

ABNORMALITY

From time immemorial, societies have consistently classified a small minority of people in their midst as psychologically “abnormal.” The classic research of Jane Murphy (1976) demonstrates that people in non-Western cultures, such as the Yorubas of Nigeria and the Yupic-speaking Eskimos of Alaska, readily recognize certain behaviors as abnormal. Moreover, many of these behaviors, such as talking to oneself, are similar to those regarded as abnormal in Western society. Murphy’s findings suggest that the concept of abnormality is not entirely culturally relative, and that individuals in disparate cultures often label comparable behaviors as abnormal.

Nevertheless, these observations leave unanswered a crucial question: What is abnormality? Put somewhat differently, what implicit criterion or criteria do individuals use to identify abnormality? Surprisingly, a conclusive answer to this question remains elusive. In this entry we examine several conceptualizations of abnormality and their strengths and weaknesses. All of these conceptualizations strive to provide a definition of abnormality that encompasses both physical and mental disorders, although most place principal emphasis on the latter.

The first and most radical conception examined here is that abnormality is entirely a function of subjective societal values. According to this *subjective values* model, which has been championed by Thomas Szasz (1960), abnormal conditions are those deemed by society to be undesirable in some way. Although this model touches on an important truth, namely that many or most abnormal conditions are perceived as undesirable, it does not explain why many socially disapproved behaviors, such as rudeness, laziness, and even most forms of racism, are perceived as undesirable but not strictly pathological. A comprehensive definition of abnormality seems to involve more than subjective values.

Advocates of a *statistical* approach, such as Sir Henry Cohen (1981), posit that abnormality can be defined as statistical deviation from a norm. Thus, any behavior that is rare in the population is abnormal. Appealing in its simplicity as this conceptualization appears, it suffers from several weaknesses. First, the cutoff points for abnormality are scientifically arbitrary. Should abnormality be defined as the uppermost 1% of population, the uppermost 3%, or some other figure? Second, a statistical approach offers no guidance regarding which dimensions are relevant to psychopathology. As a consequence, it erroneously classifies high levels of certain socially desirable dimensions, such as creativity, intelligence, and altruism, as abnormal. Third, a statistical approach erroneously classifies all common conditions as normal. For example, it implies that the bubonic plague (Black Death), which killed approximately one-third of Europe’s

population in the fourteenth century, was not abnormal because it was widespread.

Other theorists, such as F. Kraupl Taylor (1971), have embraced the pragmatic position that abnormality is nothing more than the set of conditions that professionals treat. According to this parsimonious “disorder as whatever professionals treat” view, psychologically abnormal conditions are those that elicit intervention from mental health professionals. Although this view avoids many of the conceptual pitfalls of other definitions, it fails to explain why many conditions treated by professionals, such as pregnancy, a misshapen nose corrected by plastic surgery, and marital conflict, are not by themselves regarded as pathological.

Advocates of a *subjective discomfort* model maintain that abnormal conditions are those that produce suffering in affected individuals. It is undeniable that many psychopathological conditions, such as major depressive disorder and obsessive-compulsive disorder, produce considerable subjective distress. Nevertheless, several other conditions, such as psychopathy (a condition characterized by guiltlessness, callousness, and dishonesty) and the manic phase of bipolar disorder (a condition characterized by extreme levels of elation, energy, and grandiosity), are often associated with little or no subjective distress among affected individuals, although they sometimes cause distress among those close to them. Moreover, like the statistical model, the subjective discomfort model offers no guidance concerning what cutoffs should be used to define abnormality. How much discomfort is required for a condition to be pathological?

Most of the aforementioned definitions focus largely or entirely on subjective judgments concerning the presence of abnormality. In contrast, proponents of a *biological model*, such as R. E. Kendell (1975), contend that abnormality should be defined by strictly biological and presumably objective criteria, particularly those derived from evolutionary theory. For example, Kendell argued that abnormal conditions are marked by a reduced life span, reduced biological fitness (the capacity of an organism to transmit its genes to future generations), or both. Despite its potentially greater scientific rigor relative to other models, a biological model is subject to numerous counterexamples. For example, being a soldier in a war tends to reduce one’s longevity but is not a disorder; priesthood (which results in having no children) tends to reduce one’s fitness but is similarly not a disorder. Moreover, a biological model falls prey to the same problem of arbitrary cutoffs that bedevils the statistical model: How much below average must life span or fitness be for a condition to be regarded as abnormal?

Whereas some of the preceding conceptualizations of abnormality primarily invoke social criteria, such as value judgments, others primarily invoke biological criteria. Jerome Wakefield (1992) suggested that the correct definition of abnormality requires both social and biological

criteria. Specifically, he posited that all abnormal conditions are *harmful dysfunctions*. The *harm* component of Wakefield's conceptualization refers to social values regarding a condition's undesirability, whereas the "dysfunction" component refers to the failure of a system to function as "designed" by natural selection. Panic disorder is abnormal, according to Wakefield, because (a) it is viewed by society as harmful; and (b) the fear system was not evolutionarily designed to respond with intense anxiety in the absence of objective danger.

Wakefield's analysis is a significant advance in the conceptualization of abnormality, because it distinguishes those features of abnormality that are socially constructed from those that are scientifically based. Moreover, his analysis may help to distinguish from largely expected reactions to life circumstances from genuine mental disorders. As Allan Horwitz and Wakefield (2007) argued, some conditions, such as extreme sadness triggered by life events (e.g., divorce, loss of a job) are presently classified as depressions even though they often do not reflect true psychological dysfunctions.

Nevertheless, Wakefield's analysis may have its shortcomings. It assumes that all mental disorders involve breakdowns of evolved psychological or physiological systems. Yet some disorders, such as anxiety disorders, may be extreme cases of evolved defensive reactions to perceived threats. For example, as David Barlow (2002) observed, panic disorder may reflect "false alarms," that is, extreme fear reactions that are evolutionarily adaptive but expressed in situations that do not pose direct threats to the organism. In addition, Wakefield's analysis may be difficult to apply in practice because of the lack of a clear-cut distinction between adaptive function and dysfunction. The functioning of many psychological systems, such as the human systems for anxious and depressed mood, may be distributed continuously with no unambiguous dividing line between normality and abnormality.

In response to the difficulties with earlier efforts to provide an adequate definition of abnormality, some authors, such as David Rosenhan and Martin Seligman (1995) and Scott Lilienfeld and Lori Marino (1995), have proposed a *family resemblance* model of abnormality. According to this model, the concept of abnormality cannot be defined explicitly, because abnormality is an inherently fuzzy concept with unclear boundaries. Instead, conditions perceived as abnormal share a loosely related set of characteristics, including statistical rarity, maladaptiveness, impairment, need for treatment, and perceived dysfunction.

The family resemblance view implies that all efforts to construct a clear-cut definition of abnormality are doomed to failure. Moreover, according to this view, disagreements concerning whether certain conditions, such as

attention-deficit/hyperactivity disorder or alcohol dependence (alcoholism), are truly "mental disorders" are probably inevitable, because there are no strictly defining criteria for abnormality. At the same time, this view implies that there will often be substantial consensus regarding whether many or even most conditions are abnormal, because individuals rely on largely overlapping features when identifying abnormality.

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See also: Psychopathology