The Conundrums of Psychology

1st EDITION

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CONTENTS

On Dis-ease

By: Dr. Sam Vaknin

We are all terminally ill. It is a matter of time before we all die. Aging and death remain almost as mysterious as ever. We feel awed and uncomfortable when we contemplate these twin afflictions. Indeed, the very word denoting illness contains its own best definition: dis-ease. A mental component of lack of well being must exist SUBJECTIVELY. The person must FEEL bad, must experience discomfiture for his condition to qualify as a disease. To this extent, we are justified in classifying all diseases as "spiritual" or "mental".

Is there any other way of distinguishing health from sickness - a way that does NOT depend on the report that the patient provides regarding his subjective experience?

Some diseases are manifest and others are latent or immanent. Genetic diseases can exist - unmanifested - for generations. This raises the philosophical problem or whether a potential disease IS a disease? Are AIDS and Haemophilia carriers - sick? Should they be treated, ethically speaking? They experience no dis-ease, they report no symptoms, no signs are evident. On what moral grounds can we commit them to treatment? On the grounds of the "greater benefit" is the common response. Carriers threaten others and must be isolated or otherwise neutered. The threat inherent in them must be eradicated. This is a dangerous moral precedent. All kinds of people

threaten our well-being: unsettling ideologists, the mentally handicapped, many politicians. Why should we single out our physical well-being as worthy of a privileged moral status? Why is our mental well being, for instance, of less import?

Moreover, the distinction between the psychic and the physical is hotly disputed, philosophically. The psychophysical problem is as intractable today as it ever was (if not more so). It is beyond doubt that the physical affects the mental and the other way around. This is what disciplines like psychiatry are all about. The ability to control "autonomous" bodily functions (such as heartbeat) and mental reactions to pathogens of the brain are proof of the artificialness of this distinction.

It is a result of the reductionist view of nature as divisible and summable. The sum of the parts, alas, is not always the whole and there is no such thing as an infinite set of the rules of nature, only an asymptotic approximation of it. The distinction between the patient and the outside world is superfluous and wrong. The patient AND his environment are ONE and the same. Disease is a perturbation in the operation and management of the complex ecosystem known as patient-world. Humans absorb their environment and feed it in equal measures. This on-going interaction IS the patient. We cannot exist without the intake of water, air, visual stimuli and food. Our environment is defined by our actions and output, physical and mental.

Thus, one must question the classical differentiation between "internal" and "external". Some illnesses are considered "endogenic" (=generated from the inside). Natural, "internal", causes - a heart defect, a biochemical

imbalance, a genetic mutation, a metabolic process gone awry - cause disease. Aging and deformities also belong in this category.

In contrast, problems of nurturance and environment - early childhood abuse, for instance, or malnutrition - are "external" and so are the "classical" pathogens (germs and viruses) and accidents.

But this, again, is a counter-productive approach. Exogenic and Endogenic pathogenesis is inseparable. Mental states increase or decrease the susceptibility to externally induced disease. Talk therapy or abuse (external events) alter the biochemical balance of the brain. The inside constantly interacts with the outside and is so intertwined with it that all distinctions between them are artificial and misleading. The best example is, of course, medication: it is an external agent, it influences internal processes and it has a very strong mental correlate (=its efficacy is influenced by mental factors as in the placebo effect).

The very nature of dysfunction and sickness is highly culture-dependent. Societal parameters dictate right and wrong in health (especially mental health). It is all a matter of statistics. Certain diseases are accepted in certain parts of the world as a fact of life or even a sign of distinction (e.g., the paranoid schizophrenic as chosen by the gods). If there is no dis-ease there is no disease. That the physical or mental state of a person CAN be different - does not imply that it MUST be different or even that it is desirable that it should be different. In an over-populated world, sterility might be the desirable thing - or even the occasional epidemic. There is no such thing as ABSOLUTE dysfunction. The body and the mind

ALWAYS function. They adapt themselves to their environment and if the latter changes - they change. Personality disorders are the best possible responses to abuse. Cancer may be the best possible response to carcinogens. Aging and death are definitely the best possible response to over-population. Perhaps the point of view of the single patient is incommensurate with the point of view of his species - but this should not serve to obscure the issues and derail rational debate.

As a result, it is logical to introduce the notion of "positive aberration". Certain hyper- or hypo- functioning can yield positive results and prove to be adaptive. The difference between positive and negative aberrations can never be "objective". Nature is morally-neutral and embodies no "values" or "preferences". It simply exists. WE, humans, introduce our value systems, prejudices and priorities into our activities, science included. It is better to be healthy, we say, because we feel better when we are healthy. Circularity aside - this is the only criterion that we can reasonably employ. If the patient feels good - it is not a disease, even if we all think it is. If the patient feels bad, ego-dystonic, unable to function - it is a disease, even when we all think it isn't. Needless to say that I am referring to that mythical creature, the fully informed patient. If someone is sick and knows no better (has never been healthy) - then his decision should be respected only after he is given the chance to experience health.

All the attempts to introduce "objective" yardsticks of health are plagued and philosophically contaminated by the insertion of values, preferences and priorities into the formula - or by subjecting the formula to them altogether. One such attempt is to define health as "an increase in order or efficiency of processes" as contrasted with illness

which is "a decrease in order (=increase of entropy) and in the efficiency of processes". While being factually disputable, this dyad also suffers from a series of implicit value-judgements. For instance, why should we prefer life over death? Order to entropy? Efficiency to inefficiency?

Health and sickness are different states of affairs. Whether one is preferable to the other is a matter of the specific culture and society in which the question is posed. Health (and its lack) is determined by employing three "filters" as it were:

1. Is the body affected?
2. Is the person affected? (dis-ease, the bridge between "physical" and "mental illnesses)
3. Is society affected?

In the case of mental health the third question is often formulated as "is it normal" (=is it statistically the norm of this particular society in this particular time)?

We must re-humanize disease. By imposing upon issues of health the pretensions of the accurate sciences, we objectified the patient and the healer alike and utterly neglected that which cannot be quantified or measured - the human mind, the human spirit.

Back to Table of Contents

The Normal Personality

First published here: "Personality Disorders (Suite101)"

By: Dr. Sam Vaknin

In their opus magnum "Personality Disorders in Modern Life", Theodore Millon and Roger Davis define personality as:

"(A) complex pattern of deeply embedded psychological characteristics that are expressed automatically in almost every area of psychological functioning." (p. 2)

The Diagnostic and Statistical Manual (DSM)) IV-TR (2000), published by the American Psychiatric Association, defines personality traits as:

"(E)nduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts." (p. 686)

Laymen often confuse and confute "personality" with "character" and "temperament".

Our temperament is the biological-genetic template that interacts with our environment.

Our temperament is a set of in-built dispositions we are born with. It is mostly unalterable (though recent studies demonstrate that the brain is far more plastic and elastic than we thought).

In other words, our temperament is our nature.

Our character is largely the outcome of the process of socialization, the acts and imprints of our environment and nurture on our psyche during the formative years (0-6 years and in adolescence).

Our character is the set of all acquired characteristics we posses, often judged in a cultural-social context.

Sometimes the interplay of all these factors results in an abnormal personality.

Personality disorders are dysfunctions of our whole identity, tears in the fabric of who we are. They are all-pervasive because our personality is ubiquitous and permeates each and every one of our mental cells. I just published the first article in this topic titled "What is Personality?". Read it to understand the subtle differences between "personality", "character", and "temperament".

In the background lurks the question: what constitutes normal behavior? Who is normal?

There is the statistical response: the average and the common are normal. But it is unsatisfactory and incomplete. Conforming to social edicts and mores does not guarantee normalcy. Think about anomic societies and periods of history such as Hitler's Germany or Stalin's Russia. Model citizens in these hellish environments were the criminal and the sadist.

Rather than look to the outside for a clear definition, many mental health professionals ask: is the patient functioning and happy (ego-syntonic)? If he or she is both then all is

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