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# Doctoral Disorder of Adulthood

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A misunderstood and poorly researched developmental disorder is being proposed to the American Psychiatric Association as a category needing further study. The signs and symptoms of this disorder are often confused with a number of other syndromes and disorders, making the condition extremely difficult to diagnose. Doctoral Disorder of Adulthood should not be confused with other affective disorders, such as Bipolar Disorder, Panic Disorder, Generalized Anxiety Disorder, or Post-Traumatic Stress Disorder (see American Psychiatric Association, 1987). It may be difficult to distinguish this disorder from schizophrenia, paranoid type, particularly in the terminal phase of the condition. Disruption in thought processes appears to be characteristic of the latter phases. The presence of delusions is not uncommon (e.g., "I can finish this dissertation in one semester," or "Now that I'm finished with course work everything is done!"). Paranoid hallucinations have even been noted (e.g., "The mainframe [computer] is trying to get me," or "My [doctoral] committee is conspiring against me").

*Age at onset.* The onset may occur at any time after the completion of a bachelor's degree. Males, on the average, develop the disorder at earlier ages (late 20s to early 30s) than do women. Although women appear to be particularly susceptible in the middle to late 30s, later onset is noted in numerous cases.

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*Course.* The course is variable, generally lasting from 2 to 5 years. Research indicates that a period of 10 years or more has been noted in extreme cases. An active phase of at least 6 months should be present before a diagnosis of Doctoral Disorder of Adulthood is given.

An early period of deterioration appears to precede the onset of the active phase of the condition. The residual trauma associated with the completion of the master's degree contributes to the person's confusion about beginning the doctoral program. During this period, a number of rationalizations may be offered for not applying for doctoral studies, such as (a) "A doctorate won't make me a better counselor," (b) "I don't think I could handle taking statistics," or (c) "I am a practitioner, not a researcher."

Furthermore, friends and relatives often notice an excessive tendency to dull, ruminative speech about the quality of doctoral programs. Hoarding behaviors such as collecting large piles of books about graduation examinations or files of material from doctoral programs is quite common. Anxiety and a marked lack of confidence about plans and decision making appear prior to the active phase.

The active phase begins after formal screening and planning of the doctoral program. During the active phase, disturbance in sleep and eating patterns, excessive anxiety, weight changes, fatigue, compulsive behaviors, obsessive thoughts, diminished pleasure in sex and most life activities, and withdrawal from social contacts are common. In the terminal phase, *dissertation dementia*, the patient may become incoherent, demonstrate catatonic behaviors and/or flat affect, and report hallucinations and delusions.

Residual effects, such as depression, lassitude, anxiety, and fatigue, may persist from several weeks to several years. During this period, certain phobias, including bibliophobia, researchaphobia, statistaphobia, and computaphobia, may appear and continue throughout the life span.

Although full remissions can occur, a return to premorbid functioning is rare. A tendency to ruminative, vague, and circumstantial speech is common, as are odd beliefs and peculiar behavior patterns. Research indicates that university professors are particularly prone to these patterns.

*Prevalence.* Detailed studies indicate that almost 99.5% of university professors have suffered from this disorder at one time. Studies of the *Dictionary of Occupational Titles* (U.S. Department of Labor, 1977) indicate that persons in occupations classified as professional are much more susceptible to the disorder than are those in other occupational clusters. Furthermore, certain occupational groups (e.g., clinical and counseling psychology, mental health counseling, social work, psychiatry) appear to be overrepresented in

the occurrence of the disorder. Other disorders, such as Law School Syndrome and Medical Internship Disorder, have been thought to be similar to this condition.

*Impairment.* In the early stages, impairment in social functioning appears to be mild to moderate. As the condition progresses, impairment in occupational, family, and social functioning may worsen. In advanced stages, the person may become oblivious to his or her surroundings and self-care may suffer. During the preparation of the dissertation, in particular, persons with this disorder may dress in eccentric costumes, and their personal hygiene may suffer (e.g., "I don't have time to take a shower now!").

Supervision of dietary intake may be necessary due to disturbances in eating habits (e.g., "I ate a quart of ice cream and three packages of oreo cookies while I coded data last night," or "I won't eat again until after I have my proposal meeting").

*Complications.* Frequent complications involve the development of Major Depression, Generalized Anxiety Disorder, and Substance Abuse disorders. Social withdrawal may result in long-term consequences to social relationships, with disruption in family life and divorce not uncommon.

*Predisposing factors.* Although it appears that persons who are most often predisposed to the disorder have a history of being excessively concerned with early school achievement, many actually expressed a dislike of school-related activities. Studies indicate that a tendency to compulsive behaviors may be linked to development of the disorder.

*Sex ratio.* Doctoral Disorder of Adulthood occurs at about the same rate in males as in females. The literature suggests, however, that when the disorder manifests in females the symptoms appear to be particularly severe and long lasting.

*Familial pattern.* This disorder is more common in first-degree biologic relatives of people with the disorder than in the general population. It is unclear whether genetic predisposition or environmental factors are the most influential in the development of symptoms.

*Differential diagnosis.* Active pursuit of a doctoral degree at a university granting such degrees appears to be the primary factor differentiating this diagnosis from such conditions as Major Depression, Bipolar Disorder, or



Generalized Anxiety Disorder. It should be noted that other disorders may be present in some sufferers, particularly Psychoactive Substance Use Disorders. Exacerbations of previously existing conditions appear to be common.

### Diagnostic Criteria for Doctoral Disorder of Adulthood

A. The primary criteria for diagnosis of this disorder is acceptance of and active participation in a university program granting doctoral degrees.

B. Diagnosis requires the presence of at least four of the following:

1. obsession with statistical language and rumination over terms such as "Type 1 error," "Multicollinearity," and "Homogeneity of variance"
2. extreme passivity with an overwhelming desire to please—most evident in the presence of doctoral committee members
3. complaints of extreme fatigue accompanied by a sallow complexion and dark circles under the eyes
4. predisposition to physical illness—particularly gastrointestinal distress, lower back pain, and respiratory illness
5. haggard appearance, unwashed hair, mismatched and unkempt clothing
6. daily disturbance in sleep patterns—insomnia or hypersomnia
7. peculiar eating patterns—binge eating, fasting, and forgetting to eat
8. disassociation with life events—inability to answer such questions as "What year is this? What is your age?"
9. shortness of breath and accelerated heart beat at the mention of multivariate statistics or computer language
10. lack of interest in pleasurable activities and a withdrawal from any social interaction that does not involve other doctoral students
11. presence of paranoid delusions, particularly persecutory delusions.

C. Continuous signs of the disturbance must be manifest for over 6 months.

#### *Classification of Course*

1. *Subchronic:* In the first year of the doctoral program, withdrawal from social situations and a tendency to disconnect from real-life (nonacademic) situations is only minor.
2. *Chronic*: Appearance of disturbances in sleep cycle, eating disturbances, and physical illness occurs in the second year. During this period, anxiety and questioning the reason that one began the doctoral program increase.
3. *Chronic with acute exacerbation*: This period coincides with taking higher level statistics courses and comprehensive examinations. Social

withdrawal, anxiety, and bizzare behavior interfere with daily functioning. Delusions and hallucinations appear during the dissertation process and may continue until the document is signed by the dean of the graduate school.

5. *In partial remission*: It appears that a partial remission of symptoms may be the most that can be hoped for in this disorder. Persons who have finished doctoral programs often have unusual thought patterns, circumstantial speech, and bizarre hoarding behaviors.
6. *In full remission*: The literature indicates that full remissions are rare and studies show that residual effects may continue indefinitely.

Specify *chronic* if the current episode has lasted 10 years or more and dissertation defense and final matriculation have not been achieved.

**Diagnostic Criteria for Dissertation Dementia**

There must be the presence of at least three of the following:

1. aggression and hostility toward anyone (except a committee member) who questions the dissertation topic or research methodology
2. inability to concentrate on or converse about any topic other than the dissertation topic
3. tendency to speak in computer and statistical language
4. tendency to bizarre behaviors, such as storing data sheets in the refrigerator
5. sitting motionless in front of a computer screen rereading the same sentence for hours
6. sleeping with a style manual under the pillow at night
7. carrying a current draft of the dissertation at all times
8. phobia of losing copies of articles pertinent to the dissertation
9. magical thinking (wearing same underwear to all committee meetings)
10. grandiose delusions (belief that the dissertation has some significance to anyone other than the writer).

Although only a small percentage of the general population develops this disorder, it appears that a substantial number of these persons are in the helping professions, such as mental health counseling or psychology. Treatment of the disorder by conventional psychotherapy has had mixed success. Pharmacological preparations appear to merely mask the symptoms and are of limited utility. It is hoped that recognition of this disorder will encourage research into the causes and treatment of this destructive condition.



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