PERSONALITY AND PSYCHOLOGICAL DISORDERS

GORDON CLARIDGE and
CAROLINE DAVIS

ROUTLEDGE

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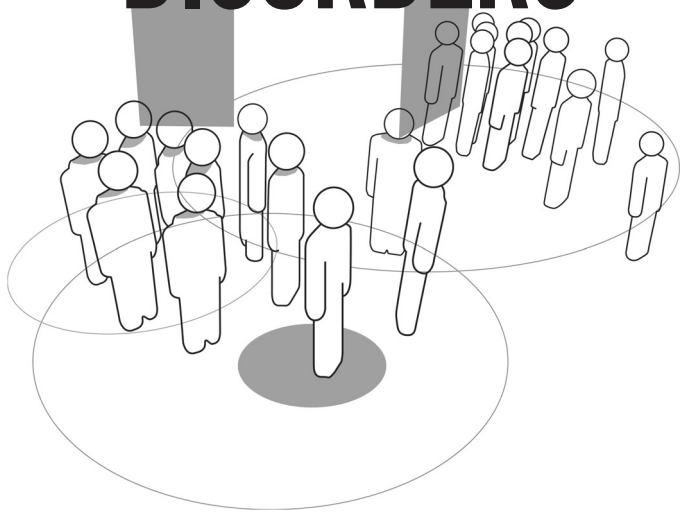

Dedication

To the 21 Oxford students on whom we tested an early version of this book.

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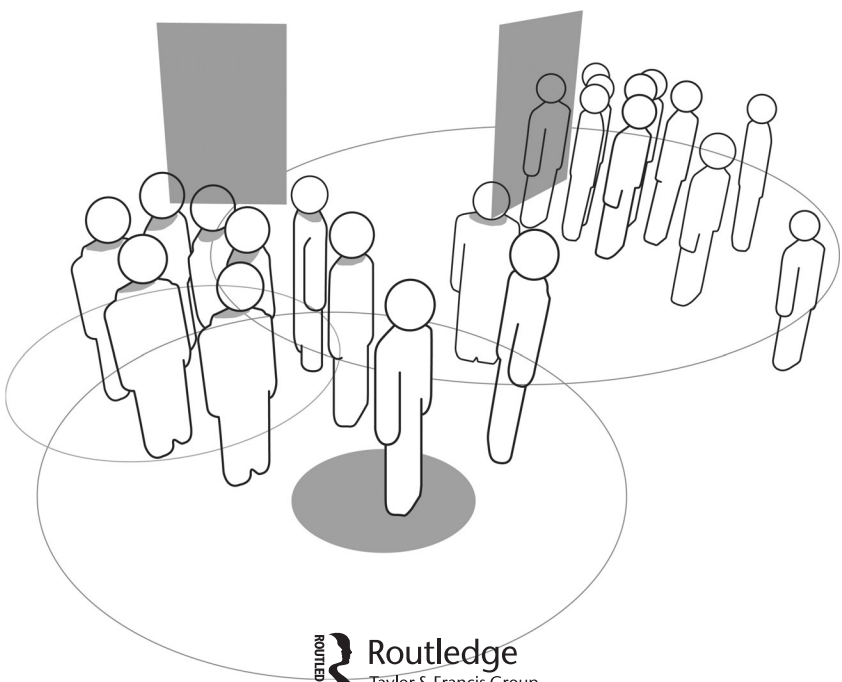

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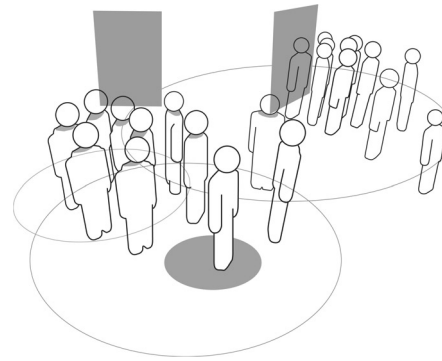

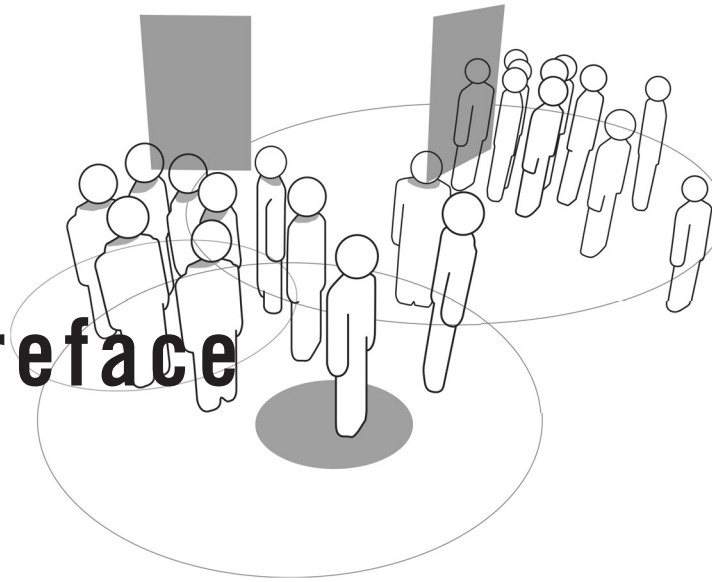

Preface

As is often the case, this book had a serendipitous beginning. More precisely, it started after one of us could not resist voicing his opinion to Arnold that there was a need for a book like 'Personality and Psychological Disorders'. Before we knew it, we were writing one! And having finished it we can now see why there hasn't been one before, at least one at a factual level of complexity sufficient to be informative, but not too detailed to be inaccessible to the readers for whom it is mainly intended. We hope we have come some way towards striking that difficult balance; for each of the two areas covered is itself a huge branch of psychology, with many different viewpoints and examples that clamour to be represented. Indeed, the two topics – individual differences and psychological disorders – are generally taught separately in psychology degree courses and, in our experience, reference from one to the other, even if occurs, is sketchy and tentative. This is a pity because, as we try to show in this book, the study of personality may be usefully enriched by looking beyond the average and the healthy; whilst the deviant states of mind and behaviour that constitute the subject matter of abnormal and clinical psychology can scarcely be understood without reference to some concept of normality.

As described in the early chapters of the book, the arguments we develop and the material we present, concentrate on a certain way of thinking about the connection between normal and abnormal: one that draws particularly on its biology, yet without embracing a straightforwardly disease view of psychological disorder. This perspective has not always been uncontroversial – and that is still the case in some quarters. We chose it because it is well-grounded in the history of ideas about the topic, is supported by considerable past and present scientific evidence, and, looking to the future, is likely to

assume increasing importance as we begin to understand more about the origins of personality and its occasional manifestations in mental illness.

Although, as co-authors, we naturally share a common interest in this approach, we don't necessarily agree on every implication of it – at the very least, we are sometimes led to place our emphases differently. We have not tried to conceal this by seeking to homogenize the text. On the contrary, we have allowed our respective interpretations of the book's title to flourish, on the grounds that the learning process is a matter of finding out about different viewpoints and different interpretations of evidence, and then making up one's own mind.

There are a number of people we need to thank for their help and understanding during the course of constructing this book. There are those among our respective family circles who did not see enough of us, or when they did found us distracted and preoccupied. At Arnold we wish to thank Christina Wipf Perry, formerly Publisher for psychology, for commissioning us to write the book in the first place and, currently, Emma Woolf, Commissioning Editor for Psychology, and Jasmine Brown, Senior Desk Editor, for seeing it through to production.

Lastly, we thank the goddess for our shared sense of humour and each other for mutual support and encouragement during moments of writing crisis.

Gordon Claridge
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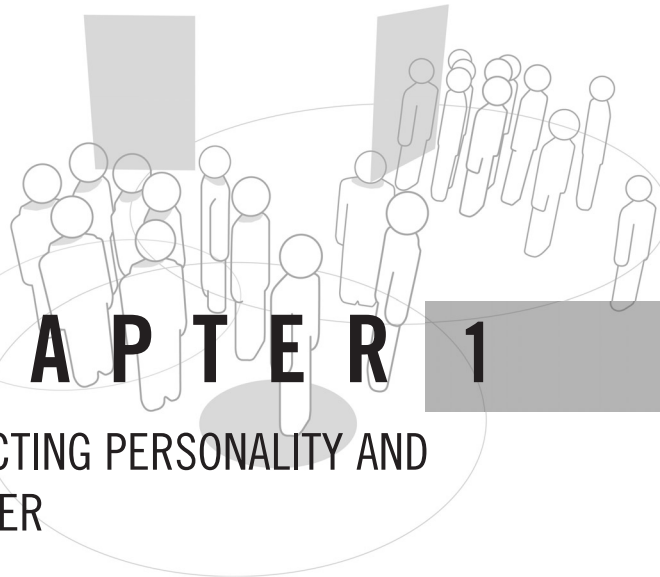
July 2002



CHAPTER 1

CONNECTING PERSONALITY AND DISORDER

SOME THEORETICAL ISSUES

That psychological disorders are intimately connected to personality might seem self-evident. Yet the idea may be interpreted in several ways and has been studied from a number of different perspectives. In this opening chapter we will discuss some of those views and, in so doing, draw out the particular themes that form the content of the rest of the book.

One interpretation refers to the impact of having a psychological disorder upon the individual; how the onset and progression of a mental illness can temporarily or permanently alter sufferers' personal reactions to events and others around them. This can be reflected in lowered self-esteem, increased emotional sensitivity, a greater tendency to depression, the exaggeration of temperamental tendencies which in the healthy state may be hidden or scarcely visible, yet, in the presence or aftermath of mental illness help to re-define the individual's here-and-now personality. Although we shall not emphasize this aspect of the link between personality and disorder, we should at the very beginning stress its importance. Personality is a dynamic feature of individuality, constantly changing, progressing (or regressing) according to environmental demands and internal developments of the organism. Although this evolution of the person is most salient in the early years – infancy, childhood and adolescence – nevertheless it continues throughout life. Indeed, the development of a psychological disorder as an adult may be seen as a particularly dramatic example of how apparently quite stable propensities to action, motivations, and other characteristics that constitute the personality can be thrown into disarray. This is particularly true in the case of the serious mental illnesses, such as schizophrenia, but it is also noticeably so in other intractable disorders like obsessive–compulsive neurosis, a point we shall

return to it in the chapter devoted to that condition.

Another interpretation of the title of this book – closer to its actual subject matter – approaches the question from the opposite direction. That is to say, it examines how personality can *predispos*e to disorder, influence an individual's response to stress, shape its severity and its progression. A straightforward example would be a client who complains to the clinical psychologist or psychiatrist of excessive anxiety, to the extent of agoraphobia, usually defined as a fear of public places and often seen as a refusal to leave the safety of the home. Whatever other formative factors, such as immediate life circumstances or recent traumatic experience, have contributed to this person's condition, it is an interesting fact that not everyone faced with such exigencies will develop agoraphobia or, indeed, any form of maladaptive behaviour. Examples abound of individuals who, exposed to the most traumatic circumstances, should by rights be mental wrecks – yet they emerge as perfectly healthy, adapted persons, able to cope with whatever life throws at them. Why is this?

One explanation is that of 'toughening up'. That is to say, exposure to early adversity might, in conjunction with certain psychosocial protective factors, make some individuals better able to cope with later stress (Masten, 1994). Another explanation – and one we shall particularly emphasize here – is that those who survive trauma possess temperamental or personality characteristics that make them inherently less likely to be affected by stressors that cause others to succumb; as a generalization, that people simply differ in the extent to which personal tendencies make them more or less liable to psychological breakdown. In the course of the book we shall see that there is good reason to believe that this is true, and we will examine some of the intrinsic differences that cause some people to become seriously mentally ill, others mildly disordered only, and yet others not disturbed at all.

As a corollary to the above, there is another, more specific question we shall address. It concerns the actual *form* of disorder a person develops if he or she does break down into mental illness. It would be surprising, too, if this were unconnected to the individual's personality. Indeed, the idea is not new; it traditionally forms part of clinical approaches to personality, the abnormal manifestations of which have been of obvious interest. The classic example was Freud's theory about the developmental stages through which individuals are supposed to go in their passage to mature adulthood (Freud, 1940). Freud labelled these so-called 'psychosexual' stages – oral, anal, phallic, and genital – according to the biological sources of satisfaction attached to them. He proposed that people normally pass from one stage to the next in an orderly sequence, resolving as they go conflicts which he believed were commonly encountered at each point. But Freud also suggested that individuals may sometimes get fixated, or stuck, at an earlier developmental stage than necessary for full maturity – and, furthermore, that this lays the groundwork for specific forms of neurotic illness or other disordered behaviour. Thus,

fixation at the anal stage is supposed to lead to extreme obsessive–compulsiveness; oral fixation to unhealthy narcissism (abnormal preoccupation with the self) or, even worse, what can be diagnosed as narcissistic personality disorder. Yet, in a more healthy form, both of these features – self-regard and a touch of obsessionality – are perfectly adaptive traits, sitting easily alongside the many other characteristics that serve to describe the well-rounded personality.

Like many aspects of Freud's writings, his explanation of why different personality types develop different psychological disorders has found limited support from empirical study (Kline, 1972). Although still popular in literary and artistic circles, the theory therefore rarely figures among discussions of personality development in mainstream academic psychology. Nevertheless, it does state an important point of principle: that it is impossible to understand the nature of psychological disorders, including the form they take in particular individuals, without knowing something about the personality characteristics from which they spring.

Contemporary psychologists formulate the question differently. This stems from the prevailing view that, at least as the starting-point for studying it, personality is best considered as being made up of a collection of traits – relatively stable tendencies, inherent in the person, which define unique ways of behaving, thinking, and feeling. What makes people different from one another is that they differ in the profiles they show across the various traits that constitute personality. Traits themselves can be, and frequently are, described with commonsense adjectives – *honest*, *worrying*, *confident*, *shy*, *rigid*, etc. – but, in the hands of personality researchers, the use of such labels is not just an armchair exercise. On the contrary, as will be discussed in Chapter 3, quite sophisticated statistical methods are required to identify those traits which, for scientific purposes, may be judged both reliable to measure and useful as predictors of behaviours that each trait is supposed to describe.

Although adopting basically the same statistical method, some personality theorists prefer to work, not with a large number of narrow traits, but with just a few broad dimensions: the most commonly quoted example of the latter is 'introversion–extraversion'. Choosing the broad dimension, as against the narrow trait, approach (or vice versa) has influenced how psychologists have then proceeded to explore personality further. But, that aside, the approaches are very similar, and identical in two important respects.

First, it is known – and this can be demonstrated statistically – that broad dimensions *encompass* narrow traits. In fact, one is a summary of the other: each broad dimension acts as a sort of collecting-point for the traits that help to define it. This may be illustrated in the case of introversion–extraversion, cited above as a typical broad personality dimension. 'Underneath' this dimension, as it were, there are several narrower traits that elaborate on what, at the more general level, we mean by extraversion (or its opposite, introversion):

extraverts are more sociable, cheerful, talkative and so on. Broad dimension and narrow trait descriptions of personality are not, therefore, incompatible; they are merely alternative ways of expressing the same thing.

The second reason the two approaches are virtually identical is that both assume *continuity* in the features – whether broad or narrow – that they use to describe personality. Individuals are *more or less* honest, worrying, confident, shy or rigid, being ranged at various points along unbroken continua that describe the traits or dimensions in question. This way of describing personality is therefore tailor-made for examining associations to the psychological disorders. The clinically abnormal can easily be visualized as, in some regard, an extension of the normal, defining the extremes of the dimensions that describe personality.

In fact, the picture is not quite as simple as that. For, as we shall see, people who have already developed a mental disorder are not *merely* individuals occupying the end-point of some normal personality dimension, even if the latter does describe part of their condition. Again, consider the agoraphobic. He or she would almost certainly be found to score highly on a rating scale or personality inventory of trait anxiety. But, by the time they are formally diagnosed as agoraphobic – and probably even before – such individuals will have developed new, pathological, behaviours (symptoms); for example they refuse to leave the house and express irrational fears that they did not have before. In other words, they are now *more* than just people of very anxious personality; so new facts are needed to explain their transition from extreme *trait* anxiety to *symptomatic* anxiety. Nonetheless, this does not alter the working rule that personality and psychological disorder are connected by virtue of the fact that one reflects, in some sense, an exaggeration of the other.

The view of individual differences just outlined is very superficial, accounting only for the *structure* of personality, how the clustering of traits or the combining of dimensions helps us to describe the variations between people. But most theories of this type try to go one step further and look for explanations or underlying causes of the personality differences – and, by extrapolation, the disorders to which they connect. This has frequently been done from a biological standpoint and has two themes.

One involves trying to characterize the neural basis of traits or dimensions, discovering what facets of brain activity might account for, or at the very least correlate with, personality variations. It then becomes possible to build up a picture of how the nervous system works in people who are, say, impulsive, sensation-seeking, or of depressive temperament. Here, personality psychologists make use of techniques or draw upon existing information, where available, from all branches of neuroscience, including psychophysiology, neurophysiology and neurochemistry, as well as studies of drugs that affect brain function. At our present stage of knowledge there is still a fair amount of approximation in all of this and the exercise very much

amounts to what the eminent Canadian psychologist, Donald Hebb (Hebb, 1955) once referred to as building a 'conceptual nervous system', an imaginary model which hopefully will eventually be found to correspond to how the real nervous system works. Hebb himself was referring to the general case in neuropsychology. But all systems show fluctuation and variation, and the brain is no exception. This rule – that nervous systems differ in the way they work – coupled to the principle that such variations partly explain why people have different personalities, provides the key to understanding much that we shall be writing about here (see Claridge, 1995) for a general introduction to these ideas).

A second important theme in the biological account of personality is genetics. Almost all theories that explain personality by referring to biology also propose that the differences observed are under some degree of genetic control. Here, two strands of evidence may be distinguished. One is represented in the search for genes that could contribute to nervous system variability in brain function, which could, in turn, find expression in psychological and behavioural differences. The other comes from use of the statistical procedures of *behaviour* genetics; that is, seeking evidence for hereditary influences by examining how far family members selected for their degree of kinship resemble one another on some personality trait or dimension – or indeed an appropriate physiological correlate of it. The classic method involves comparing twins, classified according to whether or not they are genetically identical. In these cases the aim is to arrive at a statistical estimate of the so-called 'heritability' of the trait being studied. Behaviour genetics is the older discipline and was the only source of evidence available to individual differences workers until the advent of the new era in genetics research. Nevertheless, it still has a crucial role to play in contemporary enquiry: in bolstering evidence from molecular genetics that genes do play a part in some chosen feature of human variation, and in leading researchers to possible sources of variation where such genes might be worth looking for.

Before leaving the theme of genetics we feel we should insert some cautionary remarks. It is currently fashionable, not just in popular writing but also in scientific publications, to claim that there are, or could be, genes for complex behavioural traits. We believe this to be very misleading. Genes code for very precise, literally microscopic, bits of biological material (proteins) that are both physically and conceptually very distant from the complex behavioural and psychological characteristics which they are supposed to – and perhaps in some sense – do influence. But it is unlikely that there are genes, or sets of genes, 'for' impulsivity, the preference for gay relationships, religiosity, anxiety, or even serious mental disorders, such as schizophrenia. The route from genes to behaviour is likely to be much more tortuous than that and, for any particular characteristic, to involve a multitude of genes and interactions among them – as well as an interplay between genes and

environmental factors. The reason for taking an interest in the genetic effects on individual differences – and there is good evidence that they do exist – is therefore not in order to *reduce* everything to heredity, but to see where such influences fit into the larger picture about personality.

Pursuing the above point, we should also state that, although we will be mainly emphasizing the biological aspects, our overall view of the material to be presented is, strictly speaking, *psycho*biological. That is to say, it assumes that human variation, both normal and abnormal, is an integrated whole, of biological and psychological influences, both equally legitimate fields of enquiry and sources of information. In practice, of course, it is frequently difficult to bring them together, except in parallel as alternative descriptions or explanations of the same factual data. The language used in each domain is different, it is possible only to talk in one of them at a time, and a bias towards one or the other is bound, as here, to predominate. Nevertheless, we shall, where possible, try to remind the reader from time to time of the psychobiological nature of the phenomena we are describing and draw upon more 'psychological' ideas. This especially includes reference, where appropriate, to the *cognitive* viewpoint, which is currently the one that prevails at the clinical end of the subject. At least, that is the case among psychologists, though less so in psychiatry where biological explanations of mental illness predominate. These differences of viewpoint – their history and the tensions to which they have given and still give rise – are themselves of interest and deserve further comment here, in order to place the material presented in our book in its proper context.

AN HISTORICAL PERSPECTIVE

Dispute about the relative importance of biological and non-biological explanations of personality and abnormal mental states has always existed and is merely a particular case of the age old philosophical preoccupation with brain/mind relationships. The issue has frequently been discussed around the value of the medical model in psychiatry, articulated as the question: How far can psychological disorders be judged similar to physical diseases? The contemporary scene contains several shades of opinion that mirror historically distinct disagreements, sometimes within psychiatry, sometimes between psychiatry and psychology, and sometimes between clinical psychology and its parent discipline of academic psychology.

Historically, the most publicized part of the debate was in psychiatry, stemming from challenges, for a period from the 1960s onwards, to the received wisdom of mental illnesses as brain diseases. The two pivotal critics of that view were the Scottish radical psychiatrist, R.D. Laing (1960), and the American anti-psychiatrist, Thomas Szasz (1974). Although arguing from (sometimes very) different standpoints, Laing and Szasz did agree on one thing: that biology was not relevant to disorders of the mind and behaviour.

These, they said, could only be fully understood from a social or sociological point of view. In the event, Establishment psychiatry won out: Laing drifted into mysticism and alcoholism, and Szasz became marginalized as a still vociferous, but largely ignored, polemicist. The triumph of biological psychiatry came about because of advances in the neurosciences, including pharmacology, so that, at the beginning of the twenty-first century it is impossible to ignore the fact that, whatever else one wants to believe, the brain has *something* to do with mental disorder.

Notably, the mid-twentieth century disputes within psychiatry were mostly fuelled by differences of opinion about schizophrenia and other forms of serious mental illness. This might be crucial to understanding the course of subsequent events: the biologists could not fail to win the argument given that, even in the absence of precise knowledge about why they are like they are, schizophrenic individuals have always 'looked' as though their brains were acting up. The evidence that did eventually accumulate to support this conclusion therefore very easily spearheaded a general shift towards biological explanations of *all* forms of psychological disorder. Indeed, some would argue that the trend has gone too far towards an expectation that everything that is deviant about the human condition may be explained by reference to biology. Whether or not that is true, the fact remains that the brain is here to stay in psychiatry.

The Laing/Szasz attack on psychiatrists for their overenthusiasm for the medical model was not the only one, however. At about the same time as psychiatry was being challenged from within its own ranks, it was also coming under fire from psychology, specifically from Hans Eysenck, one of the founding fathers of the dimensional, trait, view of personality that we have already introduced here. Eysenck, whose writings we shall often have occasion to refer to again, also disliked the prevailing psychiatric construction of psychological abnormality. But his arguments against it could not have been more different from those of Laing, Szasz, and their followers. Eysenck's criticism was more along the lines that, rather than being discrete disease entities, as the medical model demands, mental illnesses merely form the end-points of normal personality dimensions. Furthermore, contrary to the radicalists within psychiatry, Eysenck very much argued for there being essential biological roots to disorder. So, although being on the side of psychiatry over the importance of looking at the brain, he construed its involvement in mental illness differently. For Eysenck – in line with the view to be presented here – understanding the biology of mental illnesses was very much an extension of understanding the biology of the personality traits that predispose to them (Eysenck, 1960).

A third element in this history was the emergence of clinical psychology as an offshoot of academic abnormal psychology, separate from the latter but influenced by and influencing its ideas. It should be noted that the theoretical stance and attitudes found among clinical psychologists have always been

somewhat coloured by professional considerations; an evolving need of a group of practitioners seeking a role, independent of psychiatry, in the treatment of the mentally ill. In the early days of this new profession many clinical psychologists – mostly those of a social constructionist persuasion – were delighted by, and fiercely joined in with, the attacks launched by Laing and Szasz on their colleagues in psychiatry (Bannister and Fransella, 1971). However, this was not true of all clinical psychologists. Others, schooled – indeed sometimes through Eysenck's influence – in more behaviourist accounts (and treatments) of psychological disorder, were just as much at loggerheads with other clinical psychologists. But even they took some satisfaction at the rifts occurring within psychiatry at that time.

It would be an oversimplification to suggest that the contemporary scene in clinical psychology may be traced in a straightforwardly linear fashion to these early differences of opinion. Nevertheless, some continuity can be observed: the emergence of a predominantly cognitive view of mental disorder; the confluence, on the therapeutic front, of behavourist and mentalistic traditions, leading to the almost universal preference for so-called 'cognitive–behavioural' treatments; and a lasting indifference, in some quarters even hostility, to things biological, whether coming from psychology or from psychiatry.

The professional side of this development in clinical psychology has continued to be strongly shaped by the need, referred to above, for an independent practitioner identity, separate from that of the psychiatrist. Current practical questions are therefore often articulated in the form of, say, a comparison of the relative efficacy for panic disorder of some drug regime versus an appropriate cognitive–behavioural manipulation. Theories in clinical psychology correspondingly tend to be driven by these same treatment concerns and to be formulated in the language of cognitive psychology, with little reference to biological ideas, even of the kind found in personality psychology.

There may be two reasons why clinical psychology has been reluctant to seek a meeting-point with biological personality theory. One is that, on the face of it, the latter appears to offer little in the way of practical guidance on treatment issues. Indeed, as we will touch upon briefly in the final chapter, the reverse might be true: the idea of biological vulnerabilities (and invulnerabilities) could imply restraints on the upper limits for change in the mentally ill. Another reason is that embracing *any* kind of biological explanation might take clinical psychology too close to the psychiatric model of psychological disorder that it has tried hard, for professional reasons, to avoid.

LAYOUT OF THE BOOK

It is clear from the above that there are some subtle (as well as not so subtle) shades of opinion in the field of study covered by this book. In the following chapters we shall try to disentangle these: to provide a view of psychological disorders that takes account of the personality factors from which they

originate, and a view of personality that helps to define the abnormal. Since we shall be attempting to span two domains – or, more accurately, explore the spectrum that joins them – there is a choice of where to start. Should we first outline the personality theories that are relevant to the topic? Or should we start by saying something about the nature of psychological disorder? We decided that the latter is the more appropriate, for the following reasons.

We have already sketched out in this chapter the kind of personality theories upon which we shall draw; the bare bones of them, admittedly, but in sufficient detail to make clear the drift of the argument about how the study of personality can inform our understanding of psychological disorder. The notion of dimensionality lies at the heart of that connection and there are some issues about this that we have not yet discussed, except in our brief reference above to different views that have been expressed about the status of mental illness as medical disease. In the next chapter, therefore, we shall examine that question in more detail, explaining how psychological disorders are classified and diagnosed, the principal theoretical model that lies behind that process, and some criticisms of and alternatives to it.

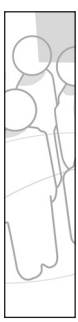
This will lay the groundwork for returning, in Chapter 3, to the personality side, when, starting from an historical perspective, we shall consider various competing dimensional theories and how these might help us to describe predispositions to disorder. The discussion there will include something on the biological underpinnings of dimensions proposed in such theories: their developmental and genetic origins; brain systems which might account for healthy variations along the dimensions; and how the idea of abnormal functioning in such systems could reveal clues to the mechanisms of disorder.

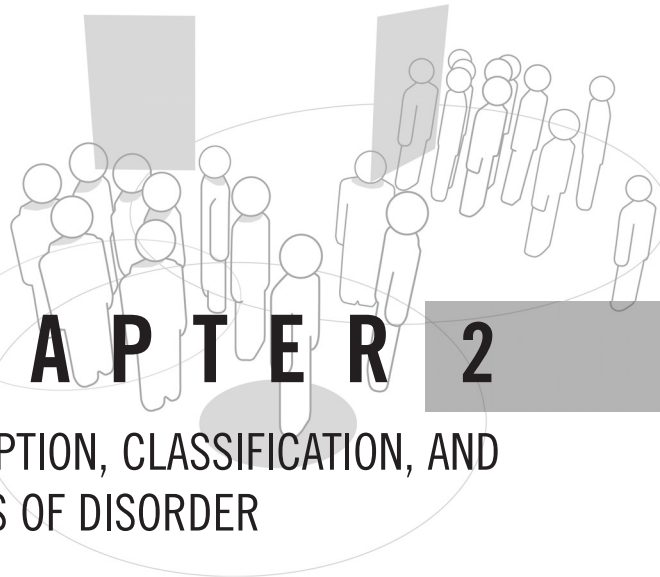
Subsequent chapters will then look at specific disorders and groups of disorder. These have been chosen as illustrative rather than comprehensive, selected so as to bring out the salient themes that we wish to develop.

The personality disorders are discussed first (Chapter 4) because they represent the clearest evidence of continuity between normal and abnormal. Anxiety disorders and depression (Chapter 5) similarly illustrate this well: in addition to being diagnosable illnesses in their own right, they are universal accompaniments of most other forms of dysfunction (physical and mental) and their underlying mechanisms have a good reference point in normal psychology and biology. Then, in Chapter 6, obsessive–compulsive disorder is introduced as a more specialized, but very informative, example of the dimensionality of psychiatric illness. Chapters 7 and 8 discuss, respectively, substance abuse and eating disorders. Taken together, these illustrate several points. In addition to being relatively common, both are good examples of the truly psychobiological nature of disorder: there are personality correlates, social factors in their aetiology, cognitive explanations of their symptoms, and strong biological statements to be made about the progression once the behaviours associated with them have been established. In Chapter 9 we

extend the discussion to the psychotic disorders and demonstrate how the dimensional model can even be applied to these more serious illnesses.

Lastly, we should state that we both believe strongly in the importance of taking an historical perspective on ideas. Explanations and theories are rarely entirely novel. Instead they almost always build upon earlier formulations and, however 'modern' a fresh viewpoint might seem, it is generally a revision or a modification of something that went before. The reader will come across several examples of this historicism in the book and sometimes we will deliberately draw the connection. The main point is to bear in mind the long time factor of the ideas to be presented, and to appreciate that this, in itself, helps to give them some credence.





CHAPTER 2

DESCRIPTION, CLASSIFICATION, AND MODELS OF DISORDER

THE MEDICAL CLASSIFICATION

Whenever natural variations are seen in some phenomenon there is always a need to classify them – to arrive at what in biology is termed a *taxonomy,* an orderly descriptive system for bringing together subsets of examples that share similar features. In the case of psychological disorders, attempts to construct such a taxonomy – in this case called a *nosology* – has traditionally been in the hands of psychiatrists. Consequently, as will be evident from our introductory chapter, the form and thinking behind psychiatric nosologies have been very much dictated by a medical model, a belief in the need to identify distinct psychological diseases. This has often attracted criticism. But it should not blind us to the fact that, irrespective of how it is done, *som*e way of systematically distinguishing between the various psychological disorders is required. Why is this? There are three main reasons.

First, it provides clinicians and others involved in the management of the mentally ill with a language in which to communicate with one another about individual cases with whom they are dealing. It obviously helps, when exchanging information about a patient or client, if some commonly agreed terminology is available and if a label can be assigned, which differentiates one person's disorder from another's. Second, classification helps in the choice of treatment. Indeed, if it did not do so, the nosology would be of limited use, since one of the main purposes of the labelling process is to match the client to a suitable form of therapy. Third, classification serves a scientific need, by defining the guidelines for studying different types of disorder; it allows researchers interested in a particular disorder to select for investigation only those cases that share defined features of the condition they wish to study. Of course, since such research has to be done in order to help to establish the

nosology in the first place, there is an element here of what is often called 'bootstrapping', that is, gradually refining the classification on the strength of new knowledge that accumulates from its use.

It is evident from the above – and emphasized in the last point – that there is nothing that is cast in stone about current attempts to classify psychological disorders. Nosologies only represent a present state of affairs, an accumulated wisdom, as interpreted by contemporary experts in the field. This is illustrated by considering the two systems of psychiatric classification currently in use. One is the *International Classification of Mental and Behavioural Disorders (ICD)* (World Health Organization, 1992); the other is the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 1994). The former, as the name implies, is a universal publication: it provides diagnostic guidelines for clinicians throughout the world and forms the basis for collating cross-national statistics on mental disorder. The *DSM*, on the other hand, is of North American origin but is also widely referred to outside the USA.

Both the *ICD* and the *DSM* are essentially handbooks, consisting of lists of disorders, each accompanied by the defining characteristics by which the clinician arrives at a diagnosis in a particular case, Both glossaries are quite similar (or can be translated across from one to the other), but the fact that they are not identical indicates that the diagnostic categories they suggest are somewhat arbitrary and often represent compromise. This is bound to be the case, since the contents of both merely result from decisions made in committee by groups of professionals, experienced in their own fields, but often of differing theoretical persuasion or clinical expertise.

Illustrating an earlier point, it should also be noted that these glossaries are not static in their definitions of disorder. At the time of writing the ICD is in its tenth edition, whereas the DSM has reached its fourth edition (DSM-IV), having gone through two previous editions since 1980 and already being in the process of revision to DSM-V. In the meantime an intermediate version has been introduced, known as DSM-IV-TR (American Psychiatric Association, 2000). There is therefore continual 'tweaking' of psychiatrists' definitions of psychological disorders, even over relatively short periods of time.

Here, whenever we have occasion to refer to these psychiatric classifications, we shall use the DSM-IV, for two reasons: it is more detailed than the ICD in its descriptions of psychological disorders; and it is much more commonly adopted as the nosology of choice for selecting subjects in research studies, even outside North America. Before considering the DSM from this more academic standpoint it will be helpful to get some idea of its structure, purely as a practitioner's diagnostic manual.

DSM-IV, like its two immediate predecessors, is organized around what is referred to as a 'multi-axial' approach to diagnosis. This means that a clinician making full use of it to assess a patient at first interview reaches a decision on five facets of the individual's condition. For information, these are listed in

Table 2.1. But note that here we shall be mostly concerned with just two components: Axis I (the classes of major clinical disorders) and the personality disorders listed under Axis II. Together these form the centrepiece of the DSM system of psychiatric classification.

Table 2.1 DSM Axes.

Axis I	Clinical disorders
Axis II	Personality disorders Mental retardation
Axis III	General medical conditions
Axis IV	Psychosocial problems
Axis V	Global functioning

The thinking behind the DSM (and the ICD) approach is explicitly categorical, drawing on the medical model of defining classes of disease according to their superficial features, before (or in conjunction with) trying to identify their causes. The general assumption of this method is that the diseases in question form relatively discrete, homogeneous entities, without overlap between them and with fairly clear boundaries between illness and health. Judged in this way, how does the DSM-IV fare? In the Introduction the authors admit that the DSM system is far from ideal, falling well short of the standards for a strictly categorical model of the kind that works well in physical medicine; they defend it largely on the practical grounds we mentioned earlier – as a vehicle for communicating between professionals in the field. But, doubts remain about it on the scientific front: whether the DSM or similar categorical systems are best suited to taking forward our *understanding* of psychological disorders. There are several areas of concern.

A central problem is that of *comorbidity*, the tendency for an individual to meet the diagnostic criteria for more than one disorder. This can genuinely occur; as in the case of someone having, by coincidence, the symptoms of two quite separate conditions. After all, it is common enough in physical medicine: diabetic individuals catch the 'flu like anyone else, and patients with cystitis can suffer hair loss. But in those cases there is factual evidence that each illness has a distinct aetiology – and anyway the disorders in question simply *look* quite different. By comparison, in psychiatry comorbid disorders often seem suspiciously similar, as though they share some common cause or underlying mechanism (One notable example, relevant to our discussion in later chapters, is the conjunction of eating disorders and substance abuse disorder).

An extension of the comorbidity problem is the overlap between what in the DSM are regarded as two separate types of disorder: the major mental illnesses

in Axis I and the personality disorders in Axis II. Several Axis II disorders are descriptively similar to and have an apparent counterpart in an equivalent Axis I disorder; for example, Obsessive Compulsive Disorder (Axis I) and Obsessive Compulsive *Personality* Disorder (Axis II). Although these two are by no means always comorbid, there is evidence suggesting – not surprisingly – that there is some relationship (continuity) between them (Nigg & Goldsmith, 1994). To consider them as belonging to two totally different classes, and as sitting on two different axes, of abnormality therefore looks very artificial. It also tempts us to believe that their respective aetiologies are quite unconnected, which is almost certainly not true. The same problem will be seen to arise in an even more serious form when we come to address associations between Axis II disorders and the psychotic illnesses.

Equally unconvincing is the DSM formulation of the Axis II disorders themselves as categorical. Even if the main mental illnesses could be said to be in some sense qualitatively distinct, the personality disorders definitely seem less like that. To view them as categorical appears to be taking the 'medical model' too far. To make matters worse, the personality disorders subsumed under Axis II are themselves highly comorbid. As we shall see when we discuss Axis II in more detail in Chapter 4, the DSM deals with the problem by acknowledging the existence of related 'clusters' of personality disorder. But this does not instil much confidence that we are dealing in that case with recognizably disparate classes of abnormal behaviour.

Another criticism to be made of the categorical approach is that it does not deal all that well with the fact that the distinction between illness (or dysfunction) and health is not itself clear-cut. Of course, this is by no means confined to psychological disorders: people with physical diseases can also experience these to a varying degree. There, too, decisions constantly have to be made – both by the sufferer and by doctors – about whether the symptoms are bad enough for the person to be considered unwell. Nevertheless, psychological disorders *are* uniquely different. In physical diseases the primary fault lies in just one part of the organism and the evidence for its failure or deficiency is usually fairly objective. Psychological disorders, on the other hand, are defined more in terms of the person's *whole* behaviour and mental functioning. This means that what is judged psychologically abnormal can sometimes seem quite arbitrary, and it may often depend on changing social criteria of what is healthy and unhealthy. In other words, the idea of 'disease process' as the *sole* cause of psychological disorders is less helpful than in the case of physical illness. To explain this point further let us consider one other, very important, distinction that needs to be made in our definition of psychological disorder – and therefore what it is we shall be covering in this book.

We are referring to the comparison between, on the one hand, the psychiatric disorders and, on the other, the *neurological* diseases. Well-known examples of the latter are Alzheimer's disease and Huntington's chorea. We shall not be

considering this type of disorder in this book. It might be asked how we justify that. After all, neurological diseases also affect a person's 'whole behaviour and mental functioning' – a criterion we used above to mark out the psychological disorders. Furthermore, the examples just quoted actually appear in the DSM, as do several other conditions that traditionally, and until recently, have been studied more within the medical specialty of neurology, rather than psychiatry.

The answer lies in the way the nervous system is implicated in the two types of disorder: neurological and psychiatric. In the former, illness results from some pathological process in the nervous system, either one that is already known or one that can be confidently assumed and therefore, at some point in the future, discovered. In other words, neurological diseases are exactly like any other physical disease: they just happen to affect the brain. The disease process involved, whatever it is, can produce a quite gross change in the brain and is often not static, causing a progressive deterioration in mental functioning. Put simply, neurological diseases *destroy* the healthy brain, either partly or completely; they never contain any element that is compatible with full health. This contrasts with the disorders we shall be considering here, where – as we shall explain more fully below – the biology of disorder is more continuous with the biology of health. Before elaborating that point, let us summarize the types of disorder we shall be discussing, either in passing or in detail, in the book. Table 2.2 will act as a guide to this, showing how the disorders are broadly distinguished, as well as how they relate to one another. The table is *not* intended as a summary of the DSM (or the ICD); in fact some terms, for example 'neurotic', no longer appear in the DSM, even though they are still in common use.

The table first draws the general distinction between the psychotic and the non-psychotic disorders and then, for each of these, makes further subdivisions. The exact details of the individual conditions will emerge in later chapters, but one point needs clarifying here: the difference between 'psychotic' and 'non-psychotic'.

Table 2.2 Main types of psychological disorder.

Non-psychotic disorders	Psychotic disorders
Neuroses	***Personality disorders***
Anxiety disorders	Schizophrenia
Obsessive–compulsive disorder	
Dissociative ('hysterical') & somatoform disorders	Manic-depressive (bipolar affective) disorder
Neurotic (mild) depression	Psychotic (severe) depression

In practice – and further illustrating the limitations of categorical description – the distinction between the two expressions of disorder is not all that easy to make. Three criteria have often been adopted, as follows:

- Psychotic illnesses are mostly more severe and psychologically disabling. But that is not always the case: some people receiving a diagnosis of psychotic illness are actually quite mildly affected.
- The label 'psychotic' usually indicates symptoms that are more weird or bizarre, like believing aliens are invading one's mind. But again some 'neurotic' symptoms, for example obsessional thoughts, can also be very strange.
- Psychotic people are more likely to lose touch with reality and lack insight that there is anything worrisome about their behaviour and their ideas. But that is relative and mostly only true in the acute phases of their illnesses.

Of course, if all three of these criteria are met then we can be fairly safe in use of the term 'psychotic' to describe the disorder and so this combination will help, for the moment, to capture what we mean when we refer to psychotic as against non-psychotic.

THE DIMENSIONAL APPROACH

HISTORICAL CONSIDERATIONS: HJ EYSENCK

The dimensional approach to psychological disorders can be almost entirely traced to the ideas of one man. Hans Eysenck, whose professional life spanned more than 50 years (he died as recently as 2000) was a writer of extraordinary research output and breadth of interest. These included many disparate areas of psychology – from astrology and parapsychology to psychosomatic medicine and behaviour genetics; indeed, almost any topic where a question about individual differences in behaviour could be raised (see Nyborg (1997) for a recent *Festschrift* appreciation of his ideas). However, the centrepiece of Eysenck's contribution – and that for which he will be mostly remembered – was his rigorously constructed theory of personality, which he continued to investigate and elaborate throughout his long career (Eysenck & Eysenck, 1985). Working in the psychometric tradition of individual differences psychology, Eysenck believed that it was possible to reduce personality to a series of continuously variable, quantitative traits, measurable at the descriptive level by questionnaire. Although there were eminent contemporaries (notably R.B. Cattell (1965)) who shared his views, Eysenck was unique, for two reasons. First, because he systematically pursued the idea that personality traits have a biological basis (Eysenck, 1967). Second, because his writings about personality made constant