THE INADEQUATE PERSONALITY IN PSYCHIATRIC PRACTICE

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THIS paper is an attempt to clarify and give content to the concept of inadequacy of the personality, for the concept has gained considerable currency in psychiatry as a hypothesis to account for difficulties encountered in diagnosis, prognosis and treatment. Before the theory can be evaluated, it should be stated in a reasonably precise form. This enquiry starts from a very general statement about the idea of inadequacy as usually encountered in psychiatric practice, and proceeds towards a formulation in more exact terms.

The concept of inadequate personality is usually employed to denote some weakness of personality or character which accompanies or "underlies" the psychosis or neurosis, but is not identical with the latter, although influencing its course. Implicit in the concept is the idea of something long-lasting and difficult to change, operating in the previous personality, in the chain of events leading to breakdown, in the course of the breakdown itself and also subsequently. In this last phase inadequacy is suspected where there are unforeseen difficulties in resettlement, or a tendency to easy and frequent recurrence. In relation to treatment, inadequacy is often called in to account for unexpected failure of therapy, which, in prognostic terms, is equivalent to an unexpectedly bad outcome. In diagnosis it appears where the clinical picture is atypical.

This concept is clearly useful, but requires further clarification if it is to be more than an ingenious excuse for relative failure in diagnosis, prognosis or treatment. The ideal form of clarity would be a classification of the phenomena of inadequacy in aetiological terms, but in the present state of knowledge such an attempt is probably too ambitious, as the considerations which follow suggest.

Inadequacy is usually thought of as probably constitutional in origin, as arising, therefore, from a complex interaction of hereditary and early environmental influences. This view may well be correct, but it is of little help in the task of clarification. The authoritative opinion of Slater (1951) indicates that the hereditary element must almost certainly be of a multifactorial kind which could only be investigated by quantitative statistical analysis. This opinion is shared by Penrose (1951). Indeed, Slater's thesis suggests that a more precise definition of inadequacy in terms of traits is a necessary preliminary to probing its heredity. If this is so, it is putting the cart before the horse to try and clarify the concept of inadequacy by reference to its possible hereditary components.

It may seem more promising to link the concept of inadequacy with that of the character neuroses, thus throwing the emphasis on early environmental influences rather than on heredity. This view has much to commend it, especially as it commands a degree of general assent, which unfortunately breaks down when attempts are made to deal in precise terms. Reasonably exact formulations, such as Freud's "Anal-Erotic Character", tend to be accepted only by

followers of the school of the originator. This state of affairs applies not only to Freud, but to Mowrer's learning theory, concepts of conditioning, Meyer's Psychobiology and other theories of the development and organization of the personality. The enquirer in this sphere therefore finds himself faced by formulations of considerable precision, which only hold good within a relatively narrow frame of theoretical reference. These are of limited value to those unwilling to bind themselves to one particular school.

It is tempting to regard inadequacy and psychopathy as closely related. Judging by the frequency in clinical practice of such terms as "Hysterical Psychopath" and "Schizoid Psychopath", this is often done, but it is not always easy to know how precisely the terms are used. The issue may be to some extent linguistic, due to the use of the term "Inadequate" to describe one variety of psychopathy. The concept of inadequacy as described at the beginning of this paper, obviously has much in common with that of psychopathy, but without the particular emphasis on anti-social behaviour implied by the latter. This, however, does not take one a great deal further, as there is fairly general acceptance of Slater's (1951) view, that classifications of psychopathy so far evolved are more satisfying to their authors than to psychiatrists as a whole.

The work of behaviourist psychologists, exemplified among others by Cattell (1946), suggests the possibility of relating inadequacy and temperamental characteristics. This school has given considerable precision to the term "Temperament" and has indicated a number of factors which can justifiably be called aspects of temperament. This work, although sophisticated, is essentially descriptive. So far as the author is aware it has not been pursued far into the realms of aetiology.

Finally, there is the possibility of relating inadequacy to varieties of reaction to stress. At first sight this is an extremely promising approach, as the cardinal clinical feature of the inadequate personality is that he breaks down under stresses which the normal person survives, which, indeed, the doctor may have expected the inadequate himself to overcome. The Oxford Symposium on Stress (1958) is, however, distinctly discouraging. Sir Geoffrey Vickers was reported as follows: "The stressful situation which concerned the psychiatrist was produced not by events, but by the organism's interpretation of events in relation to itself. This in turn was a function of the way in which the individual personality was organized: and any conceptual model of this must include the organization of experience." Dr. Denis Hill did not think that the stressor could be defined: it owed its stressing quality to the nature of the individual, and it was the meaning of experience that mattered. These authoritative opinions suggest that before stress theory in psychiatry can become precise, solid progress must be made in solving some of the major problems of psychology. These include the organism's interpretative apparatus, a psychology of the self, learning theory and the organization of the personality, while the phrase about the meaning of experience faces the scientific enquirer with the rather dread presence of existentialism. Thus the approach to stress theory may be like the broad smooth road of the allegory, and lead to destruction.

There are good grounds, then, for regarding the aetiological approach as premature. Progress may be more possible on a descriptive-classificatory basis; that is, by returning to an earlier phase of the scientific method. Clinical history suggests that this approach may be sound, for the descriptive recognition of such syndromes as Addison's Disease preceded understanding of the morbid

processes involved, and indeed acted as a pointer to research workers as to where to apply their efforts. This paper tries to follow established clinical tradition in accepting descriptive precision as a pre-requisite to aetiological studies. The achievement of precision in present-day psychiatry, however, requires rather more emphasis on statistics than was necessary for the great clinical masters of the nineteenth century.

Considered statistically, the signs and symptoms of Addison's Disease (or Lobar Pneumonia or Bright's Disease) are a group of phenomena which show high positive intercorrelations, but low or negative correlations with other phenomena which may be common enough in medicine as a whole, but do not occur in Addison's Disease. These intercorrelated phenomena also co-vary; that is, they tend to appear and disappear together. Statistically, therefore, they form a correlation cluster. Addison's Disease is so striking a correlation cluster that it did not require statistical techniques to reveal its existence. Brilliant clinical observation was enough. Once it was described, however, it became a focal point for research which has led from the initial descriptive phase to greater aetiological understanding, and so to improved therapeutic control. In psychiatry the number of syndromes as striking as Addison's Disease is small. The correlation clusters which may prove to be fruitful areas for research cannot all be recognized by observation, but may require statistical techniques for their discovery. Once their existence is established, they have at first only descriptive, not aetiological status, but they can indicate where further research may transform descriptive recognition into aetiological understanding, and perhaps lead to therapeutic control.

This investigation studies certain correlation clusters yielded by the controlled observation of a mentally disordered population, and the possible relevance of some of these clusters to the problem of inadequacy. The details of the research yielding the clusters have been published elsewhere (Monro 1953, 1954). Briefly, a sample population of two hundred patients was chosen, to be as representative as possible of the disordered population of the country as a whole. Each patient was rated on a scale derived from that devised by Cattell (1946). This scale was so arranged as to give a comprehensive description of all aspects of the behaviour of the patients in the most economical terms. It consisted of 246 trait-terms and each patient was rated for the presence or absence of each trait. Operational definitions in terms of actual behaviour were worked out for each trait, as a guide to rating. Twenty of the patients were also rated by two colleagues, under test conditions, and positive correlations of the order of 0·85 were recorded between the three observers. Tetrachoric correlation coefficients were computed between the scores on each trait and every other trait. From these data, 35 groups of traits, or correlation clusters were derived. Each constituent trait of a cluster had a positive correlation of at least 0·55 with every other trait in the cluster. The full list of these clusters and their constituent traits is given in the works already referred to (Monro, 1953, 1954). At a later stage (Monro, 1956) the product-moment intercorrelations of the 35 clusters themselves were worked out in relation to the original sample population studied. These intercorrelations have some relevance to the present study.

These basic studies stemmed from the suggestion of Professor Drever of the Department of Psychology, University of Edinburgh, that it might be profitable to regard mental disorder as a defect or deviation of behaviour. This outlook is indeed fruitful, but requires discussion in relation to the study of inadequacy, for implicit in this viewpoint is the concept that all mentally dis-

ordered behaviour is inadequate. Socially speaking this is true, but inadequacy, in the sense used in this paper, is a term which excludes the recognized syndromes of mental illness and mental deficiency. It is also taken, in this study, to exclude personality types recognized as closely associated with particular forms of disorder, such as the cyclothyme temperament and the hysterical personality. It is the author's view that it should exclude the phenomena of psychopathy, so far as these can be shown to have a reasonably adequate descriptive basis. The data from the 35 clusters have some relevance to this latter point.

Consideration of the 35 clusters and their intercorrelations allows of their classification into broad groups:

1. Those corresponding to recognized psychiatric syndromes and morbid personality types: of these there are 14, including those relating to mental deficiency. Two clearly relate to psychopathy, one denoting the passive-inadequate psychopath, and the other the aggressive psychopath. It must be stated, however, that aggression is not really the keynote of this cluster, which describes essentially a predatory social attitude.

2. Those representing a capacity for mental health, or recovery potential: of these there are 5. Only those clusters have been included in this class which denote socially useful or desirable behaviour, and which also have no positive correlations of any magnitude with psychiatric syndromes.

3. Those representing modes of behaviour which may be socially desirable, and are certainly not socially undesirable, but which either have no positive correlations with class 2 above, or have positive correlations with psychiatric syndromes. Examples of the former kind are aesthetic interests and activities and ordinary sexual behaviour; examples of the latter are a rather strait-laced virtue which tends to be associated with obsessional states, and a rather self-denying humanitarian outlook which is often associated with depression. There are 6 of these clusters, which for the purpose of this paper may be regarded as "neutral".

The nature of inadequacy, as described in the first paragraph, suggests that if it appears at all, it should be shown by correlation clusters which do not represent psychiatric syndromes or either of the other two classes described above. Moreover the clusters denoting inadequacy should have relatively low positive correlations with a number of psychiatric syndromes, and negative correlations with the clusters denoting recovery potential. After eliminating the three classes of cluster described in the previous paragraph, ten remain, of which five fulfil these conditions adequately. These are described in detail below, in the order of the frequency of their occurrence in the sample population. The remaining five clusters are only dealt with briefly, as they are not directly relevant to a description of inadequacy, but have some importance as indicating behaviour patterns which fall somewhere between inadequacy and the other classes of cluster.

Cluster 1. The people denoted by this trait-group show failure to carry out tasks which they have been entrusted to complete, and which are within their powers. They make inadequate plans for fulfilling even obvious obligations, or, if they make them, they do not carry them out. Their sentiments do not remain attached for long to any one object, person or idea, and they are constantly changing their allegiances. Their social arrangements are free and easy, impromptu and and left to chance. They tend to be off-hand in manner

and to ignore formalities and established punctilio. They are also lax in fulfilling social obligations.

Cluster 2. People in this trait-group have an exalted opinion of themselves, usually shown by talking a great deal about themselves and their affairs. They cannot tolerate unpalatable truths about themselves or their capacities, and take refuge from the risk of being shown up accurately by equivocation or flight into fantasy. They either refuse to believe propositions with strong personal significance for them, even when demonstrably true, or they believe such propositions in spite of strong evidence to suggest their falsity. They do not admit to being wrong in the absence of conclusive proof, and even then struggle to the last against the admission. They frequently blame others for the results of their own actions, and are more critical and fault-finding towards others than towards themselves. They have a strong tendency to grouse, and give the impression that they are the victims of hard luck, or they labour under a sense of injury or grievance.

Cluster 3. This trait-group denotes people who show few signs of pleasure or displeasure in human intercourse, whose predominant attitude to others is indifference. They do not necessarily feel inadequate in company, but prefer being on their own. They tend, however, to be stiff and stilted in manner, or clumsy and ungraceful in their movements, and are difficult to have dealings with. It is not easy to get them to make a forthright statement, as they seem to like mysteries and concealment. Nevertheless they show no eagerness to find out about things either at work, in the realm of ideas, or about their fellows.

Cluster 4. This group is composed of people who make no display of feeling in relationships in which strong feelings are usually shown. Many of them avoid intimate relationships and have few or none. They deprecate the display of emotion by others. They evade danger, difficulty, adversity and pain wherever possible, and complain excessively if evasion is impossible. They express a sense of grievance, of not having what is due to them, and often wish to change their position and circumstances although no good reasons exist for so doing.

Cluster 5. This trait-group denotes people who show ill-will to others on account of the latter's greater prosperity, endowment or achievement in any respect, associated with the sense of being outdone by those others. They look with a grudging eye on the success or good fortune of others, and desire to supplant them because they feel they have a right to the advantages enjoyed by those others. They think that others intend to hurt or belittle them when this is not the case, and often show this by unnecessary self-justification. They adhere firmly to their own opinions and avoid exposing them to critical investigation, and often display demonstrable prejudice.

These five behaviour patterns are ones which the clinician can recognize as familiar, in psychiatric wards, out-patient departments and even in the populace at large. They fulfil the statistical requirements for acceptance as descriptions of inadequacy. There are therefore grounds for accepting them as five types or categories of inadequate personality to be met with in psychiatric practice. There is, of course, no reason why an individual patient should not show signs of more than one of the above varieties of inadequacy.

Discussion

The frequency of occurrence of these five clusters is given in the table below. Each patient in the sample population was, as described, rated for the presence or absence of the 246 traits in the comprehensive trait list. This rating was converted by the technique described elsewhere (Monro, 1953, 1954) into a score on a five point scale for each of the 35 clusters under consideration. The figure in the lower row of the table gives the percentage of the sample population with the maximum possible score on the cluster in the row above it.

Table

Cluster	1	2	3	4	5
Percentage Frequency	27·5	27·0	21·0	10·0	7·5

The problem as to whether these behaviour patterns occur frequently in patients diagnosed as suffering from inadequacy presents certain difficulties. As long as the concept of inadequacy is somewhat vague, the diagnosis cannot be made with precision. A group of patients diagnosed as inadequates would therefore be relatively ill-defined, and its composition might vary greatly according to the outlook of the clinician selecting the sample. This paper has therefore approached the problem from the opposite direction. It has attempted to provide a more precise description of inadequacy. By further work it should be possible to determine whether this provides a tolerably satisfactory working hypothesis for dealing with the phenomena of inadequacy, as tentatively described in the first paragraph.

The five categories of inadequacy require some further consideration. Provisional titles might also save awkwardness in referring to them, but should not imply emphasis on any one aspect of the behaviour pattern at the expense of others.

The first cluster, in general terms, denotes lack of persistence or continuity of effort or attachment, while obligations are largely ignored. This is not simply lability, which appears quite separately associated with the surgent aspect of cyclothymia. Equally it is not anergia, which appears closely connected with depressive and schizophrenic states. It is also not mere frivolity of the "Butterfly" type, as it has no significant correlation with this quality. It does correlate fairly highly with the hysterical personality type, but not highly enough to warrant its inclusion as a hysterical manifestation. It may provisionally be called the Low Tenacity Type of Inadequacy.

The second cluster denotes hypersensitivity of the ego coupled with a rather passive kind of defensiveness, and may therefore be labelled Egoic Hypersensitivity.

The third cluster suggests a particular kind of social withdrawal which is nevertheless distinct from the emotional flattening common in schizophrenia. It may be provisionally entitled Diminished Social Responsiveness.

The fourth cluster, in contrast to the third, relates particularly to intimate relationships, and there is active deprecation of emotional display coupled with a sense of deprivation. This state of affairs can be called Feeling Avoidance.

The fifth cluster has a good deal in common with the second, and indeed has a fairly high positive correlation with it. Further investigation might show this group to have considerable egoic hypersensitivity, but it is more concerned with others than the second cluster. It is almost as though its members had discovered that attack is the best form of defence. It would appear to be related

to the "Othello" complex, and may provisionally be labelled Defensive Denigration.

The five remaining clusters may be briefly considered. Two of these show positive correlations only with depressive and obsessional states. One describes a tendency to excessive reserve, and the other indicates marked conventionality, meticulous conformity and a rather dependent outlook, especially in relation to authority. These may be either manifestations of depression or obsessional states, or aspects of the depressive or obsessional personality. In either case they are not at this stage relevant to this enquiry.

The other three clusters relate respectively to pedantic fussiness, bumptious pushfulness and a group which appears to be the exact opposite of this. They are rather simple, trustful and liable to be put upon. These are all patterns of behaviour which can lead to socially stressful situations, and may therefore be contributory to psychiatric illness. It may be that a full exploration of the concept of inadequacy will require to take more account of these patterns. For the present, however, they may be taken as lying in the hinterland between inadequacy and those behaviour patterns described above as "Neutral".

The data surveyed in this study therefore allow only of the description of five categories of inadequacy. It is suggested that this is a step in the direction of clarifying an obscure subject. If it provides starting points for further investigation of the subject, it will have fulfilled its purpose.

SUMMARY

The concept of "Inadequacy" or "Inadequate Personality" as this is usually used in psychiatric practice, is described. The difficulty of classifying inadequacy in aetiological terms is discussed, and an attempt to give greater clarity and precision to the concept, in descriptive terms, is described. This was done by applying statistical techniques to the data yielded by a previous study of a sample population of 200 patients. It was contended that behaviour patterns characteristic of inadequacy should be distinct from recognized psychiatric syndromes or from accepted types of pre-morbid personality. They should furthermore correlate negatively with behaviour patterns characteristic of recovery potential or tendencies to mental health. Finally they should have positive correlations of relatively low magnitude with a number of recognized psychiatric syndromes. Five behaviour patterns were found, which fulfilled these criteria, and their manifestations in terms of actual behaviour were described in detail. It was suggested that these patterns could be regarded as five types or categories of inadequacy, and they were given the following provisional titles Type 1: Low Tenacity; Type 2: Egoic Hypersensitivity; Type 3: Diminished Social Responsiveness; Type 4: Feeling Avoidance; Type 5: Defensive Denigration. The hope was expressed that this clarification of the concept of inadequacy might be a preliminary step towards a more precise investigation of the subject.

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