Wren, who sits on a misdemeanor mental health court in Broward County, Florida describes the community needs that accompany a mental health court.

Those old enough to remember stories about World War II and Viet Nam may remember that some men who did not want to go into combat preferred the socially stigmatizing label of 4F which meant they had mental problems and, therefore, were ineligible for the draft. In fact, many of the standardized psychological tests whose updated versions we use today were first developed during the 1950s to screen out the mentally ill or provide better services for them when they returned.
The Role and Importance of First Responders

Excerpts from a Conversation with the Judge of the First Mental Health Court

*Face to Face: A Conversation with Judge Ginger Lerner-Wren*

The judge discusses the stigma and reality of mental illness.

Q: Judge Lerner-Wren, it’s no secret that the recidivism rate for the mentally ill in the criminal justice system is very high. What should be done about that?

A: Well, first of all, the recidivism rate as it relates to those individuals, for example, going through Broward’s mental health court is not very high. We actually have a recidivism rate that, I think, floats at about 12%, which is extremely wonderful. Which means that when individuals who need mental health care get access to it and there is a mechanism for ensuring that the care is sufficient and continuous, people respond extremely well to treatment and live very wonderfully in the community.

Q: Are the county’s mental health courts working as well as they should?

A: I don’t think that these courts were ever supposed to be a panacea. I don’t think that the issue that often gets focused on, in terms of the criminalization of the mentally ill, should be the primary focus of any policymaker or journalist. I think that the symptom of the criminalization of the mentally ill is a shameful, shameful trend. But the underlying causes of that, I really think, should be the focus, and that has to do with the high fragmentation of services in communities, the rationing of care, the lack of access to health insurance that covers mental health care, and just the overall stigma that surrounds these disorders and this illness generally.

Q: You’ve spoken of the need to “build capacity for treatment” in this community. What do you mean by that?

A: That means that communities have a full array of treatment and services for children and for adults that really spans the lifespan. It includes traditional psychiatric treatment, medications, psychotherapy, counseling, substance abuse treatment, but it also includes more than that.

It includes services and supports like housing, like access to disability benefits, case management services, day treatment services, and that’s really what we’re talking about.

The theory is, if we have communities that could really adequately provide the care to individuals with mental health needs, then you would not have people constantly recycling through jails and hospitals and the streets. We’d be able to meet their needs better.

Q: Do you think the community can afford that kind of full array of treatment over the lifespan of an individual, considering that there are many such individuals?

A: I do. I think that our governmental leadership, our policymakers, have not really been wise about the cost-effectiveness of providing care. The consequences of not having well-developed mental health care systems have been enormous, both in wastes, as far as over-utilization of hospitals and jails, to loss of productivity for employers. . . . Absenteeism is a huge issue in this country. The president commissioned data [that] supports economic loss, for example, just from productivity, in the millions. And so the waste of not—from a policy standpoint—treating mental health issues as we do other medical care issues has been enormous.

Q: Some people have proposed building a forensic hospital to treat the mentally ill once they enter the criminal justice system. Would such a hospital be helpful?

A: I wouldn’t advocate for that. I think that we know what we need, in terms of different types of programs and housing. I think that if individuals can be safely and appropriately in the community, they can be and they should be. Where there are individuals that need forensic hospitalizations, which really is a very nice word for a jail, we have sufficient jail space in the county. And so, monies really need to go into the community, where they belong.

Q: In 2003, the President’s New Freedom Commission on Mental Health, of which you were a member, recommended “a fundamental transformation of the nation’s approach to mental health care.” Yet little seems to have changed. Why is that?
A: I think a lot has changed, but it hasn’t trickled down across the states yet. But on the federal level, there’s been a tremendous amount of change, through the Department of Health and Human Services. The agency for substance use and mental health has gone through their own implementation process nationally, meaning that they’re working on the national level to bring all of these federal agencies into alignment, consistent with the recommendations, and also reaching out to the states, to advocacy groups, to practitioners, policymakers, to educate about the recommendations of the president’s commission report. And so I think that we’re starting to see change happen, but transformation is clearly not an overnight process. Different states are implementing in their own way.

Q: Are the county and state spending enough on mental health care, and if not, how much should they be spending?
A: No. 1, they’re not spending enough, and they have historically not spent enough, because for some reason these mental health issues have not been given the kind of prioritization that they really deserve. I’m not sure that the policymakers in our state understand that we are not going to be able to build and develop a strong workforce, for example, if we don’t have healthy families and children that could succeed in school. And all of these issues are directly related to good mental health. And so there’s got to be an investment—a strong, clear investment—in our mental health care delivery system in this state in order for us to really have a very strong citizenry.

Q: Why is there such a problem of access to mental health care? Is it just that there are too many patients and not enough providers, or is there more to it than that?
A: There’s a little more to it than that. It’s a combination of a lack of enough, just a lack of treatment and services generally, services and treatment systems that we have [are] highly, highly fragmented, not well organized, very, very difficult to get information, know who to call. If a parent wants help for their child, the schools don’t have enough counselors, they don’t necessarily address the issues from a therapeutic way. For example, if a child behaves poorly in school, they may not see that as a mental health issue, they may see that as a behavioral problem and not make any recommendations, for example, for evaluation.

One thing we learned from the President’s Commission is that the earlier one intervenes for mental health, the better. And one of the recommendations clearly is that all children should be evaluated on mental health issues, and evaluated early, in whatever setting, whether it be the pediatrician’s office or a school-based clinic or some other fashion. Early intervention leads to prevention.

Q: What’s the best way to educate the public about the problems of the mentally ill?
A: I think the best way is really through very, very strong educational and anti-stigma campaigns. You know, one in five individuals have some kind of mental health disorder. It’s not just this mythical, stereotypic idea or image of, you know, a scary homeless person muttering on a street. It’s our mothers, it’s our fathers, it’s our grandparents, it’s our children. It’s individuals who suffer from severe depression and they’re too ashamed to talk about it. The research shows only half of individuals that suffer from depression ever seek care. We have to recognize that mental health issues are just the same as having any other kind of physical or medical condition, and that requires treatment, and there’s absolutely no shame in going to see a doctor, for example, if you have a cardiac condition, and I think that’s the education that we need to keep promoting: that these are real, authentic medical conditions, and we have to become much more enlightened about that.

Q: Is there anything else you’d like to say?
A: I just really want to emphasize that treatment works, treatment works for individuals with some of the most profoundly disabling conditions…that we are all human beings, and that if there are medical conditions that require treatment, jails should never be used as an alternative to hospitals or health care.
from war. Today, in the all volunteer military in the United States of America, there are mentally ill men and women who join, as well as those who are exposed to trauma and become mentally ill while in the military. Women and men returning from Desert Storm, Afghanistan, and now Iraq tell of terrible skin rashes and trouble breathing, along with high levels of anxiety disorders, including PTSD, mood disorders, and even psychotic breakdowns. The Veterans Administration Hospitals routinely care for these mentally ill former soldiers while the base clinics and specialty hospitals provide needed services for those still on active duty. Although we think of PTSD in connection with combat, it appears that many of the other mental illnesses are also commonplace, and they are treated in the mental health units on the bases, both in the United States and at temporary sites in combat zones. Those who serve as military police and emergency medical technicians in these military hospitals need to know what to expect when they encounter someone with a severe mental illness as well.

**SUGGESTED READINGS**


Suggested Readings


CHAPTER 2
Normal vs. Abnormal Behavior: A Continuum

A common question posed to every mental health expert by the “person on the street” is “Who is really normal?” The answer to the question is very complex and one that is open to significant areas of disagreement among professionals. To understand the issue more clearly, let us first consider the concept of normality and abnormality in the area of physical health and disease.

When someone is feeling ill and manifesting symptoms of pain, muscle aches, coughing and dizziness, the physician will take his or her temperature, look into his or her throat and ears and typically take blood and a swab of the patient’s throat for analysis. When the physician discovers that the temperature is 102°F, the throat is red, the throat culture reveals bacteria and the person’s blood values are askew, the diagnostician can safely say the patient is “abnormal.” These “signs” of illness are objective, easily verifiable and would generally be agreed upon as abnormal by all experts. When we apply this “medical” or “disease” model of abnormality to psychological and psychiatric illness, however, agreement over what behaviors represent abnormality is not so clear cut.

In deciding whether psychological symptoms and behavior are “sick” or abnormal, mental health professionals do not typically rely on objective, physical evidence like blood tests, X-rays, or CAT scans. The decision to diagnose an individual as psychiatrically ill or abnormal is far more subjective and relies on clinical judgments that are influenced to some extent by a number of factors that take into consideration the appropriateness of people’s behavior in the context of their environment, the effect of their behavior on others, and their culture as well as that of the judge making the evaluation of normality vs. abnormality. While each of these factors is important, no single one can be used to definitively label a person’s behavior as “abnormal.” We will discuss some of these factors in this chapter.

The Diagnostic and Statistical Manual of the American Psychiatric Association lists symptoms and behaviors for a variety of disorders to
enable professionals to “diagnose” a patient and thus view him or her as “abnormal.” Each of these disorders typically involves several symptoms that must be present in order for the diagnosis to be made. However, no single symptom or behavior can be assumed unequivocally to equal abnormality. Some individuals may feel that anxiety is “abnormal,” yet it is quite normal when we face dangerous situations. The desire and intent to kill another human being may be seen as a sign of abnormality until we remember that we award medals to soldiers for killing our enemy. Self-mutilation sounds clearly sick until we recognize that tattoos and piercings are common today. The point is that these behaviors and symptoms, when viewed alone, do not provide the basis for an “abnormal” label. We must take the social context and the culture into account as well. This is not usually the case in medical abnormalities. A virus is a virus regardless of the context.

We also rely on statistics as a yardstick to define normality and abnormality. What is statistically most frequent or common in the population may be considered “normal” and what is infrequent or occurs less often would be labeled “abnormal.” While we often use this model to assist us in evaluating behavior, especially in psychological testing, it has serious flaws. Most importantly, common or normal reactions may be considered abnormal at times. Many people, civilian and military, participated in the Holocaust that involved nearly annihilating an entire race of people. Despite the numbers of people involved, it would not be realistic to view their behavior as normal. Yet when many of Hitler’s top lieutenants were formally evaluated psychologically, their actual responses were quite average or “normal” in a purely psychological sense. In summary, what is common in a population is not necessarily normal in the context in which we are attempting to understand it and cannot stand alone in defining these terms. There is no question that the ability to conform or behave like most people is useful in coping with and adjusting to the demands of life, but it is not usually an end in and of itself.

Often, the general population views abnormality in very simplistic terms that lead them to label others as sick in a very circular manner. For instance, some assume without question that if an individual has ever been labeled with a psychiatric diagnosis, then he or she is by definition “abnormal.” They never ask who labeled that person or on what basis the label was assigned. In effect, abnormality becomes what the professional says it is, regardless of the basis of that judgment. Another potential error occurs when someone is seen as abnormal when he or she has been admitted to a psychiatric hospital. While that certainly should be a strong indication of psychiatric illness, community and cultural standards and values are often involved with that decision. Obnoxious teenagers, delinquents, and children whose parents become frustrated with them can often find themselves hospitalized for reasons that do not really reflect true psychological abnormality. Many
subcultures within our society tolerate the idiosyncrasies of their members and never would consider them “abnormal” or admit them to a hospital. Move them out of that subculture, and they may immediately find themselves viewed as mentally ill.

Psychologist David Rosenhan and his colleagues performed a classic study in the early 1970s in which he sent eight of his graduate students into psychiatric admissions offices to act as pseudo patients. They were told only to complain of hearing a voice say “thud” or “empty.” Every pseudo patient was admitted to an inpatient unit, but after admission, feigned no other symptoms or strange behavior. They behaved normally and made no further attempt to present as sick. Nevertheless, the staff continued to view them as ill, interpreting all of their behavior from the prism of the original diagnosis of psychosis. If they walked around the ward when they were bored, staff interpreted that behavior as resulting from anxiety. If they became appropriately angry at an attendant who mistreated them, they were seen as projecting the rage stemming from some delusion. In effect, every normal behavior was viewed as abnormal. When the pseudo patients were finally discharged after an average of 19 days, all were diagnosed as Schizophrenia, Residual Type. Here we see a most vivid example of the power of a psychiatric diagnosis and how even trained staff perceive abnormality in the most subjective way, based solely a single and ultimately faked symptom (“thud.”).

As a result of the rather subjective nature of psychiatric diagnosis and the ambiguity surrounding the concept of abnormality, many researchers and clinicians have challenged the application of the medical or disease model to psychological problems. Albert Bandura, a noted psychologist, has written that psychopathology or “abnormality” is really a function of social judgments we make when others deviate from social norms regarding “appropriate” behavior. He describes this as social labeling of deviant behavior. He goes on to list several bases we use in making these social judgments.

First, we take into consideration the appropriateness of the individuals’ behavior to a particular situation. If we experience the consequences of their behavior as positive, we view the behavior as positive. If it has a negative effect on us, their behavior now is labeled as deviant. A very quiet police recruit who rarely speaks and never challenges a very rigid, demanding sergeant may be seen as extremely cooperative and pleasant. When the same recruit goes to a SWAT team simulation and is expected by the training officer to be active and aggressive, his identical behavior may be seen as depressed and uncooperative. The behavior did not change, but the evaluation of its appropriateness to the situation had.

A second basis of social judgment revolves around behavioral deficits or the lack of necessary skills and behaviors to cope with problems. These deficits are labeled as symptoms of disorders when consequences are troublesome and problems are handled poorly. A firefighter who is
promoted to Assistant Chief may have difficulty disciplining his men because he is concerned that they “like” him. He has great difficulty in setting limits, ordering others to perform tasks and may be labeled by his superiors as “needy,” “dependent,” and “insecure.” When he is demoted to a basic firefighter position, the same behavior is perceived as “cooperative” and “non-authoritarian.” The only thing that has changed is the role he played. In one role he is labeled “deviant” and in the other as quite healthy.

The ability of the judge to understand the actor’s intention is a third basis of social judgment. When an individual’s intention or motivation for a particular act is not understood, that behavior is likely to be labeled as deviant or mentally ill. Take the example of a teenage boy who follows an elderly woman into an alley noticing that she has a very big purse. He walks up to her, strikes her on the head with a crowbar and leaves the scene without taking anything. How would a police officer typically label that behavior, as a sign of delinquency or as a product of psychiatric illness? Imagine the same scenario, but this time the boy takes the purse. Delinquency or mental illness? When the intention for striking her does not appear obvious and is not understood by the officer, the most typical perception is that the behavior would be labeled mental illness, while the more obvious, “understandable” behavior that involved stealing would be seen as delinquency. Remember that the assaultive behavior is identical in both situations. Basically, when we do not understand someone’s behavior, we are prone to call it mental illness. How does the judgment of the assaultive behavior change if we suggest that in the first example, the teenager was required to assault the woman as part of his induction into a street gang?

The personal attributes of an individual like age, sex, and occupation serve as a fourth basis of judgment. Certain behaviors are considered appropriate for one sex or at one age, but not for others. One gender-based example involves assertiveness. Assertive men in leadership roles often are considered strong, “go-getting,” and competent, while women displaying the same behavior are frequently labeled as aggressive, mean spirited, and controlling. Thumb sucking at two years old is perceived as quite normal, until the very same behavior manifests itself at ten years old when it is viewed quite negatively as a sign of emotional problems. In these examples, the behavior is labeled “abnormal” as a function of a personal characteristic rather than on the nature of the behavior itself.

Keep in mind that the value and social judgments that come into play in these examples of behavior play a far more insignificant role in the diagnosis of physical illness. Consequently, it is incumbent on us to be aware of our own values, background and culture when we evaluate an individual’s behavior as “abnormal.”

As we can see, our ability to define abnormality and normality is a highly complex process involving a number of factors. Regardless of the
complexity, First Responders will be called upon regularly to make these judgments and will need some basic criteria to support their decisions. The following represent fairly broad areas that define abnormality in rather abstract terms. More specific information regarding several psychiatric disorders and how to recognize them will be provided in the subsequent chapters.

Defective psychological functioning is one major criterion of abnormality. Specifically, impairments in attention, concentration, perception, judgment and memory all result in serious behavioral problems, including disorders like dementia, attention deficit disorder, psychosis and depression. When these functions are disturbed, judgments of abnormality are typically made. Defective social functioning is a second criterion of psychopathology. Here we will encounter mentally ill individuals who cannot refrain from engaging in behavior that is drastically at variance with the cultural norm. This is in contrast to the criminal who is more typically unwilling, rather than unable, to conform. Signs in our culture of defective social functioning include inadequate control of aggression, significant distrust and suspicion, and the inability for self-care and autonomy. A related criterion is basic loss of control. Many individuals are unable to control not only aggression, but their thoughts, fears and moods. Obsessive-compulsive patients are plagued by unwanted thoughts and rituals; phobic individuals understand intellectually that a bridge is safe to cross, but cannot bring themselves to drive over it; bipolar patients are tormented by their mood swings which seem to have a life of their own. They are all out of control. Society, including law enforcement officers, firefighters and emergency medical personnel, also serve to define abnormality along with family friends and mental health professionals. As we saw above, we all make social judgments that play an important role in how others are viewed. Finally, the last criterion of abnormality is the self-evaluation of our own behavior and feelings. Feelings of anxiety, depression, guilt and general subjective distress will play a very significant role in understanding abnormality and represent the most common basis for an individual to seek help from mental health professionals.

**SUGGESTED READINGS**


