PART ONE

Normality, Abnormality, and Adjustment Disorder

CHAPTER 1

Defining and Classifying Psychopathology

Irving B. Weiner

Learning about psychopathology through case studies begins with identifying the nature of abnormal psychological functioning and determining how it differs from normal behavior. This is not a simple matter because normality has traditionally been defined in various ways and from different perspectives. Experts have also disagreed about whether psychologically normal and abnormal conditions are continuous phenomena involving similar dimensions of personality or whether they constitute distinctive states of mind that require separate sets of concepts if they are to be described adequately. The first two sections of this chapter discuss alternative ways of defining psychological normality and some implications of considering it continuous or discontinuous with abnormal functioning. The third section of the chapter addresses the utility of a classification system in grouping and distinguishing among different types of psychological disorders, and the fourth section indicates the basis for choosing the topics of the case studies presented in Chapters 2 through 19.

Identifying Psychological Normality

Psychological normality has most often been defined either as an *average,* an *ideal,* or a *level of adjustment.* Normality as an average is a statistical definition that identifies the typical or most common behaviors among a group of people as being normal for that group. This average perspective on what it means to be normal is what someone means when he or she says to another person, “Why can’t you be like everyone else?” or “Get with the program!”

Identifying some large middle percentage of a group of persons as showing normal behavior has the benefit of providing a precise criterion for deciding whom to consider abnormal, namely, those who fall outside this middle range. Attention to typical patterns of behavior also promotes *cultural sensitivity* and helps clinicians avoid seeing psychopathology

where none exists. Cultural sensitivity in this regard consists of recognizing that what is normal for a person depends in part on the attitudes and behavior patterns that are valued in the groups to which the person belongs. Being aware of respects in which normality is relative to the customs, traditions, and expectations in a person's sociocultural context helps observers avoid inferring psychological disturbance from seemingly strange characteristics that may be common or even advantageous in a subculture with which the observers are unfamiliar.

Although useful for selecting "normal" comparison groups in experimental studies and for minimizing cultural bias in clinical evaluations, a statistical perspective on normality also has some disadvantages. When being normal is defined as being average, highly intelligent as well as intellectually limited people are considered abnormal, as are extremely happy people as well as those who are despondent, and highly creative as well as unproductive persons. Likewise, in a situation of mass panic or mob violence, the many who are acting impulsively or irrationally are considered normal, while the few who remain calm and clearheaded despite the crisis are labeled abnormal. Thus, being different does not necessarily mean being abnormal, as the statistical approach would imply. Moreover, it is unwise to assume that people who become acutely upset in a traumatic situation have no need for mental health assistance simply because most of the people around them are showing similar signs of distress.

As an alternative to defining normality in statistical terms as what is average or typical, normality defined as an ideal refers to a state of perfection that people aspire to but seldom attain. This utopian perspective, as reflected in the expression "Nobody's perfect," assumes that all people struggle with psychological limitations of one kind or another that prevent them from being as happy and successful as they would like to be. Regarding normality as an ideal way of being avoids statistical decisions that label unusually intelligent, happy, or productive people as abnormal. In addition, by calling attention to the potential for people to become more than what they are, the ideal perspective on normality encourages striving toward self-improvement and the active pursuit of greater happiness and success.

On the other hand, by implying that almost everyone is disturbed to some extent, normality as an ideal is a difficult concept to apply. Scientifically, it provides little help in separating normal from abnormal groups of people for research purposes. Practically, unless you take the questionable stance that everyone is more or less in need of therapy, it provides little help in determining whether a person's psychological limitations call for professional mental health attention.

Level of adjustment as a criterion for normality refers to whether people can cope reasonably well with their experiences in life, particularly with respect to being able to establish enjoyable interpersonal relationships and work constructively toward self-fulfilling goals. When normality is defined in these terms, abnormality becomes a state of mind or way of acting that prevents people from dealing adequately with the social and occupational demands of their daily lives. The adjustment approach to normality is more useful than either the average or the ideal perspective in determining which conditions psychopathologists should study and clinicians should treat. For this reason, normality defined as reasonably good adjustment serves the purposes of this book by providing a clear frame of reference for identifying the presence and severity of psychological disturbance.

Continuity and Discontinuity in Conceptualizing Psychopathology

Normal and abnormal behavior can be regarded as either continuous or discontinuous phenomena. From a continuity perspective, differences between disturbed and well-adjusted persons are *quantitative.* A quantitative approach conceives normal and abnormal behaviors as deriving from the same psychological dimensions or traits, with maladjusted individuals having more or less than the optimum amount of these traits. For example, a moderate amount of self-control contributes to good adjustment, whereas too little self-control can lead to pathological impulsivity and too much self-control, to pathological inhibition

and rigidity. Similarly, a moderate capacity to reflect on yourself and your experiences tends to promote good adjustment, whereas insufficient reflection can lead to limited self-awareness, and excessive reflection can lead to paralyzing self-consciousness.

From a continuity perspective, every aspect of a disturbed person's behavior constitutes an exaggeration of normal ways of thinking, feeling, or acting. Any normal person can be expected on occasion to think, feel, or act the way disturbed people do, but the key consideration is one of degree. Normal people show maladaptive exaggerations of behavioral traits less frequently, to a lesser extent, and for shorter periods of time than people who are psychologically disturbed.

From a discontinuity perspective, by contrast, differences between normal and abnormal behavior are considered *qualitative,* that is, as differences in kind rather than degree. A qualitative approach emphasizes the study of abnormal psychology in its own right, rather than as an extension of normal psychology, to focus on the unique circumstances that give rise to psychological disturbance and on the special kinds of care and treatment that disturbed persons require.

Both of these approaches to the relationship between psychological normality and abnormality serve useful purposes. The continuity perspective helps mental health professionals and the general public avoid regarding disturbed persons as "different" from the rest of us. Being able to think of psychologically disordered people as having more or less of certain characteristics that we all have, instead of being in an entirely different dimension, fosters understanding of their problems and enlightened and sympathetic efforts to help them overcome these problems. By contrast, the discontinuity perspective has at times resulted in psychologically disturbed people being viewed as alien and unfathomable, with the regrettable consequence of relegating them to places where they are out of sight and out of mind and treating them with little regard for their humanity.

The continuity perspective on psychopathology also brings with it some downside, however, particularly with respect to minimizing the implications of apparent psychological disorder. Perceiving manifestations of disorder as being only an extension of normal behavior and as

something we all have may be a prelude for insensitive advice ("Snap out of it"; "Pull yourself together"), unwarranted expectations ("He'll be okay in a few days"; "She just needs a good vacation, and she'll be fine"), and failure to recommend or seek needed professional care. In this regard, the discontinuity perspective can be very helpful by virtue of its stress on the uniqueness of psychopathology. A qualitative approach has the benefit of increasing the likelihood that disturbed people, their family and friends, and mental health professionals who evaluate them will recognize and respond to their needs for help.

Accordingly, the problems of psychologically disturbed persons and the case presentations in the chapters that follow are best viewed from both continuity and discontinuity perspectives. To what extent can the adjustment problems of these people be seen and understood as exaggerations (too much or too little) of characteristics common to all people? At the same time, to what extent have these tendencies to think, feel, and act in certain ways become sufficiently exaggerated to warrant a diagnostic classification and a treatment recommendation, both of which qualitatively distinguish these persons from most people?

Using a Classification System

Classification of disorders serves important purposes in research and clinical practice. To study the origins and effects of a condition and its course over time, researchers must be able to identify people who have that condition and would be appropriate participants in such studies. To draw on their experience and cumulative knowledge concerning treatment methods that are helpful to people with certain kinds of disorders, practitioners must be able to identify which disorders their patients have. Whether a particular classification system serves these research and practical purposes well depends on how reliable and valid the system is. A reliable classification is one in which (1) the individual categories are reasonably distinct from one another, and (2) knowledgeable professionals can agree reasonably well on which category

best describes a patient's disorder. A valid classification is one in which the characteristics used to describe and differentiate among disorders have been confirmed by research findings to be in fact associated with these disorders.

With respect to classifying psychological disorders, the best known and most widely used system is the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) published by the American Psychiatric Association. The *DSM* first appeared in 1952 and is now in its fourth edition. *DSM-IV* was published in 1994 and was followed in 2000 by a text revision, *DSM-IV-TR,* which lists the same categories of disorders as *DSM-IV* but includes some changes in how these categories are described. A key feature of the *DSM* is a multiaxial approach, in which a person being evaluated can be described on each of five separate axes, according to the following guidelines:

> Axis I is used for reporting clinical disorders, which are conditions defined mainly by the kinds of symptoms people present. Symptoms in this context refer to maladaptive ways of thinking, feeling, or acting that are causing people to feel distressed, that are not a natural or welcome part of themselves, and that they would like to be rid of.
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> Axis II is used for designating personality disorders and mental retardation, which are conditions defined by the way people are and have been, rather than by symptoms they have developed and that come and go. The maladaptive characteristics of people with personality disorders consist of well-entrenched traits and behavioral dispositions that they are comfortable with and see no need to change, regardless of whatever difficulties may be resulting from them. Personality-disordered individuals would like to see the world change to accommodate their style and preferences, whereas symptom-disordered individuals would like to change themselves to fit more happily and productively into the world around them.
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> Axis III of the *DSM* is used for reporting any general medical conditions that may be relevant to understanding or treating a

patient's mental disorder (e.g., cancer, seizure disorder, ulcerative colitis).

Axis IV is used to report psychosocial and environmental problems that have a bearing on the person's treatment needs and prognosis (e.g., family disruption, stressful work situation, homelessness).

Axis V is used for rating the overall adequacy of a patient's level of functioning from 1 to 100 according to criteria specified in a Global Assessment of Functioning (GAF) scale.

Despite its popularity and the years of effort that have gone into preparing and revising it, the *DSM* has some notable shortcomings. First, many of the criteria that are provided for individual categories of disorders are overlapping rather than discrete. Because some symptoms and personality traits characterize two or more of the disorders classified in the *DSM,* clinicians may have difficulty agreeing in their differential diagnosis of these disorders. To minimize this difficulty, the *DSM* recognizes that a person's disorder may meet criteria for more than one Axis I or Axis II condition, in which case all of the conditions that seem present should be diagnosed. This flexibility takes appropriate account of the fact that most psychological disorders are complex and multifaceted. However, it does not resolve the reliability issue, nor does it resolve how people should be selected for a research sample or some form of treatment on the basis of their diagnosed condition when they have been diagnosed with multiple conditions.

A second shortcoming of the *DSM* resides in its calling for categorical classification. Each *DSM* disorder comes with a list of criteria and instructions to diagnose the condition as present if a certain number of these criteria are met. The clinician decides categorically whether each criterion is met, determines whether the required number of positives is present, and decides on this basis, yes or no, whether the condition should be diagnosed. This categorical approach does not fully capture the variability of the disturbing symptoms and maladaptive personality characteristics that constitute psychopathology, particularly with respect to the degree to which they are present.

The alternative to categorical classification is a dimensional approach that considers not just whether five of eight criteria for a condition are met, for example, but also the differential implications of showing all eight instead of just five of the criteria, or four as opposed to the five necessary for a categorical diagnosis. Similarly, in a dimensional approach, the individual criteria for a condition can be examined not only for whether they are present, yes or no, but also for their severity and pervasiveness. Improved reliability and dimensionality in diagnostic classification are issues for the future in the study and treatment of psychopathology, and the readings recommended at the end of this chapter elaborate the current status and anticipated directions of research and practice in this area.

The *DSM* has, despite its shortcomings, fostered substantial improvements in diagnostic reliability and proved extremely valuable in promoting systematic research and treatment efforts with persons considered to have particular disorders. Empirical findings have also documented the validity of many of the descriptive and predictive statements in the *DSM*. Additionally, as a consequence of its widespread use, the *DSM* has facilitated communication among mental health professionals and between the mental health community and people in other walks of life whose work or interests touch on mental health issues. Among persons who are familiar with the *DSM* terminology or have access to a copy of the manual, reference to a *DSM* condition conveys exactly what is being referred to and why. The *DSM* classification was, accordingly, used to guide the selection of case studies for this book.

Selection of Case Studies

The 18 case studies in this book were selected to represent several broad categories of psychopathology identified in *DSM-IV-TR* and to illustrate some of the most commonly occurring disorders in each of these categories. In keeping with the previously described continuity perspective on psychopathology, in which psychological disturbance

is conceptualized as a maladaptive exaggeration of normal ways of thinking, feeling, and acting, the first section of the book moves from normality to Adjustment Disorder in Chapter 2. Of all the conditions codified in the *DSM,* Adjustment Disorder represents the least deviation from psychological normality. Adjustment disorders consist of an abnormal and maladaptive reaction to a stressful situation, but they are typically short-lived and have no implications for persistent or recurring psychopathology.

When psychological traits or dispositions become persistently maladaptive, they result in personality disorders. Chapters 3 through 7 present case illustrations of five relatively common and dramatic types of personality disorder: Dependent, Borderline, Antisocial, Schizotypal, and Paranoid. Turning next to symptomatic disorders, in which people experience distressing and unwelcome thoughts, feelings, and action tendencies, the third section of the text illustrates five types of anxiety and somatoform disorders: Panic Disorder with Agoraphobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Generalized Anxiety Disorder, and Pain Disorder (Chapters 8 through 12).

Two specifically focused categories of symptomatic disorder, identity disorders and habit disorders, are the focus of the next two sections. Identity disorders are illustrated by Dissociative Identity Disorder in Chapter 13 and Gender Identity Disorder in Chapter 14. Habit disorders are addressed with a case involving addiction (Polysubstance Dependence in Chapter 15) and a case of eating disorder (Bulimia Nervosa in Chapter 16). The text concludes with case illustrations of the most serious forms of psychopathology, mood disorders and schizophrenia: Depressive Disorder in Chapter 17, Bipolar Disorder in Chapter 18, and Schizophrenia in Chapter 19.

Recommended Readings

Beutler, L. E., & Malik, M. L. (2002). *Rethinking the DSM: A psychological perspective.* Washington, DC: American Psychological Association.

Blashfield, R. K., & Livesly, W. J. (1999). Classification. In T. Millon, P. H. Blaney, & R. D. Davis (Eds.), *Oxford textbook of psychopathology* (pp. 3–28). New York: Oxford University Press.

Nathan, P. E., & Langenbucher, J. (2003). Diagnosis and classification. In G. Stricker & T. A. Widiger (Eds.), *Clinical psychology* (pp. 3–26). Volume 8 in I. B. Weiner (Editor-in-Chief), *Handbook of psychology*. Hoboken, NJ: Wiley.

Offer, D., & Sabshin, J. (Eds.). (1991). *The diversity of normal behavior*. New York: Basic Books.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.