

Journal of Humanistic Psychology

<http://jhp.sagepub.com>

Political Apathy Disorder: Proposal for a New DSM Diagnostic Category

Geoffrey D. White

Journal of Humanistic Psychology 2004; 44; 47

DOI: 10.1177/0022167803259255

The online version of this article can be found at:
<http://jhp.sagepub.com/cgi/content/abstract/44/1/47>

Published by:



<http://www.sagepublications.com>

On behalf of:



[Association for Humanistic Psychology](#)

Additional services and information for *Journal of Humanistic Psychology* can be found at:

Email Alerts: <http://jhp.sagepub.com/cgi/alerts>

Subscriptions: <http://jhp.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations <http://jhp.sagepub.com/cgi/content/refs/44/1/47>

POLITICAL APATHY DISORDER: PROPOSAL FOR A NEW DSM DIAGNOSTIC CATEGORY



GEOFFRY D. WHITE is the editor of "Campus, Inc: Corporate Power in the Ivory Tower," concerning the intrusion of big business into higher education. He has received humanitarian awards from the California Psychological Association and the Los Angeles Psychological Association for his work with trauma victims in the Balkans and Africa. He was also a volunteer with Green Cross Projects assisting survivors of the September 11 disaster. He is currently working on the screenplay adaptation of "Were We Our Brothers Keepers," about the controversy surrounding the

inaction of American Jews between 1938 and 1944 to the Holocaust.

Summary

Political Apathy Disorder (PAD) is proposed as a new *DSM* diagnostic category for the failure to develop a social conscience. The essential feature is a pervasive pattern of failing to help reduce human suffering in the world combined with overconsumption of society's limited resources. Those suffering from PAD fulfill the basic *DSM* criteria of a mental disorder: distress, disability, and increased risk of suffering death, pain, disability, or an important loss of freedom. It is proposed that failure to achieve the characteristics necessary to live a constructive moral life that benefits society should be considered grounds for inclusion in the diagnostic nomenclature.

Keywords: *psychopathology; diagnosis; political psychology; apathy*

All it takes for evil to exist is for good people to do nothing.

—Edmund Burke

Journal of Humanistic Psychology, Vol. 44 No. 1, Winter 2004 47-57
DOI: 10.1177/0022167803259255
© 2004 Sage Publications

The official diagnostic system of the American Psychiatric Association (APA, 1994) is an evolving approach to the classification of mental disorders, criticized by some (Caplan, 1996) and revered by others. Its primary purpose is to “provide a helpful guide to clinical practice” (p. xv). As such, insightful and creative clinicians have suggested new diagnostic categories, keeping pace with our changing culture and enlightened ways of thinking. One example is Levy’s (1992) Pervasive Labeling Disorder.

Political Apathy Disorder (PAD) is proposed as a new *Diagnostic and Statistical Manual of Mental Disorders (DSM)* Axis II (Personality Disorder) category. The essential feature is a pervasive pattern of failing to help reduce the suffering of others (particularly the underprivileged, oppressed, and poor) combined with overconsumption of society’s limited resources.

As used here, the concept of *political* does not refer to the science of government but rather how the resources of a society are managed (DeLaney, 1995; McLean, 1996). The questions relevant to the current proposal are, Who owns, manages, controls, distributes, and benefits from society’s resources?

Therapists are typically concerned about how their patients’ suffering is related to important relationships in their life (parents, siblings, and spouses), yet they almost never ask how that pain is connected to the world (Mindell, 1996). “Not one of the approximately 360 diagnoses of the DSM IV . . . makes any connection between our emotional disturbances and the state of the world” (Greenspan, 2003). The current proposal attempts to correct this apparent oversight.

PAD is consistent with the *DSM-IV* definition of a mental disorder (APA, 1994): “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with (1) *present distress* (e.g., a painful symptom) or (2) *disability* (i.e., impairment in one or more important areas of functioning) or with (3) a *significantly increased risk* of suffering death, pain, disability, or an important loss of freedom” (p. xxi).

Present distress. Those suffering from PAD are not likely to attribute their distress (which may include anxiety, depression, paranoia, hypochondria, addictions, and eating disorders) to the absence of a social conscience. Similarly, individuals with Narcissistic or Antisocial Personality Disorder often do not see the relationship between their suffering and their psychopathology. In some cases, however, a social conscience may have once existed but

has since atrophied. Such individuals have moved past despair and demoralization into apathy where they no longer care about their lack of motivation to help others (Marin, 1990). This is similar to cases of low or absent sexual desire (Kaplan, 1995), where the condition is not experienced as distressing (except perhaps to the sexual partner). Nonetheless, it is clear to the clinician that the person is in the grips of the “dysfunction regulation of a motivational state” (Kaplan, 1995) similar to anorexia nervosa (where the desire for food is absent).

In certain cases, the lack of distress may reflect the co-occurrence of other disorders such as Narcissistic Personality Disorder or Antisocial Personality Disorder. These two conditions, both Cluster B Personality Disorders (APA, 1994, pp. 629-630), can be distinguished from PAD in several ways. For one, individuals with PAD often exhibit empathy—a quality lacking in Narcissistic and Antisocial Personality Disorders—for family, friends, pets, and others in their immediate community. The problem is that they lack sufficient empathy and compassion to compel action on behalf of those outside their inner circle.

Those with PAD may complain of a wide range of symptoms. Lasn and Grierson (2000) recently described “malignant sadness,” a postmodern mood disorder: “On the crest of the boom, there is sadness. In a time of peace, there is anxiety. Amidst unprecedented stimulation, there is boredom. Just what’s going on?” The boom of the 90s is over but Lasn’s concerns continue to be valid. As for what’s going on, Wachtel (1989) has speculated about the cause of malignant sadness in his book, *The Poverty of Affluence*: “Ironically, no amount of things can ever meet the nonmaterial needs formerly met by community.” The work of Kasser (2002) and his colleagues clearly demonstrates the disturbing relationship between materialism and psychopathology (e.g., lower self-esteem, increased anxiety, high-risk behavior, and decreased generosity).

There are other interesting, if unexpected, associated conditions. Riebel (2001) suggests that certain “eating disorders, which involve the misuse of vast quantities of food by millions of people, are a direct threat to the environment. Eating disorders are also suggested as a metaphor for the psychopathology underlying our environmental crisis” (p. 38). Riebel points out that 55% of the U.S. population is overweight, half of those being clinically obese. This amounts to 97 million adults. Overconsumption of food (e.g., obesity, bulimia) is not enough in itself to qualify as PAD but may be an important symptom. Riebel sees eating disorders as both the

cause and the effect of socially irresponsible behavior with respect to the environment.

Overconsumption is also exemplified in the recent corporate scandals involving people such as Kenneth Lay of Enron fame (Tran, 2002). Lay and his robber baron cronies looted the company to the tune of hundreds of millions of dollars leaving nothing for loyal lower level employees, not to mention thousands of shareholders who were depending on Enron stock as their retirement security. It is likely in cases such as these that several personality disorders in addition to PAD will be present (e.g., Antisocial Personality Disorder and Narcissistic Personality Disorder).

Disability (impairment in one or more important areas of function). PAD reflects a failure in social functioning: failure to engage in activity designed to reduce the suffering of others. This may be related to recent work on the importance of early attachment in the development of self-regulation (Shore, 1995). Bandura (1990, 1999) has written about the role of self-regulation of moral conduct (Bandura, 1999):

Moral agency is manifested in both the power to refrain from behaving inhumanely and the proactive power to behave humanely. Moral agency is embedded in a broader sociocognitive self-theory encompassing self-organizing, proactive, self-reflective and self-regulatory mechanisms rooted in personal standards linked to self-sanctions. (p. 193)

Bandura's theory of moral agency has two components. One is concerned with self-sanctions against inhumane conduct. Those with Antisocial Personality Disorder are likely to have deficits in this self-regulatory ability. The other component is concerned with positive self-sanctions for positive conduct. This is where one may find deficits for those with PAD. Bandura has several additional concerns. One is that "psychological theories of morality focus heavily on moral thought to the neglect of moral conduct." Ultimately, it is a person's behavior that is the issue in the social arena where organized behavior is necessary to create a humane society.

If caretaker-infant attachment problems lead to self-regulatory dysfunction, it should not be surprising to find overlap between personality disorders. PAD and Antisocial Personality Disorder represent two sides of the same moral coin. Both conditions concern moral deficiencies. That is, a moral issue exists whenever one

is in a position to help or hurt another person (Dobrin, 1993). The official psychiatric diagnosis system (the *DSM*) only recognizes half the moral spectrum. The individual with Antisocial Personality Disorder (formerly referred to as a psychopath) violates the rights of others through acts of violence, theft, destruction of property, and "blue-collar" crime.

The *DSM* may have a "class bias" in that it only classifies tendencies to behave inhumanely that are more typical of underprivileged groups. The official diagnostic system (APA, 1994) defines Antisocial Personality Disorder as "a pattern of disregard for, and violation of, the rights of others" (p. 629). Failure to help, however, can produce the same ill effects as actively harming someone. Passivity, indifference, and inaction are what Edmund Burke (1964) had in mind when he wrote, "All it takes for evil to exist is for good people to do nothing." One may reasonably ask why there is no *DSM* diagnostic category for selfish and greedy overconsumption and for failure to help those in need.

A partial explanation for this bias may be found in the Freudian underpinnings of the diagnostic system. In a series of papers, particularly the one titled "Psychoanalysis and Moral Apathy: The Case of the Unpatriotic Prostitute," Carl Goldberg (1998, 1999) states,

My thesis is that Freud's lack of responsiveness to the importance of community and social responsibility of analytic patients has prevented psychoanalysis from developing a theory of moral imperatives for human behavior. Moreover, this insufficiency has not only hindered analysts from their moral and social responsibilities for others, it also has had a subversive effect on American society as well. (p. 221)

To the extent that the *DSM* and clinical practice have been influenced by psychoanalytic theory, Goldberg's thesis supports the concept of PAD. Goldberg (1998) is proposing that psychoanalytic theory expand to include notions of compassion and responsibility to others "rather than to affluence and influence" (p. 229), instead of hoping that a mature sense of social responsibility will automatically develop in a successfully analyzed patient.

Denial and rationalization are two of the key defense mechanisms used to defend against the awareness of the overwhelming suffering. Poverty in the world today is widespread (United Nations, 1998): "Human poverty is multidimensional. More than a

lack of what is necessary for material well-being, poverty can also mean the denial of opportunities and choices most basic to human development" (p. 16). One need look no further than the 50 million Americans who lack health insurance or the one in five children in states such as California who go to bed hungry each night (Ellis, 1997; McGovern, 1998).

Suffering and injustice in the world today are unacceptably high. The question is, what do we do with this knowledge about the suffering of others and what does this knowledge do to us (Cohen, 2001)? A common reaction is to block it out. "People react as if they do not know what they know. Or else the information is registered but its implications are ignored. People seem apathetic, passive, indifferent and unresponsive—and they find convenient rationalizations to explain themselves" (p. x).

Significantly increased risk of suffering death, pain, disability, or an important loss of freedom. Although this criterion was originally intended to apply to the individual, it can equally apply to the effect of PAD on others. For example, it is clear that failure to help can produce the same ill effects as actively harming another person. The famous case of Kitty Genovese—which led to the concept of the passive bystander—is a classic illustration of how minding your own business can lead to the death of an innocent person. On a hot summer night in Manhattan, Kitty's neighbors listened to her screams as her rapist returned again and again, raping and beating her to death (Aronson, 1992). No one so much as made a phone call to the police to help her. The truly frightening story, of course, is how common these occurrences are in American society.

PAD is proposed to fill the moral vacuum in the *DSM* by creating a category of mental disorder reflecting the failure to help others when helping is possible. Indeed, an essential feature of theories of moral development (Erikson, 1950; Gilligan, 1982; Kohlberg, 1964) contains the notion that mature phases of adult development include helping one's fellow human. Erik Erikson refers to the crisis of middle adulthood (ages 40 to 65) as "Generativity versus Stagnation." Generativity is an adult's ability to look outside himself or herself and care for others. Kohlberg's highest stage of moral development (Universal Ethical Principle orientation) defines a moral responsibility to make societal changes regardless of consequences to oneself.

More recently, Gilligan's (1982) research distinguishes between male and female approaches to morality. The male approach is that individuals have certain basic rights that must be respected. Thus, morality imposes restrictions on what you can do. The female approach to morality is that people have responsibilities toward others. In this case, morality is an imperative to care for others. Gilligan summarizes this by saying that male morality has a "justice orientation" and that female morality has a "responsibility orientation." The notion of PAD is obviously more grounded in the female approach.

Helping when possible suggests that the resource-rich members of society bear a greater responsibility and moral obligation to help. This is supported by the fact that the citizens of wealthy nations consume a disproportionate share of the world's limited resources (United Nations, 1998, p. 46). Thus, the diagnosis of PAD depends on assessing an individual's helping behavior relative to their net worth and opportunities. An illustration can be found in the business press. A report and survey by John Byrne (2002) in *Business Week* focused on patterns of giving (philanthropy) by wealthy individuals. The article contained a section on "cheap-skates," that is, billionaires who give a lot of money but where it is a relatively tiny percentage of their net worth (e.g., Rupert Murdoch, Warren Buffett). These individuals exhibit a key feature of PAD because they "give back" to society relatively little in proportion to their resources.

It is significant that the term *morality* is absent from the index of the *DSM-IV* and one is hard put to find it anywhere in the text. Nevertheless, the description of Antisocial Personality Disorder clearly invokes the notion of morality when it says that "deceit and manipulation" are central features of this disorder (APA, 1994, p. 645). As discussed earlier, moral issues arise every time there is a choice about helping or hurting others. In fact, it is precisely moral deficits that characterize Antisocial Personality Disorder.

Indeed, traditional moral philosophers considered their tasks incomplete until they specified the mentality and motivational structure of reliable moral agents who could be counted on to affect the world in a certain way (Rorty, 1993). It is being proposed here that failure to achieve the characteristics necessary to live a constructive moral life that benefits society should be considered grounds for inclusion in the diagnostic nomenclature.

Clinical implications. Psychopharmacologists and medication-oriented clinicians reading this proposal may begin to speculate about how to medicate PAD. It is more likely that individuals with PAD are overmedicated. If anything is “prescribed,” it should be more along the lines of participating in political action such as joining organizations, campaigns, and demonstrations. Such activity has been shown to produce “an improvement in psychological well-being that can help overcome stress, pain, anxiety and depression” (Reuter’s Health, 2002).

Clinicians can begin using PAD as part of their diagnostic armamentarium. The *DSM* contains a category (301.9—Personality Disorders Not Otherwise Specified) that allows for diagnosing “a specific personality disorder that is not included in the classification . . . This category can be used when the clinician judges that a specific Personality Disorder that is not included in the Classification is appropriate” (p. 673). Consequently, PAD can be used for an Axis II diagnosis if the clinician believes that the criteria (see below) have been met.

Future research and refinement of the concept of PAD will be aided by the recent development of an inventory (the Activism Orientation Scale) designed to measure individuals’ propensities to engage in social action (Corning & Myers, 2002). This scale cuts across a wide variety of ideological positions and thus is not specific to a particular political orientation. It will be useful in understanding how an activist identity develops and how it can be nurtured.

With these ideas in mind, the following criteria are offered as a beginning attempt to describe this new syndrome.

Political Apathy Disorder—Diagnostic criteria for 301.88

- A. Current age at least 18.
- B. A pattern of irresponsible and politically apathetic behavior including the overconsumption of society’s limited resources. Must have at least four of the following:
 - 1. Does not carefully consider the effect on others when thinking about making a purchase. For example, (a) buys clothing without determining if it is produced by child or sweatshop labor in third-world countries; (b) does not weigh the pros and cons of buying from national chain stores (e.g., Gap, Starbucks, Walmart) versus independent merchants.
 - 2. Does not carefully consider the effect of purchases and lifestyle on the environment. For example, (a) buys an SUV (sports utility vehicle) without awareness that they emit five times the toxic emis-

sions as a conventional vehicle and have 10 times the risk of causing serious injury to passengers in a conventional vehicle during a collision; (b) does not re-recycle; (c) would not consider buying an electric or hybrid car because it is "not stylish."

3. Lifestyle is determined more by strivings for wealth, attractiveness, and fame rather than intimacy, personal growth, and contributions to the community. For example, (a) spends more time and money on luxury vacations, expensive cars, cosmetic surgery (including botox injections), and nonessential clothing than on community building and social justice projects and being with family and friends; (b) conversations at home and at social events reflect strivings for wealth, money, power, prestige over affiliation, interpersonal concern, community involvement, and political activity; (c) money and power dominate approach to life.
 4. Self-worth is based primarily on financial worth, social status, and material possessions. This is often exhibited as a temporary sense of satisfaction with new purchases, followed by increased dissatisfaction that drives further materialistic behavior. For example, buys a new home (or does extensive remodeling) when current home is more than satisfactory.
 5. Is not involved in social or political organizations that work for the common good, a more humane society, equal rights, and a decent lifestyle that includes but is not limited to education, health care, housing, and child care.
 6. Does not understand the difference between moral sentiment and moral action. For example, verbalizes concern about social problems (poverty, injustice, racism, war) but does nothing about them.
 7. Is not informed from diverse points of view (the political right, left, and center) about events, critical issues in society, and relevant history. Does not consume print and broadcast news from the full range of the political spectrum. For example, reads only the corporate-owned newspapers (*New York Times*, *Los Angeles Times*, *San Francisco Chronicle*) and the like.
 8. Does not vote in midterm and general elections. For example, does not carefully study the issues; waits until in the voting booth to read the pamphlet.
 9. Engages in elitist activity. For example, lives in a gated community; tries to get out of jury duty.
 10. Talks a lot about what he or she owns, plans to buy, and what others own.
 11. Political conservatism to the extent it reflects justification of social and economic inequalities (Jost, Glaser, Kruglanski, & Sulloway, 2003).
- C. Occurrence of three or more of the following thoughts or statements when asked, "Why aren't you actively involved in social issues and the political process?"
1. "I don't have the time."
 2. "I'm already helping the world through my profession" (e.g., psychologist, physician, or other health care professional).

3. "One person can't make a difference."
 4. "If I can't fix everything, then what's the use of fixing anything?"
 5. "Smarter people than myself aren't doing anything."
 6. "I don't know enough about the situation to make an intelligent decision about what to do."
 7. "I'll get involved—later."
 8. "I'm a good person—that's all that counts."
 9. "I meditate and/or pray for peace."
 10. "What's the problem? The world is doing fine."
- D. Occurrence of Political Apathy Disorder not exclusively during the course of major mental disorder (schizophrenia, bipolar disorder), mid-term elections, divorce, or basketball playoffs.
- E. May coexist with Narcissistic Personality Disorder and Antisocial Personality Disorder.
- F. Work done for pay by a health care professional is not sufficient in itself to count as social activism or political activity.

Must fulfill Criteria A through F.

REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Aronson, E. (1992). *The social animal*. New York: Freeman.
- Bandura, A. (1990). Selective activation and disengagement of moral control. *Journal of Social Issues*, 46(1), 27-46.
- Bandura, A. (1999). Moral disengagement in the perpetration of inhumanities. *Personality and Social Psychology Review*, 3, 193-209.
- Burke, E. (1964). *Encyclopedia britannica*. London: Oxford.
- Byrne, J. A. (2002, December 2). The new face of philanthropy. *Business Week*, pp. 22-28.
- Caplan, P. (1996). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal*. New York: Basic Books.
- Cohen, S. (2001). *States of denial: Knowing about atrocities and suffering*. Malden, MA: Polity.
- Corning, A. F., & Myers, D. J. (2002). Individual orientation toward engagement in social action. *Political Psychology*, 23(4), 703-729.
- DeLaney, A. (1995). *Politics for dummies*. Foster City, CA: IDG Books.
- Dobrin, A. (1993). *Being good and doing right*. New York: New York University Press of America.
- Ellis, V. (1997, July 10). Poverty rate among state's children rises sharply. *Los Angeles Times*, p. 6.
- Erikson, E. H. (1950). *Childhood and society*. New York: Norton.
- Gilligan, C. (1982). *In a different voice*. Cambridge, MA: Harvard University Press.

- Goldberg, C. (1998). The indifference of psychoanalytic practice to social and moral responsibility. *International Journal of Psychotherapy*, 3(3), 221-230.
- Goldberg, C. (1999). Psychoanalysis and moral apathy: The case of the unpatriotic prostitute. *International Journal of Psychotherapy*, 4(3), 329-336.
- Greenspan, M. (2003). Healing through the dark emotions in an age of global threat. *Tikkun*, 18(2), 19-23.
- Jost, J. T., Glaser, J., Kruglanski, A. W., & Sulloway, F. J. (2003). Political conservatism as motivated social cognition. *Psychological Bulletin*, 129, 339-375.
- Kaplan, H. (1995). *The disorders of sexual desire: Dysfunctional regulation of sexual motivation*. New York: Brunner/Mazel.
- Kasser, T. (2002). *The high price of materialism*. Cambridge, MA: MIT Press.
- Kohlberg, L. (1964). Development of moral character and moral ideology. In M. Hoffman & L. Hoffman (Eds.), *Review of child development research* (pp. 13-57). New York: Russell Sage.
- Lasn, K., & Grierson, B. (2000, June/July). Malignant sadness. *Adbusters*, pp. 28-39.
- Levy, D. (1992). A proposed category for the diagnostic and statistical manual of mental disorders (DSM): Pervasive labeling disorder. *Journal of Humanistic Psychology*, 32(1), 121-125.
- Marin, R. S. (1990). Differential diagnosis and classification of apathy. *American Journal of Psychiatry*, 147(1), 22-30.
- McGovern, G. (1998, November 23). Too many in the world are left out. *Los Angeles Times*, p. 18.
- McLean, I. (1996). *The concise Oxford dictionary of politics*. Oxford: Oxford University Press.
- Mindell, A. (1996). Discovering the world in the individual: The world channel in psychotherapy. *Journal of Humanistic Psychology*, 36(3), 67-84.
- Reuter's Health. (2002, December 23). *Protesting may be good for your health*. Available from: <http://www.reuters.com/newsArticle.jhtml>
- Riebel, L. (2001, Spring). Consuming the earth: Eating disorders and ecopsychology. *Journal of Humanistic Psychology*, 41(2), 38-58.
- Rorty, A. O. (1993). What it takes to be good. In G. Noam & T. E. Wren (Eds.), *The moral self* (pp. 47-63). Cambridge, MA: MIT Press.
- Shore, A. (1995). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Lawrence Erlbaum.
- Tran, M. (2002, January 24). Kenneth Lay: Enron's embattled ex-chairman. *The Guardian*. Available from: <http://www.guardian.co.uk/enron/story/0,11337,638645,00.html>
- United Nations. (1998). *Human development report*. New York: Oxford University Press.
- Wachtel, P. (1989). *The poverty of affluence*. Philadelphia: New Society.

Reprint requests: Geoffry D. White, 2566 Overland Avenue, Suite 780, Los Angeles, CA 90064; e-mail: GeoffryW@aol.com.