Psychopathology

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Psychopathology

For Edith

Preface

Two assumptions underlie the organization and content of this book. The first is that the exposition should be rigorous and systematic. This means that observations should be separated from explanations, data from inferences, and facts from theories. We shall start with the facts—the events to be explained—and then proceed to an understanding of these events. The "events" of psychopathology consist of symptoms. Once we know what the symptoms are, we can proceed to the theories that attempt to explain them.

The theories are described with an attempt at impartiality. Each of us is allowed to have his personal preferences, but fair play demands that we allow for and give an adequate hearing to the major approaches to the field. The assumption is that polemic belongs in a journal, not in a textbook.

This does not mean that theories are not evaluated. Many theories are assessed against a body of evidence and found wanting; a few receive praise. Some theories are amenable to such evaluation because they are sufficiently precise and quantified to be tested. We have only to examine the data to discover whether they are correct. Other theories are too broad or too qualitative to be checked against data. They are approaches to an area rather than precise formulations that have testable deductions. Their worth depends on whether investigators and students find them a useful source of ideas or explanations.

In discussing theories, we shall attempt to state their basic assumptions and their consequences. Where there are competing theories, comparisons will be made. In comparing theories, differences among them will be empha-

sized so that the student may understand each theory in its pure form. Of course, similarities will not be neglected.

The second assumption is that progress may be marked by advances from the clinic to the laboratory. In any field, the early, crude, qualitative observations are supplanted by later, refined, quantitative data. At first the clinician's subjective observations and inferences predominate and are the basis of most knowledge. Later the laboratory researcher's objective, quantitative data predominate and are the basis of most knowledge. This appears to hold in medicine, in which progress can be accurately gauged by the extent to which laboratory procedures have replaced clinical impressions in diagnosis and to the extent that treatment is derived from research rather than clinical tradition.

There are analogues in clinical psychology. An intelligence test marks a real advance over clinical impressions of intelligence. Similarly, we favor facts obtained in the controlled context of the laboratory over observations made in the less controlled context of the clinic. Of course, many facts cannot be obtained in the laboratory, and a complete description of psychopathology must include clinical observations. Psychopathology, like medicine, is far from being a laboratory science, although there has been considerable progress in recent years. Clinical impressions will continue to be of value, but they are to be trusted less than the more reliable data that emerge from the laboratory.

One consequence of both assumptions is an emphasis on issues, facts, and theories, and the omission of case histories. Like autobiographies and novels, accounts of patients' lives are interesting to read. They are also of value in that they illustrate how symptoms develop in individuals, but there is almost always a bias built into the case presentation, which can be selected to "prove" or to illustrate any theory or point of view. The bias is usually in favor of social or interpersonal approaches and against impersonal or biological approaches. Furthermore, case histories, although intrinsically interesting, tend to distract the reader from the rich and complex issues of abnormal psychology. There has been a proliferation of research on psychopathology in recent years, and the lines between opposing viewpoints have been drawn more sharply. There is enough to occupy our attention without the addition of case histories.

The book has four main sections. The first three chapters deal with broad issues: the nature of abnormality, definitions, models, and classification. Chapters 4 through 8 are concerned first with neurotic symptoms and then theories of neurosis. The third section, Chapters 9 through 15, involves symptoms and dimensions of psychosis and then theories of psychosis. The last two chapters are expositions of psychosomatic disorders and conduct disorders.

Many persons assisted in the writing of this book. Bertram D. Cohen

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CHAPTER 1

Normality and Abnormality

There have been many approaches to normality and abnormality, but three of them appear to be fundamental: normality as a statistical concept, normality as ideal mental health, and abnormality as the presence of certain behaviors. The statistical concept is the simplest, stating merely that normality consists of whatever tendencies are most frequent in the population. Abnormality is defined by exclusion, that is, by the presence of features uncommon in the population. Abnormality may be unidirectional, as in vision. Normality is represented by 20-20 vision: seeing at 20 feet what an *average* person sees at 20 feet. Better vision (say, 10-20) is still normal, but poorer vision (say, 20-40 or 20-100) is abnormal. Thus visual acuity becomes abnormal only when it is worse than average, and normality is represented by both average and better-than-average vision. However, abnormality may be bidirectional, as in body temperature. The normal or healthy temperature range is roughly 97 to 100° Fahrenheit, and *both* lower and higher temperatures are abnormal or unhealthy.

One problem with the statistical concept is that it does not in itself supply a basis for deciding whether abnormality should be unidirectional or bidirectional in any given instance. Thus assembling frequency distributions is not sufficient in defining normality. It is also necessary to specify what is being counted, that is, to define the *content* of normality and abnormality. Although the statistical concept is not a sufficient definition of normality, it cannot be ignored. Normality implies that the majority of any population has the attribute in question. It would not be acceptable to define normality so as to exclude most people because that would destroy the meaning of the term *normal*.

Unfortunately, defining normality in terms of ideal mental health makes precisely this assumption, that normality is an ideal state attained only by a selected few. We shall examine this approach in detail in the next section, after introducing the third approach, which focuses on the content of abnormality.

A rough definition of abnormality or maladjustment is needed to carry us through a discussion of the issues, a definition that will suffice until a more precise one can be attempted. Let us define abnormality, then, in terms of misery or an inability to manage one's own affairs. *Misery* refers to anxiety, depression, and allied dispositions. *Inability to manage* is self-defining. This temporary definition uses two vantage points in viewing maladjustment: that of the individual (discomfort) and that of society (not fulfilling a role in society).

The definition states in general terms what abnormality is, but in recent years the mental health movement has supplied the impetus for an alternate approach, defining abnormality as the absence of mental health. This approach emphasizes the positive aspects of adjustment: normality, positive striving, and productivity, as opposed to abnormality, defensive maneuvers, and inefficiency.

IDEAL MENTAL HEALTH AND NORMALITY

Reflecting a psychoanalytic position, Kubie (1954) suggests that in the normal person there is a predominance of conscious over unconscious urges; in the abnormal person there is a predominance of unconscious, irrational urges. This position has been criticized by Redlich (1957), who states that Kubie implicitly assumes that behavior determined by conscious, rational forces is healthier than behavior determined by unconscious, irrational forces. If this assumption were correct, then the behavior of children, lovers, and artists would be considered abnormal. Redlich's argument is that not all unconscious behavior is irrational.

The criterion of consciousness is poor because it emphasizes awareness and neglects behavior. Pseudoliberated individuals can usually give an accurate account of the nature of their problems, especially after a course of unsuccessful psychotherapy, but keen awareness of the roots of their difficulties apparently has no effect on their continued maladjustment. On the other hand, many adjusted, reasonably productive individuals are unaware of their basic motivations. The ability to verbalize correctly about oneself is evidently not highly related to the ability to adapt well to one's environment.

This position is consistent with the current trend among clinicians of downgrading the importance of insight. In psychotherapy, for example:

Insight is manifested when a client makes a statement about himself that agrees with the therapist's notions of what is the matter with him. This is not a particularly useful formulation. (Hobbs, 1962, p. 742)

Consciousness or insight is only one of several criteria proposed by advocates of the positive-mental-health approach to normality. Shoben (1957) listed five other criteria: self-control, personal responsibility, social responsibility, democratic social interest, and ideals. Jahoda (1958), who has written the most comprehensive work on concepts of mental health, lists six criteria. The first is self-insight, which is essentially the same as Kubie's criterion of consciousness. One of the others has been separated into two attributes, making a total of six criteria of positive mental health to be discussed:

balance of psychic forces
self-actualization
resistance to stress
autonomy
competence
perception of reality

Balance of psychic forces implies a set of opposing tendencies which must somehow be reconciled. This notion, which is part of such depth theories as psychoanalysis, is difficult to pin down in behavioral terms. As such, the criterion cannot be dealt with outside of the context of a particular theoretical framework. Since the present discussion assumes a neutral stance regarding theory, balance of psychic forces cannot help in the quest for criteria of normality.

Self-actualization, or the full realization of one's potential as reflected in productivity in science, the arts, or other fields, is an ideal state which few persons attain. If it is a requirement of mental health, then very few persons are mentally healthy. Most segments of society lead a routine life, hemmed in by the petty details and drudgery of everyday existence. Realizing one's potential requires not only the presence of latent creativity but also the motivation and means to break out of the mold of the habits and trivial demands of day-to-day living. Few people possess these attributes, yet the majority who do not possess them are not ordinarily considered maladjusted, that is, they are not miserable and can manage their own affairs.

Conversely, there is the possible coexistence of creativity and abnormality. Vincent Van Gogh had psychotic episodes during his career, and there are many other examples of creative genius' occurring in men who were unquestionably abnormal. Thus self-actualization, in the sense of realizing one's potential, has serious faults as a criterion of mental health.

The next three criteria, *resistance to stress, autonomy,* and *competence,*

all appear to be aspects of maturity. The concept of maturity is fairly straightforward in its application to the develoment sequence. During childhood, children are expected to progress through a series of age-graded roles which require increasing self-control and self-help. A child of eight who performs in familial and social contexts at a level expected of eight-year olds is mature; if he were to perform at a six-year level, he would be called immature. Similarly, adults who manifest behavior patterns typical of adolescence or childhood are labeled immature.

The three salient capacities underlying the age-graded roles are autonomy, competence, and resistance to stress. The child is expected to increase in all three as he becomes older, the peak being attained in adulthood. The infant is completely dependent upon its parents; the mature adult is expected to be self-sufficient and in no need of parental assistance. The infant has a very small behavioral repertoire; the mature adult is expected to be competent in work, play, and personal relations. The infant can respond to stress only with diffuse excitement and panic; the mature adult should be able to tolerate threat and failure sufficiently well to persevere in attempting to solve problems and reach goals.

Thus maturity can be grossly defined in terms of autonomy, competence, and resistance to stress, but the basic issue confronting us is its relationship to normality. Presumably most mature adults are normal in that they are not miserable and can manage their own affairs, but a minority might well be abnormal. Consider an individual whose life is plagued with an inordinate amount of stress (disappointments, failures, threats, rejections, deaths of friends or relatives). At first he may respond with resilience, bouncing back to solve problems after each setback, but eventually he would probably become despondent and perhaps even hopeless in the face of continued misfortune. In brief, the definition of normal must take into account the fortunes of life; maturity may not be sufficient to guarantee normality.

Autonomy presents special problems. Independence does not necessarily lead to normality. In the course of moving away from dependence on parental figures, there may be an over-reaction to all control. Thus the adult might be excessively autonomous: he might be insulated from the care and affection of others, negativistic and defiant of authority. Excessive rebellion involves the individual in conflict with authority in its various forms. Consequently he either is not allowed to manage his own affairs or is judged incapable of doing so, that is, he is judged abnormal.

Even if an individual is not excessively autonomous in the sense of being negativistic and defiant of authority, he may become maladjusted. One connotation of the term *adjustment* is accommodation to the pressures of society. Conformists find life easier in the sense of "belonging" and of accruing the material rewards of a prosperous society. The life of the dissenter is more difficult because although we prize rugged individualism as

part of our democratic values, we tend to deal with it harshly in everyday life. By nonconformity we are referring to the individual's right to go his own way in his private affairs, not rebellion against authority. An example of such nonconformity is a white man marrying a Negro woman. Although society recognizes this right in the abstract (except for some Southern states in which it is unlawful), such nonconformity usually results in censure, rejection, and a blocking of many means to achieve social and vocational goals. In brief, the nonconformist must face a stressful and frustrating environment, which in turn may lead to misery and difficulty in managing his affairs, that is, abnormality.

Thus maturity is not always identical to normality or adjustment; nor does immaturity necessarily lead to abnormality. It is possible to maintain a childlike dependence on others without being maladjusted, so long as persons are available to play the opposite, parental role. There are moderately successful marriages in which one partner plays a dominant, parental role and the other plays a submissive, dependent role. Similarly, on some jobs an individual can find a niche in which he is protected from facing adult responsibilities. People who do not move all the way to adult independence can still find satisfaction in life and (with help) manage their own affairs. They are immature but not necessarily maladjusted.

Having pointed out the defects of maturity as a criterion of normality, we must be fair and mention that the two are positively related. With the exceptions noted, mature people tend to be adjusted and immature people, maladjusted. The relationship is especially strong when there is extreme immaturity, which leads inescapably to abnormality. Let us note for later discussion that abnormality is more closely linked to immaturity than normality is to maturity, and immaturity is easier to specify than maturity.

Perception of reality is certainly an important aspect of maladjustment, but the proper emphasis must be on its absence. The person who distorts reality is obviously abnormal, and those around him will respond immediately to his bizarreness. However, a relatively accurate perception of everyday stimuli does not guarantee normality. The cognitive apparatus needed to read reality correctly may function very well, but the behaviors necessary for adjustment may be missing. Thus an individual might correctly ascertain that he is in immediate danger and then freeze into immobility, being unable to cope with the threat. Note that here again it is easier to define abnormality than normality.

This examination of the various criteria of normality reveals that although some of them are clear and relevant, others are unclear. In any event, it is obvious that very few individuals will meet all the criteria that describe an ideal person. If this ideal is normal, are the rest of us abnormal? The answer is no, because the concepts of normality and adjustment implicitly refer to most persons.

Are the criteria highly correlated? There are no data to guide us because the criteria have not been used in research. However, it is reasonable to assume that some of them are more closely related than others. Thus attitudes toward the self probably are more closely related to clear perception of reality than to autonomy.

If some of the criteria are not related, how many of them must be met for an individual to qualify as mentally healthy? A person might fail in self-attitudes, self-actualization, and perception of reality but pass in autonomy and competence. Is he mentally healthy? There can be no clear answer to this question because there is no way of deciding which criteria are of greater importance. There are many ways to be adjusted and to lead a reasonably happy and productive life. One mode of adjustment might meet some of Jahoda's criteria, and another mode, other criteria.

The positive striving approach attempts to spell out the psychological values and goals of "the good life" in our society. We can applaud these goals and the attempt to reach them, but this way of dealing with mental health has the following defects:

(1) its ideal nature excludes too many persons;
(2) some of its criteria necessarily lack precision because some goals are excessively vague and abstract;
(3) there are many ways to adjust to the world and achieve some happiness or sense of well-being, too many to allow a reasonably short list of criteria.

This third defect is crucial. Abnormality is a smaller domain and is best defined in its own terms rather than as the absence of normality, which is a larger domain of behavior.

RESEARCH CRITERIA OF ABNORMALITY

An alternative to defining normal or ideal adjustment is specification of the criteria of *abnormality*. Scott (1958) reviews five criteria of abnormality which have been used for research purposes:

psychiatric diagnosis
presence in a mental hospital
social maladjustment
subjective unhappiness
objective psychological inventories

Psychiatric diagnosis is an obvious criterion of abnormality. Individuals diagnosed as psychotic or neurotic are clearly abnormal, being either miserable or unable to manage their affairs. Those with psychosomatic complaints or conduct disorders constitute borderline instances because it is difficult

to make these diagnoses. Furthermore, mild neurosis is difficult to distinguish from normality. Aside from the problem of diagnosing borderline conditions, psychiatric diagnosis is a circular kind of criterion because it defines abnormality as what the psychiatrist says it is. The only way out of the circularity is to use the *bases* of diagnoses as criteria of abnormality, but these turn out to be certain kinds of symptoms, which will be described later in the book. Symptoms or complaints, as we shall see, are good measures of abnormality.

Presence in a mental hospital appears at first glance to be a reasonable criterion of abnormality, but closer inspection reveals several faults. As Szasz (1961) has forcefully commented, admission and discharge procedures depend largely on community pressures, the mental hospital being an instrument used to protect the community as well as to help psychiatric patients. Admittance and discharge also depend in part on the financial and personal support offered by the patient's family. Furthermore, whether a disturbed person is admitted to a hospital depends on whether he comes to the attention of professional personnel. Surveys such as the Midtown Study (Srole et al., 1962) have turned up substantial numbers of disturbed persons who have never been inside a mental hospital and have never had professional attention. Lastly, hospital admissions are limited principally to psychotics, the majority of nonpsychotics being seen on an outpatient basis, in clinics, or in private practice. Thus admission to a mental hospital is a limited and incomplete criterion of abnormality.

The third criterion, *social maladjustment,* requires that we specify cultural norms and appropriate reference groups. One norm might be legal, with maladjustment defined as being in trouble with the law. Another possibility is conformity to community values; on this basis a white Mississippian who favors desegregation is maladjusted, whereas if he moved to the North, he would be adjusted. The problem is thus one of spelling out "adjustment to what." Maladjustment, so defined, is too flexible. Furthermore, dissidence in itself does not equal maladjustment, just as conformity does not equal adjustment.

The fourth criterion, *subjective unhappiness,* presents difficulties because the individual's mood may be determined by his immediate environment. In the face of a business failure or military service in Antarctica, unhappiness might be an appropriate reaction. In addition, some individuals who might be abnormal on the basis of other criteria (diagnosed as psychotic and admitted to a psychiatric hospital) might still report feeling happy; a manic probably would. However, these difficulties do not appear to be as serious as those confronting the other criteria. Environmental stress is one of the determinants of abnormality, and therefore its effect on subjective happiness is entirely appropriate. There are no data suggesting that psychiatric patients are as happy as others; on the contrary, Scott (1958) reports