PSYCHOPATHOLOGY AND THE SOCIAL SCIENCES

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INTRODUCTION

It is a privilege to participate in honoring the opening of the new department of Social Psychology. Biometrics Research, like this new department, was born by fission, but developed by fusion of the several disciplines concerned with mental health—abnormal psychology, psychiatry, sociology, anthropology, social work, statistics, mathematics, and last but not least biometrics. Fission, as you know, is a primitive form of propagation, while fusion characterizes the more advanced forms. I hope that the new department of social psychology, though born in fission, will also prosper through fusion.

Professor Klineberg's invitation reached me in Hawaii last summer when the world looked very rosy and nothing seemed impossible. When I returned, and realized what I had undertaken to do, I hurriedly reviewed the areas of contact that exist between psychopathology and social science. To my dismay, simply enumerating these areas would have consumed my whole allotment. A selection had to be made out of the following: (1) social factors in the causation of psychopathology, (2) contributions of psychopathology to social science, (3) contributions of social science to psychopathology, (4) impact of psychopathology on the social order, (5) impact of society on psychopathology, (6) epidemiology
of the mental disorders, (7) social management of the mentally ill, (8) the social organization of the mental hospital, and so on.

Each of these areas is important, and, no doubt, the overlap among them is high, but nothing short of a factor analysis would be sufficient to unravel the independent components. Instead, I performed a logical factor analysis, and emerged with the single dimension of personality as a possible transcending concept which might serve to integrate my comments.

RELATION BETWEEN PSYCHOPATHOLOGY AND PERSONALITY

First, let us spend a few moments on definitions. I hardly need define personality in a group such as this, except to indicate which of the fifty-odd different varieties of definitions I have adopted. By personality, I mean the systematic way of behaving which characterizes a person, and which permits prediction of behavior across many laboratory and life situations. Not being a personality theorist, I reviewed, very carefully, the variety of available theories, and have selected Murphy's (1947) as the most congenial to my research interests. You will recall that Murphy gives as the principle components of personality: (1) physiological dispositions, (2) canalizations formed early in life, (3) conditioned responses, and (4) perceptual and cognitive habits—the joint product of canalization and conditioning. In our own work on the personality of mental patients, we have dealt with each of these components, but concentrated on the physiological, perceptual, and cognitive.

Psychopathology, like personality, depends on social and biological factors, and on their interaction. This is such a truism nowadays that we often look back with longing to an earlier, simpler period when the notion of unicausality was more popular. Then the social scientist argued that anyone could become mentally ill if given enough environmental stress and strain, while the biological scientist countered: if you do not have the genetic predisposition, it's no use trying to be abnormal, you'll never make it.

What is meant by psychopathology? It refers to the behavior of the sick person suffering from mental disorder. This mental disorder may be accompanied by demonstrable somatic disorder,
or may occur without any presently known somatic dysfunction. If there is a somatic dysfunction, we are more prone to call it disease. If there is no accompanying somatic disorder, we hesitate to call it disease, and some of us prefer such terms as reaction pattern, emotional disorder, behavior disorder. This dichotomy is unfortunate, since every type of behavior in man has somatic or neurophysiological substrates. How then can mental disorders be defined in a way which will circumvent the dual role that mind and brain play in them?

The dilemma presented by the attempt to define mental disorders has been stated by Barbara Wootton (1959, p. 225) in the following way:

... the anti-social behaviour is the precipitating factor that leads to mental treatment. But at the same time the fact of the illness is itself inferred from this behaviour: indeed it is almost true to say that the illness is the behaviour for which it is also the excuse. But any disease, the morbidity of which is established only by the social failure that it involves, must rank as fundamentally different from those of which the symptoms are independent of social norms.

This distinction will, moreover, still remain even if we reach the stage, as we very well may, when every mental process has its known physical accompaniment, and when our present dualistic language, along with the distinction between “organic” and “functional” disorders, can be discarded. For even then it will still be true that some abnormalities are deplored because they cause fever or boils, others because they induce a disregard of property rights—even though it may be shown that the latter no less than the former, are associated with happenings in the stomach, the liver or the brain, and can be cured by suitable pills, injections or electric shocks. Even in this case a social judgment is still implied in the decision to rank the thieving tendency together with its bodily concomitants as symptoms of disease or dysfunction; for if it had not been for their social consequences, these physical concomitants would never have been reckoned as abnormal at all. In a sense, therefore, the effect of extending physical “explanations” to cover all forms of aberrant conduct would be to infuse into certain conceptions of physical health elements of value-judgment comparable to those which already bias the terms in which mental health is defined. Long indeed is the road to be traveled before we can hope to reach a definition of mental-cum-physical health, which is objective, scientific and wholly free of social value-judgments; and be-
fore we shall be able, consistently and without qualification, to treat mental and physical disorders on exactly the same footing.

This dilemma is especially felt in dealing with the geriatric and adolescent problems. We have certain expectancies for the mature behavior of adults, based on investigations as well as life experience, which permit us to differentiate deviation in adults in the middle-age range. In the case of the young, it is often difficult to differentiate slow rates of maturation from mental disorder, and similarly, in old age, it is often difficult to distinguish between normal senescence and deterioration.

For heuristic purposes we shall define mental disorder, or mental disease, reaction pattern, behavior disorder, as a progressive state, which if unattended will lead to premature death, or to otherwise inexplicable or unexpected persistent and severe reduction of efficiency. This state is to be distinguished from a defect, which is a stationary condition, leading to a reduction of efficiency only. From this point of view, the role of therapy in severely chronic cases is to stop the progress of the disorder, that is, make it stationary, and by reducing it to a defect teach the patient to accept his defect or exploit it. In mild transient disorders, the complete return to premorbid status is, of course, quite possible, and no defect may remain.

Having defined personality and psychopathology, we can now turn our attention to the relationship that may exist between them. Three possible relationships have been suggested (Zubin, 1958): (1) identity, (2) interaction, (3) independence. The identity hypothesis states that personality and psychopathology are one and the same. The personality of the schizophrenic is thus the source of his behavior disorder and the latter is his psychopathology. The interaction hypothesis states that psychopathology emerges from the interaction of personality and a disease process. The turn that the personality takes is determined by the disease, while the type of disease is determined by the personality. The independence hypothesis states that psychopathology is independent of personality. Thus personality is but little changed by the course of the disease, nor is the type of disease developed in any way influenced by the personality of the patient. Each of these hypotheses has had its adherents and has given rise to a con-
siderable amount of research. The first can perhaps be identified 
with the Freudian school, which regards psychopathology as the 
result of infantile strivings and clashes between instinctual drives. 
The second is closest to the Meyerian school, which searches for 
the causes of illness in the variety of crises that the individual 
experiences through life. They regard psychopathology as a reac-
tion pattern, formed by the interaction between personality and 
disease, or disorder, resulting from certain inadequacies or deficits 
from within or from without at critical moments in development. 
It is this interaction between personality and psychopathology 
which makes for the tremendous variety in behavior produced by 
a given disease. The independence hypothesis is tantamount to a 
null hypothesis, since it postulates no relationship until proved, 
and may perhaps be most akin to the Kraepelarian point of view. 
In truth, neither Sigmund Freud, nor Adolf Meyer, nor Emil 
Kraepelin, ever enunciated these hypotheses. Perhaps they would 
have been horrified to have these attributed to them. There is, 
however, enough truth in the above statements to assist in under-
standing the three hypotheses. At the present time, the evidence 
for each of the three hypotheses is rather negligible. Presumably, if 
one accepted the first, identity, research would be directed at early 
detection of illness, and at tracing its early development through 
personality studies. If one adopted the second hypothesis, interac-
tion, environmental stress and strains involved in weaning, social-
ization, puberty, vocational choice, heterosexual adjustment, mar-
riage, family, senescence, retirement, and so on would constitute 
the foci of interest and the personality at each of these stages 
would be our chief concern. If the third hypothesis, independence, 
were adopted, the search for the connections between personality 
and psychopathology would not be important in etiological re-
search, although the study of their connections might still be 
prognostically important. The personality of the patient may dic-
tate the future course of the illness—whether he will recover or 
not.

This is not to be taken to imply that there are not certain 
kinds of relations which are always present between personality 
and psychopathology in all three alternatives. Insofar as the in-
dividual's behavior is involved in both personality and psycho-
pathology, the two are necessarily related. The independence
hypothesis would rest on the notion that some behaviors—"symptoms"—have their source primarily in a disease process, and are essentially unrelated to the individual's more systematic ways of behaving, his personality.

MEASUREMENT OF PERSONALITY

Having suggested personality as the nexus between psychopathology and social science, we may now turn to its measurement.

The question is often raised about the lag between measurement in personality and in the physical sciences. We regard personality evaluation as still highly intuitive, subjective, and hence, unreliable and invalid. But all measurement began in this fashion.

The first measures of length, weight, time, temperature, touch were originally subjective, self-referred and intuitively based. Let us look at the measurement of subjective warmth. Since there is no documentary evidence for man's initial attempts at gauging the cause and degree of subjective warmth, we shall resort to fantasy. Come with me to a cave in some prehistoric Ice Age, before fire was invented, and listen to a symposium on the origin of subjective warmth feelings. One savant declares that warmth depends on the number of skins covering the body. Another claims that it depends on duration of exposure to the sun. A third postulates swift running as the source of warmth and the distance covered as a measure. The medicine man in their midst raises a controversy because of his claim that his patients often report and feel warm without the benefit of any of the other factors mentioned. The symposium ends without a resolution. But someone later invents fire and demonstrates that by adding faggots to the fire, subjective warmth is raised in all the inhabitants of the cave and by the same token removal of faggots reduces it. The first breakthrough has occurred. Man can manipulate an external agent to raise and lower the temperature at will. But this is still far from measurement. The first known historical breakthrough occurs in Egypt, where rating scales are developed for measuring warmth in four steps—with warmth likened at one extreme to the hottest day of summer, and at the other extreme to the coldest day of winter. Eventually, the expansion of mercury with increase of subjective warmth is noted, and the thermometer is born, and
finally, humidity and air pressure are recognized as important factors, and the present-day discomfort index emerges. What were the essential steps in the process? First, the discovery of a means of inducing a subjective experience by external control. Second, the development of an external criterion for measurement independent of the self-referred subjective experience. The same process, no doubt, held true of the other measures which have attained great objectivity. Pain is still a subjective phenomenon without an external criterion, and without measurable ways of inducing it, though recent efforts along these lines show considerable promise. Intelligence tests became objective when mental age scales were substituted for subjective impressions. Anxiety, depression, elation are still in the rating stage. In my fantasy, I sometimes imagine that we may find a life-bearing planet, somewhere in space, where anxiety has already been measured, but where warmth or length are still on the intuitive level.

It would be interesting to deal with the relationship between personality and social science in the same way that we dealt with personality and psychopathology. In fact many parallels could be found, but it would take us far afield, away from our major interest—psychopathology and the social sciences.

It is interesting to muse over the fact that psychology as well as psychopathology cede their hard-won gains to other fields, once they have transmuted the subjective experience to objective data. Thus, in psychology, a large part of psychophysic has become the domain of illuminating and acoustical engineers; educational psychology has been taken over by the educators; while in psychopathology, general paresis, as soon as its etiology became known, was lost to the field, as were epilepsy, phenylketonuria, etc. Psychopathology retains only the diseases of unknown aetiology, and psychology deals only with the still generally intractable aspects of experience. The applied fields take over everything susceptible of measurement.

RELATIONS BETWEEN PSYCHOPATHOLOGY AND THE SOCIAL SCIENCES

The areas where psychopathology and social science meet are (1) etiology, (2) detection and diagnoses, and (3) therapy and re-
habilitation, and in each of these the personality of the patient plays an important part. It is important to determine in which areas social-cultural factors play the most important role, since it is in such areas that most progress in interaction between psychopathology and social science is likely to occur.

With regard to etiology, the question uppermost in our minds is: what role do social-cultural factors play in the causation of mental illness? After reviewing this field, it becomes clear that the social-cultural factors may play one of two roles—they may elicit an illness when it is latent, or they may occlude it—but they will rarely if ever create mental illness. That is to say they constitute a necessary but not sufficient cause. For example, Kardiner (1953) suggests that frigidity must not have been a problem for our pioneer grandmothers because they had no expectation of sexual potency. Modern woman, who has such an expectancy, readily develops frigidity if her potency is low, thereby helping to fill our psychoanalytic couches. On the other hand, among the Marquesans, where polyandry is the rule, not frigidity, but pseudocyesis, or false pregnancy, is the common complaint, since the climate of expectation demands a high degree of fecundity. It is doubtful whether our pioneer grandmothers differed biologically from the women in the present generation. Physiological proneness to frigidity was probably no different in the two groups. Similarly, there is no evidence that a greater physiological propensity for pseudocyesis exists among the Marquesan than among American women. Thus, culture may elicit an abnormal condition, or occlude it, depending on the climate of expectations, but most likely will not generate it on its own account.

While these two examples deal with physiologically based propensities, it is easy to see how other aspects of personality may be either occluded or elicited by social factors. It is for example conceivable that, in a culture which is highly prescriptive, individuals with a tendency toward compulsions will make an easy adjustment, while those with low levels of compulsiveness may find it very difficult to adjust, and vice versa.

In the detection of psychopathology, and its diagnosis, social factors play a more important role. The tremendous variability in hospitalization rates, even in our country, from state to state, bears witness to the fact that factors other than biological play an im-
important role in the detection and diagnosis of mental disorders. In 1938 (Zubin & Scholz) regional rates were computed for the nine regions of the United States (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, and Pacific) on hospitalization for various mental disorders. There were tremendous differences from region to region in every disorder. However, a comparison of the mortality rates (ratio of patient death rate to the death rate in the corresponding general population) in the hospitalized group, across regions, showed very little variability. The coefficient of variation was only 7.0 for mortality rates but was 18.8 for the hospitalization rates.

Apparent death takes no holiday in the hospitalized mental population, as shown by the low regional variability. Despite this apparent biological equivalence, the hospitalization rates themselves are quite variable, indicating regional patterns in the social-cultural factors leading to hospitalization. The differences in hospitalization rates between countries is even more indicative of cultural differences in the detection and diagnosis of mental disorders. Several years ago, a Work Conference dealing with this problem, organized by the American Psychopathological Association, reached the conclusion that nothing short of field studies by cross-cultural experts could ever disentangle the cultural factors imbedded in the national and regional norms for diagnosis. As a possible approach to such field studies, a proposal was made to utilize the population of registrants for the military draft in the various NATO countries (Zubin, 1961).

With regard to therapy and rehabilitation, social-cultural factors play the greatest role of all. Of all the changes that the current revolution in psychopathology has brought, increase in tolerance for the mentally ill stands very high. Our entire concept of remission from psychosis has undergone a tremendous change. Since the days of Esquirol and Pinel, about one-third of the patients has improved markedly, one-third has improved only slightly, while one-third has deteriorated. It used to be that only the markedly improved group was released. The increased tolerance in the present era has pushed the middle third out into the community, either permanently or for some period of time. This increase in tolerance is due to many factors including the influence
of the somatotherapies, the improvement in hospital management, and the reduction in the number of severe cases brought about by the lowering of the reservoir of the population from which schizophrenic patients are drawn. Since the population of twenty-to thirty-year-olds is now smaller, by several million, than it was in the last generation, because of the low birthrate of the 1930s, fewer severe cases are available for hospitalization and more mild cases are being treated.

Perhaps the greatest factor in the redefining of remission comes from the adjustment that the family and society are making to the remitted patient. Formerly, any erratic behavior was taken as a symptom, or as a warning of worse things to come—that the psychosis is returning and that the patient must be sent back to the hospital. Today we are beginning to view slight aberrations as personality quirks, harmless in nature, and to be adjusted to, rather than looked upon with concern. We have known for a long time that remitted patients are more law-abiding, less aggressive by and large, and not nearly as prone to get into mischief as the rest of the population. We have also known that they often exhibit behavior which we tend to classify as compulsive, senseless or wasteful, paranoid, depressive, querulous, and so on. As long as we regard these quirks as idiosyncrasies, and not as harbingers of full-blown episodes to come, we can live with them, and the patient, too, can accept them as slight lapses. Suppose he goes through a series of wasteful efforts in a compulsive manner in performing a given task—this can be contained. The first shock of required adjustment to such senseless behavior may jolt the family—but, the alternative of returning the patient to the hospital is no solution.

It is important to point out that not every relapse should be regarded as a failure on the part of the family. Illnesses have their own cycles, and when the patient feels the need for asylum, he should receive it. However, society and family should not aid and abet or create this need.

The late Professor Landis prepared a book published by Holt in 1964, reviewing all the extant autobiographies of mental patients. There are about five hundred of these. There are only three autobiographies of relatives of patients: Good-bye, My Son (Woolson, 1960), The Layman Looks at the Doctor (Fierce &
Pierce, 1929), and The Cliff's Edge (Hackett, 1954). We need a counterpart to The Mind that Found Itself, which might be called "A Family that Found Itself" through the accepting of a remitted son or daughter, wife or husband, or books on "Life with a schizophrenic" or "I married a manic-depressive."

It is not yet established, but the evidence points to the possibility that carriers of certain dysgenic traits are also among our most talented. The father of a phenylpyruvic oligophrenic is a Nobel-prize winner, and a Kierkegaard can repay society for a thousand schizophrenics whose lives were, perhaps, needlessly wasted. This may sound like a revival of the link between insanity and genius—but this is not my intention. What I am trying to say is that the forbears, as well as offspring of mental patients, do not exclude genius.

We are also gradually gathering more evidence on the factors in the social environment which affect hospitalization. For example, in a recent study in our laboratory (Hammer, 1961) some aspects of family structure were investigated and found to be important in determining duration of time interval between appearance of first symptom and hospitalization. Patients whose activities prior to hospitalization were critical to the maintenance of their household—that is, patients who were the major source of support, or who were responsible for care of children, or of the home—seemed to be allowed less margin for behavioral deviations, and according to retrospective accounts obtained in interviews with family members, were generally hospitalized sooner after the appearance of overt symptoms. In addition, it was found that family relationships with the patient are less likely to be severed, if those who are associated with him are connected with each other—that is, if the patient's closest ties are with individuals who are close to each other, over and beyond their relationship with the patient. One would expect that such a connected network of ties would not only tend to have greater permanence, but also, would tend to have a greater potential for maintaining the patient out of the hospital, if he occupies a noncritical position in the family. The work of Ozzie Simmons (Davis, Freeman & Simmons, 1957, Freeman & Simmons, 1958) at Harvard seems to show the importance of differences in household structure, namely that among former mental patients, sons may be maintained at home at a lower level
of job performance than husbands. Of particular relevance in this connection is a study in London by George W. Brown (1959) reporting a higher rate of return to the hospital for chronic schizophrenic patients discharged to parent- or spouse-households, than for those discharged to sibling-households or to "lodgings." Our own work indicates that although a person in a very close relationship with a patient is more likely to give assistance, he is also more likely to initiate hospitalization. Some structural characterization of the patient's social situation seems essential to an adequate study of the patient's social performance and the maintenance of his remitted status.

Another aspect of the interaction between psychopathology and the social sciences is the contrast in terminology utilized to describe the phenomena of each field. While psychopathology deals primarily with the abnormal, it has, nevertheless, provided the social sciences with many useful concepts. Thus, the psychopathological concept of phantom limb has given rise to body image, the concept of retrograde amnesia probably to retroactive inhibition, the concept of depersonalization has illuminated that of self, and many of the concepts of psychoanalysis have often been translated into social-science concepts, albeit sometimes uncritically.

On the other hand, the debt of psychopathology to the social sciences is rising. Thus, anomie, isolation, sensory deprivation, institutional organization, family network, and so on, have helped psychopathology to reorient its tasks and points of view.

The correspondence between psychopathological terms and their social-science correlates is not always perfect. Thus, mental disorder is not invariably to be equated with maladjustment. For example, senile demented who live in a controlled environment, such as an old-age home, do not show any spectacular maladjustment, when contrasted with normal senescents. One patient who complained to the examiner that he was changing into a woman was nevertheless quite well adjusted, and one of the most popular men in the home. On the other hand, homosexuality, even when presenting no psychopathology per se, brings with it considerable maladjustment and conflict in society.

The methods used for integrating data in the two fields also presents an interesting contrast.

It has often been claimed that psychopathology, embracing
as it does all the underpinnings of behavior, from the physiological to the conceptual, is tougher or harder than the social sciences. This is debatable, and arises primarily from the fact that many of the social-science constructs depend upon group phenomena, while psychopathology is more individual and hence perhaps not so dependent upon central tendencies and their ever-present variabilities.

The explanatory principles used in the two fields offer another contrast. While psychopathology utilizes such principles as heredity and internal environment, social sciences include in etiology such factors as overcrowding, deprivation, isolation, socioeconomic status. Although the statistical relationships on which these claims are based are respectable, how these factors bring about their effect is still unknown. That general paresis was associated with syphilis was a well-established statistical and even immunological fact long before the spirochete was discovered in the brain of the general paretic. But until this discovery was made, the treatment of the illness was purely empirical, and its full understanding lacking.

**USE OF PERSONALITY TRAITS IN PROGNOSIS.**

Prediction of the future course of an illness must rest on an understanding of the individual systematic way of behaving—what I have called personality—as well as of the structure of the environment with respect to which he behaves and which acts on him. A survey of the literature on the efficacy of the various therapies in 1957 (Staudt & Zubin), before the present drug era was ushered in, revealed a definite immediate advantage for each therapy over spontaneous improvement, but no long-term advantage in five-year follow-up. In an attempt to explain this finding, we postulated that the therapies still might prove highly efficacious, but each therapy would prove beneficial to only certain types of patients. When therapies are administered without regard to the personality of the patient, only average results are to be expected. If each therapy were selected in accordance with the potential of the patient to benefit from it, much better results might ensue.

In order to develop prognostic procedures for the selection of therapy, a rather extensive investigation was undertaken of the personality traits of patients which could be related to outcome.
This study is reported in the publication entitled *Comparative Epidemiology of the Mental Disorders* (Hoch & Zabin, 1961), and cannot be given in detail here.

The most striking finding of this survey was the fact that in 80 per cent of these traits, the relationship with outcome has remained unchanged during the past sixty years. Therapies have come and gone, but what the patient brought to the therapy—his personality—has apparently remained more predictive than the type of therapy.

Most traits belong to the category of what one could designate as soft data, that is data whose reliability is not very high and whose validity is often in doubt, as contrasted with hard facts of high reliability and validity. This is symptomatic of a major methodological problem, common to both psychopathology and the social sciences.

One is often faced with the choice of either getting hard facts that are readily available, or soft facts that are difficult to obtain. Unfortunately, the hard facts often turn out to be not as important as the softer facts. For example, it is easy enough to get hard, objective data on age at hospitalization, or on duration of illness from hospital records, but these facts are not nearly as important in prognosis as is type of onset—whether sudden or insidious. But judgments of type of onset are difficult to get and are highly unreliable.

One unfortunate tendency in response to this problem is to use hard statistics, especially factor analysis, as a compensation for soft data. But hard treatment cannot improve soft data. At the present time our standard statistical techniques and computers have far outrun the quality of our data in both fields under examination. However, we need new techniques for dealing with such problems as the classification of individuals, that is, the fractionation of a population into like-minded subgroups. Schizophrenia, for example, is a category which contains a wide spectrum of heterogeneous individuals, and, unless methods are applied to group together the like-minded or like-structured into homogeneous subgroups, no progress in the investigation of schizophrenia is likely.

It is important to develop methods for "hardening" the soft facts, and some of our work is aimed at doing this. For example, in our search for objective indicators of type of onset of illness,
we have considered friendship patterns as a possible source of information which might lend itself to more objective treatment. A preliminary study has indicated that the adolescent friendship patterns discriminate those who have an insidious onset and eventually become long-standing chronic patients from those whose illness is of sudden onset and is short-lived.

It must be noted here, tangentially, that prediction is commonly confused with causation. Not every predictor is a cause, nor is every cause a predictor. Thus, the fact that insidious onset is a forerunner of poor outcome should not lead to the conclusion that insidious onset produces poor outcome. They may both be the product of a third factor, such as the type or severity of the illness.

Friendship is a relationship with rather loosely defined role prescriptions, and hence can be more sensitive to psychopathology than more rigidly prescribed relationships. In comparing friendship patterns in schizophrenics, socioeconomic status seems to be an important consideration. A comparison of middle-class and lower-class adolescents indicated that the former expects from his friend much in the way of intimacy, confidences, social and emotional support, and time together. The lower-class adolescent, while frequently having a pal, spends little time with him alone, the entire group functioning as a friend, with easy substitution of one member for another (Kreisman).

Another example of the hardening of soft facts is the provision of an objective measure for the subjective concept of flatness of affect. Here, a focused interview in which affective utterances were reinforced (Salzinger & Pisoni, 1958) led to a measure of affect which proved to be differential between schizophrenics and normals (Salzinger & Pisoni 1960a), as well as prognostic of outcome of illness within the schizophrenic group (Salzinger & Pisoni, 1960b). Patients tend to extinguish their affective responses much more quickly than normals, once reinforcement is withdrawn, while patients who subsequently improve tend to condition more readily in this respect than those who do not improve.

Another example is the study of the comprehensibility of schizophrenic speech. By the use of the "cloze" technique (Taylor 1953, 1956; Salzinger, Pisoni & Feldman, 1961a), in which every fifth word is omitted from the typescript of recorded speech, comprehensibility can be gauged by the number of gaps which can
be filled in correctly by a group of judges. The change in comprehensibility in schizophrenic speech with drug administration (Salzinger, Pisoni, Feldman, & Bacon, 1961b) has been investigated with this method. The technique could also be used for the evaluation of the changes in comprehensibility during the course of illness. The pains taken with psychological testing, usually regarded as hard data, provide an interesting contrast to the loose procedures in clinical interviewing, which often are described as given by a “skilled interviewer,” with no further indication of the controls used. Studies in verbal behavior will eventually transform the soft data provided by clinical interviews into hard facts.

A somewhat different approach to this problem lies in the utilization of potentially important data which are often neglected because they are routine and unspectacular.

In hospital wards, for example, nurses ordinarily record only major traumas, or only those aspects of the personality of the patient which are dramatic. The day-to-day events go unrecorded. To remedy this, we have introduced simple behavioral inventories of everyday events to be recorded, periodically, about the patient’s observable behavior (Burdock, Hakerm, Hardesty, & Zubin, 1960). This has already paid off in giving a better picture of the course of illness, and a better and more subtle indicator of change than is afforded by global clinical judgment (Burdock, Elliot, Hardesty, O’Neill, & Sklar, 1960). In one drug experiment (Burdock, Hakerm, et al., 1960) the clinicians failed to note any change, but the ward behavior inventory revealed a change for the better when the patients moved from placebo to experimental agents, and a change for the worse when they moved from the experimental agent to a placebo.

One difficulty, which is common to both psychopathology and the social sciences, arises from the role of morals and ethics in theory construction and practice. While all of us agree that it is more democratic and more in keeping with the dignity of the individual to have open wards with self-determination, this belief is often based on a moral and ethical consideration more than on empirical fact. For some patients, especially those who have failed to make an adjustment to their home and their community, being thrown into an open ward, run by patients, may be far more damaging than being placed in a controlled ward. Since they have
failed in community life, return to community life in the hospital may only aggravate their failure.

One of the interesting contrasts between psychopathology and the social sciences is the relative stressing of the individual in contrast with the institutions which surround him or which have been provided for adjustment. While psychopathology seeks for causes within the individual, social science stresses causes in the environment. There seems to be some reluctance to examine the faults of institutions in the same way that we examine the faults of the individual. This holds especially true of the institutions organized to care for the mentally ill. One of the difficulties emerges from the large size of these institutions—the state hospitals, for example. Their organization is so complex as to defy total analysis. One way to overcome this difficulty is to use a sampling procedure to assess the workings of a hospital. Such a sampling procedure has been applied to a research hospital (Burdock, Glass, Hardesty, & Beck, 1961), and it yielded data about the structure and the activities of the hospital which were rather revealing, and which will constitute a base line for future comparisons in this hospital.

SUMMARY

The role that personality may play in the development of psychopathology and its amelioration has been examined and the importance of social factors in both personality and psychopathology has been stressed. It was pointed out that social factors play a progressively more important role as one moves from etiology to classification to amelioration. With regard to etiology, social factors may elicit psychopathology or occlude it, but rarely, if ever, create it alone. With regard to classification, social factors are important in detection and diagnosis, but they alone are insufficient. We must know something about the biological variables involved. To the extent that diagnosis depends upon externally observable behavior alone, or upon internal factors alone, which do not influence overt behavior, the classification and diagnosis will perforce be faulty. With regard to amelioration or improvement of the patient’s condition, social factors seem to be most important. The
increase in tolerance towards mental illness is one of the greatest breakthroughs that we have seen emerge in the recent past. In order to safeguard the continuation of this tolerant spirit, prognostic studies must be instituted to determine the characteristics and personality traits of patients who are likely to benefit from the open hospital, day hospital, clinic, early return to the community, and other recent innovations aimed at hastening recovery. Unless such prognostic knowledge becomes available, we may find the gates of tolerance closed again and the hospital returned to its former condition as a place of detention.

Social psychology is playing an important role in the development of these prognostic studies, in the evaluation of the various facilities for treatment, and in the development of criteria for "evaluating" outcome. For this reason, we welcome the creation of this new department and look forward to continued collaboration towards the goal of improving the lot of the mentally ill.

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