A BARNES & NOBLE OUTLINE

ABNORMAL Psychology

WALTER J. COVILLE
TIMOTHY W. COSTELLO
FABIAN L. ROUKE

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PREFACE

This Outline presents a descriptive and interpretative summary of the field of abnormal behavior beginning with a discussion of the differences between the abnormal and the normal, tracing the history of man's efforts to understand deviations in behavior, and analyzing current theories which attempt to explain the development of personality and the causes of mental illness. After examining the various kinds of abnormal behavior in accordance with the most recent classification system of the American Psychiatric Association, this book describes diagnostic and therapeutic procedures and techniques used in the field of prevention. The Outline is not exclusively oriented toward any one school of thought, although the principal theoretical orientations are summarized objectively. This book may be used either in conjunction with a standard textbook or as a basic text to be supplemented by assigned outside readings in accordance with the preferences of the instructor.

In preparing this Outline, the authors had in mind its usefulness not only to the college student but also the general reader as well as practitioners in the fields of personnel, teaching, law, social service, religion, nursing and the medical specialties. They hope that for these groups it will provide a ready compendium of accurate and up-to-date factual material about human behavior. Particular care has been devoted to the index for this purpose.

For editorial assistance and constructive help in the organization of materials, the authors gratefully acknowledge their debt to Dr. Samuel Smith and to Mrs. Suzanne Della Corte of the Barnes and Noble staff, to Mr. George Cantzlaar, who smoothed their phrasing in many places, and who also prepared the index, and to Miss Dorothy Heslin, who typed the manuscripts.

ABNORMAL PSYCHOLOGY

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THE NATURE AND SCOPE OF ABNORMAL BEHAVIOR

The newcomer to the study of abnormal psychology does not approach the subject totally unprepared. Indeed, he is likely to come too well prepared—"conditioned" would be more to the point—with scattered bits of information and misinformation, preconceived notions, and fixed emotional prejudices toward abnormal people. Perhaps he has witnessed examples of bizarre behavior in public places or even in his own home; or he may have overheard or participated in family discussions about a mentally ill relative or friend. At the very least he has had ample glimpses of abnormal personalities in news releases and feature articles; in radio, television, and stage productions; and in books and magazines. In some of these instances the sources have been reliable and the content valid, but more often authenticity has suffered because the intention was to divert or shock rather than to enlighten.

Such isolated encounters with the subject of this Outline are not conducive to an ordered appreciation of the factors operative in abnormal behavior. Lacking are two of the requirements essential to the scientific method: controlled data and trained, unprejudiced observation. A more significant point, however, is that considerable disagreement prevails as to what constitutes abnormality. It is therefore necessary at the outset to bring this concept into proper perspective. This will be done in the present chapter by (1) discussing the relation between normal and abnormal, (2) describing the science of abnormal psychology and related disciplines, (3) examining the scope of the social and medical problems that are generated by personality disorders, and (4) finally, discussing the classification of mental disorders.

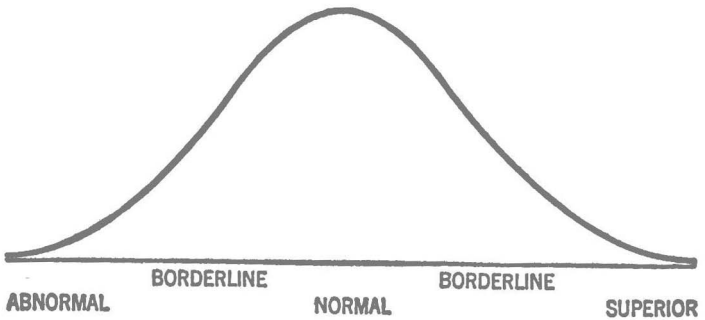
THE NORMAL AND THE ABNORMAL

Considered from any point of view, the concept of normality-abnormality is a relative one. Departures from whatever norm one

may accept can be so slight as to cause no concern at all, or they can be so striking as to leave no doubt of their abnormal nature. There is, however, no strict dichotomy in which normal and abnormal will always be readily distinguishable. In any large group of persons studied we cannot say with assurance that "these are normal" unless the abnormalities are so extreme as to be obvious. Observe how this holds true from the principal points of view: the pathological, the statistical, and the cultural.

Pathological Point of View. Considered from the pathological point of view, abnormal behavior is the result of a diseased or disordered state evidenced by the presence of certain clinically recognized symptoms (for example, unfounded fears in the psychoneurotic, delusions or hallucinations in the psychotic, antisocial behavior in the person suffering from a sociopathic personality disturbance). Carried to its ultimate conclusion, this point of view would lead to the assumption that one who is possessed of a "normal" personality is without symptoms. Experience teaches otherwise, for it is the rare individual who is entirely symptom-free, especially under conditions of stress. Nevertheless, certain symptoms or syndromes (complexes of symptoms) are undeniable signs of a disordered personality, and persons exhibiting such symptoms can be regarded as abnormal.

Statistical Point of View. This is the graphic, mathematical approach to the question of what (or who) is normal or abnormal. The curve of *normal distribution* seen in the accompanying illustration (showing the results of a study of levels of intelligence in the



After James D. Page, *Abnormal Psychology* (New York: McGraw-Hill, 1947), p. 14.

general population) portrays the statistical concept of normality and abnormality. It will be noted that most of the subjects studied are

clustered about the middle of the curve; from the statistical point of view, it would be held that these subjects are normal and that the fewer cases on either side of the middle of the curve are abnormal. By statistical convention the "normal range" embraces roughly the middle two-thirds of most groups studied.

This approach offers undoubted reliability and usefulness when one is measuring tangible factors such as weight and height. Psychological traits offer a much greater challenge. Statistical methods are used with success in the measurement of intelligence (see Chapter 16, Mental Deficiency), but the more complex characteristics of the total personality present serious problems, particularly in the areas of phenomena to be investigated and in their evaluation. The validity and applicability of findings in statistical studies of abnormal behavior and personality depend on the traits selected for measurement and the statistical criteria employed.

Cultural Point of View. From this vantage point, the behavior and attitudes of an individual are regarded as normal or abnormal according to the social (cultural) milieu in which he moves. The community is a hard taskmaster and tends to be impatient with departures from its established mores. Reasonable latitude may be allowed for individuality of expression, but radical digressions which create turmoil in the individual and those about him are usually held to be evidence of abnormal personality. Today, however, two factors influence this situation: First, in a world society in which culture patterns are ever crossing and mingling, it must be increasingly recognized that customs and attitudes felt to be normal in one cultural group may be called abnormal in another. Second, what was considered abnormal a generation or a century ago may be accepted in present-day society; in some areas of human relationships such change is slow, while in others it is meteoric. The impact of these two factors and of immediate community pressure on the personality of the individual cannot be ignored and must be made a part of any conclusion as to whether a person is normal or abnormal.

Criteria for a Normal Personality. A comprehensive description of a healthy and normally functioning individual is provided in a list of criteria published by Maslow and Mittelmann.* Somewhat modified by the present authors, this list of criteria follows.

1. Adequate feelings of security.

* See A. H. Maslow and B. Mittelmann, *Principles of Abnormal Psychology* (rev. ed.; New York: Harper, 1951), pp. 14–15.

2. Reasonable degree of self-evaluation (insight).
3. Realistic life goals.
4. Effective contact with reality.
5. Integration and consistency of personality.
6. Ability to learn from experience.
7. Adequate spontaneity.
8. Appropriate emotionality.
9. Ability to satisfy the requirements of the group, coupled with some degree of emancipation from the group (as expressed in individuality).
10. Adequate but unexaggerated bodily desires, with the ability to gratify them in an approved fashion.

The reader is cautioned to examine these criteria carefully, with the understanding that they all suggest relative standards. The normal person is not expected to be a paragon of excellence with regard to each of them. He may be somewhat deficient in one or more characteristics, but still enjoy good over-all mental health; that is to say, he will be considered normal. If, however, he is deficient in too many of these characteristics or woefully deficient in one or two, he will probably be considered abnormal.

ABNORMAL PSYCHOLOGY AND RELATED DISCIPLINES

In its efforts to master the problems of disordered personality and behavior, abnormal psychology comes into contact with and draws upon many other disciplines. Some of them are closely related to abnormal psychology in the professional or scientific plane. Others are more or less indirectly associated with it, depending on the nature of the particular problem that is being studied; these include religion, education, law, sociology, biometrics, and anthropology, to mention a few. Definitions of the more intimately related fields follow.

Abnormal psychology—the branch of psychology which concerns itself with the study of all forms of mental disorder or abnormality. It strives to define and classify the causes of personality and behavioral disturbances, with a view to establishing a basis for their treatment in individuals and for the resolution of the social problems which they generate.

Clinical psychology—the applied aspect of abnormal psychology, which includes diagnostic interviewing and testing, remedial work

(as with speech disabilities), counseling, and the treatment known as psychotherapy.

Psychiatry—a branch of medicine specializing in the diagnosis, prevention, and treatment of mental and emotional disorders.

Psychoanalysis—a method of psychological interpretation of the personality; a specialized form of psychotherapy based on the Freudian conception of psychodynamics.

Neurology—a branch of medicine concerned with the diagnosis and treatment of disorders of the nervous system. Within neurology is the specialty of *neurosurgery*.

Psychiatric social work—a branch of social work concentrating on the social problems associated with psychiatric disorders. From its clinical application, recommendations are made for the management of the patient's social situation (e.g., his family relationships, work and career objectives, and marital problems) as part of the therapeutic program.

Mental hygiene—not a professional discipline, but a movement primarily dedicated to the prevention of psychological disturbances and the promotion of improved treatment facilities for persons suffering from mental illnesses.

SCOPE OF THE PROBLEM OF ABNORMAL BEHAVIOR

Abnormal behavior constitutes a major medical and social problem. In its most measurable aspect (institutional population) it commands serious attention. Each day in the United States nearly 700 persons are admitted to mental hospitals or to psychiatric services of general hospitals. Close to 800,000 hospital beds (about half the beds in hospitals of *all* types in this country) are occupied by patients suffering from mental disorders. Another 120,000 persons are under care in institutions for mental defectives. Still another 100,000 or more convalescent patients are carried on the books of mental hospitals while they are receiving treatment at follow-up clinics or being cared for under a foster home plan.

Hospital statistics, however, provide only one segment of the total picture of personality disturbance and abnormal behavior. Several other groups of persons contribute to the growth of this social and medical problem. One such group comprises 950,000 chronic alcoholics, 4,000,000 problem drinkers, and 50,000 drug addicts. Another includes an indeterminate number of psychopaths and criminals, not

to mention 265,000 children seen in juvenile courts each year. Divorce statistics (one out of every four marriages) are indicative of the prevalence of maladjustment. Personality problems are surely evident in the 17,000 suicides yearly. In addition to the foregoing is the large number of individuals with personality or behavior disorders who are treated in outpatient mental hygiene clinics or by privately practising psychiatrists and clinical psychologists.

Psychosomatic Illness. With the increasing attention that is being accorded the psychosomatic approach to medicine has come the realization that, among a great many of the patients being treated for the general run of medical disorders, psychological factors play either a minor or a major role in the background of the illness. One director of a large general hospital has estimated that 75 per cent of the patients seen at his institution's outpatient department during one year were suffering from either purely psychoneurotic symptoms, psychoneurotic symptoms superimposed on somatic disease, or somatic symptoms superimposed on psychoneurotic disorder.

Lessons from Industry and the Military. In recent years, numerous studies of the effect of psychoneurotic disorder have been taken from industry and the military.

INDUSTRY. Studies of absenteeism in industry show that nearly two-thirds of industrial absences are due to illness that is principally or exclusively neurotic in nature. "Accident-prone" individuals aggravate problems of safety in industrial plants. The extent to which personality disorder affects the economy can be deduced from the estimate that about $1,750,000,000 in potential earnings is lost annually because of mental illness or maladjustment.

MILITARY. Fruitful sources of information on the scope of personality disorders are the statistics amassed in two world wars. Before Pearl Harbor nearly 50 per cent of all patients being cared for in veterans' hospitals suffered from neuropsychiatric disorders. Approximately 18 per cent of all men called up for service in World War II were rejected as being mentally or emotionally unqualified. Over one-third of the medical discharges during that war prior to V-E (Victory in Europe) day were neuropsychiatric cases.

Summary. The scope of the problem of abnormal behavior is summed up in two statistical predictions which are generally accepted in the mental health field:

1. Of every twenty persons now living, one will eventually be

admitted to a mental hospital and another will at some time during his life be at least temporarily incapacitated by some form of mental disorder, though not seriously enough to require hospitalization. This indicates that 10 per cent of the newborn will at some time in their lives experience either permanent or temporary, severe or mild, mental disorder.

2. In one of every five families there will be occasion within the year to call on the services of a psychiatrist, clinical psychologist, or mental hygiene clinic, if not indeed to make use of mental hospital facilities.

HOW THE PROBLEM IS BEING MET

It cannot be said with assurance that mental disorder is more prevalent today than it was, either at the turn of the century or a hundred years ago. Data are not available which would permit a reliable comparison. There can be little doubt, though, that mental abnormality as a medical and social problem has received increasing attention. As the stigma attached to mental disorder has subsided and the mental hospital has been gradually accepted as a substitute for the "upstairs back room" or the almshouse, the demand for public facilities has grown by leaps and bounds. Need has consistently outdistanced supply; as many new mental hospitals have been built and as more effective therapeutic techniques have been devised, the greater has become the load which the hospitals have had to carry.

There are now about six hundred mental hospitals in the United States. About half of them are public, the largest being state hospitals with resident patient populations ranging from a little over a thousand to more than eight thousand. There are specifically designated psychiatric services in roughly one hundred general hospitals. In 1957 there were over two thousand outpatient psychiatric facilities. In 1956 the cost of public facilities (federal and state) dedicated to the treatment of patients with mental illnesses was about four billions of dollars.

Nevertheless, three of every four state mental hospitals are seriously overcrowded. The average mental hospital is 55 per cent understaffed in physicians, 74 per cent in psychologists, 67 per cent in psychiatric social workers, 79 per cent in registered nurses, and 20 per cent in ward attendants. (This problem is discussed further in Chapter 20, Mental Hygiene.) Although substantial progress has

been made, it is apparent that the major tasks of diagnosis, prevention, and treatment remain to be accomplished.

CLASSIFICATION OF MENTAL DISORDERS

The modern grouping of mental disorders in a systematic classification has its basis in the work of EMIL KRAEPELIN (1856–1926). He was among the earliest investigators to observe that certain symptoms of mental illness tended to appear in clusters. This suggested to him that the clusters of symptoms (syndromes) were manifestations of specific types of mental disease. On this slender circumstantial basis Kraepelin described various disease entities and from his findings worked out the first modern classification of mental disorders.

Evolution of Classification. Kraepelin's nosologic system was followed for several decades, but with the evolution of improved diagnostic techniques and more discriminating interpretations of personality problems significant changes took place. For example, with the passage of time (into the third and fourth decades of this century) a large accumulation of clinical experience forced a new interpretation of the mental disorder called dementia praecox ("insanity of youth")—so named because it was commonly observed to emerge in adolescence. However, as more accurate statistics were compiled, individuals showing the clinical picture of "dementia praecox" grew to comprise the largest single diagnostic bloc of patients in mental hospitals; it was soon apparent that the most frequent age of onset was not during adolescence. A more dynamic approach to this disease led to the descriptive term "schizophrenia," which means a splitting up or a fragmentation of mental life so that the individual is incapable of appropriate, integrated responses to external reality.

Classification in America. In America the Kraepelin classification system underwent several modifications at the centers devoted to the study of mental diseases. Therefore, each large teaching center had its own classification system based on the predilections of the center's leading investigators. Such diversified interpretation was bound to hamper communication and complicate research efforts in the field. In 1917 the first rudimentary nomenclature was set up by the American Psychiatric Association (then known as the American Medico-Psychological Association), and through the

efforts of Dr. Thomas Salmon and the National Committee for Mental Hygiene the system was adopted in hospitals and research centers throughout the country.

It is interesting to note that the tendency was still strong to assume a cause-and-effect relationship between mental states and immediate environmental influences. The largest category of psychoneuroses at that time included a diagnosis of "shell shock," which many psychiatrists regarded as a definite misnomer because a large number of men so diagnosed never left training camp and never heard shellfire. In World War II the same condition was described as "combat fatigue." However, this syndrome, like that which may be seen in response to economic disaster, or in the course of a great debacle, is now more properly recognized as an aspect of transient situational personality disorder (see Chapter 6).

The "APA" Classification Today. A major revision in the APA (American Psychiatric Association) classification was made in 1934 and this remained in use through the early years of World War II. The system, designed primarily for civilian use, proved to be inadequate for the clinical description of mental breakdowns occurring under military stress. Relatively minor personality disturbances arising specifically in the military setting were classified under "psychopathic" personality; men were diagnosed as "psychoneurotics" who were merely responding with transient neurotic symptoms to excessive stress. It was estimated that 90 per cent of the cases treated by the military were not being properly classified. Under these circumstances the Navy in 1944 and the Army in 1945 established systems of classification which were more adaptable to their purposes. This only added to the already existing confusion and by 1950 there was general agreement on the need for a single psychiatric nomenclature. A proposed revision, developed through the joint efforts of the National Institute for Mental Health and the American Psychiatric Association, was circularized among a nationally representative group of medical practitioners in neurology, psychiatry, and psychoanalysis. The resultant classification was adopted in 1951 and a manual was published in 1952.

This new APA classification, which will be found as an Appendix of this book, separates all mental disorders into two major groups:

1. Those in which the disturbance in mental functioning is associated primarily with brain damage (that is, "organogenic").