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SOCIAL MALADJUSTMENTS

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Thomas Kreilkamp

Social maladjustment was one of several specific diagnostic categories under the general heading of "Conditions without Manifest Psychiatric Disorder" in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II). Some of the other categories under this heading were occupational and marital maladjustment. The mere existence of this heading is already indication of the difficulties faced by anyone who wants to provide a diagnostic manual that will be of use to practitioners. Clinicians see a wide variety of people, for a wide variety of difficulties, some of which are not psychiatric in any simple sense. This occurs for many complicated reasons, but two important ones include (1) the role of the psychiatrist in our society, which is vaguely defined and which permits attempts to treat almost any manner of problem in living; and (2) the ever-broadening notions of what constitutes mental illness, which in turn are based on that form of psychiatric theory that points up the continuity between illness and health, or that, as in some forms of Freudian theory, even erodes the distinction between illness and health altogether.

"Social maladjustment" does not appear in the same form in the new edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III).

There is instead a section called “Codes for Conditions Not Attributable to a Known Mental Disorder that Are a Focus of Attention or Treatment.” This includes, for example, malingering, childhood or adolescent antisocial behavior, marital problems, parent-child problems, and a residual category of “other interpersonal” problems. In addition, there is a section called “Adjustment Disorders.” In describing this section, the new manual states that “The essential feature is a maladaptive reaction to an identifiable psychosocial stressor . . . It is assumed that the disturbance will eventually remit after the stressor ceases. . . .” This attempt at adumbrating the essential features of the “Adjustment Disorders” condition is a good place to begin consideration of social maladjustment.

First of all, it is clear that the emphasis here is on a circumscribed maladaptive reaction. That is, it is not a chronic condition that is being talked about, but instead importance of the life event that is assumed to precipitate the maladaptive reaction. DSM-III goes on to make explicit that this category of adjustment disorder must be distinguished both from “normal” adjustment reactions (such as “Simple Bereavement”) and from more chronic life problems (such as would be included under “Conditions Not Attributable to a Known Mental Disorder”). Furthermore, the draft goes on to make explicit that yet other diagnostic categories must take precedence, such as “identity disorder” and “emancipation disorder,” both of which would presumably refer to difficulties typical of those adolescents who are attempting to solidify

a sense of themselves as separate individuals, and who are engaged in moving away from the family of origin toward some more independent status in the world.

Second, we can see that this category of “adjustment disorders” is not meant to include conditions that can reasonably be seen as exacerbations of already existing mental disorders. This sounds perhaps an easier discrimination than in fact it is. Sorting out various maladjusted reactions into different groups based on whether those manifesting them were or were not previously afflicted with a mental disorder is always a hazardous enterprise, since it depends both on one’s theoretical stance with regard to all psychiatric disorders and on an accurate knowledge of the past, which is not always obtainable. A discussion of this difficulty will help to explore the implications of the preliminary definitions of adjustment disorders.

DSM-III is overly inclusive on purpose, according to those who have created it, and the emphasis is not on either etiology or treatment, but rather on descriptive completeness. Regardless of its attempt to eschew etiology for description, any psychiatric practitioner, in order to be able to operate effectively, must have some kind of theoretical orientation toward psychiatric disorders, though it need not be one that specifies etiology for any or all diseases. An example of a general orientation common in psychiatry is that which sees mental disorders as characterizing individuals. The individual is

the site of the “disease” and the field within which it makes itself known. However, psychiatrists must of necessity acquaint themselves with the larger social field within which the afflicted individual lives, in order to determine whether or not, for example, a depression is reactive or chronic. If the psychiatrist finds that the patient’s spouse just died, then the diagnosis is more likely to be simple bereavement than depression. Similarly, in all psychiatric diagnostic endeavors, one needs to find out what has been happening in the patient’s life in the recent and sometimes in the more remote past.

This necessity is especially acute with regard to the category of social maladjustment. In order even to consider such a diagnosis, one must know what the patient might be reacting to, and what social world he might be having difficulty coming into satisfying relation with; this necessity immediately broadens the horizons of the psychiatrist. That is, the psychiatrist is no longer simply examining a patient, but is assessing the nature of the fit between an individual and a social realm with which the psychiatrist may or may not be familiar. The less familiar he is with that social world, the harder it will be, of course, to assess the nature of the difficulty the patient is having in coming to terms with that world. Here the psychiatrist will want to consider the nature of the patient’s coping mechanisms in general: the way in which past difficulties have been coped with and the variations, if any, in the nature of the patient’s social world (what changes have occurred,

such as moves, new jobs, additions to or subtractions from the family). The need to consider all these matters makes the psychiatrist's task a very broad one, and this breadth is sometimes overwhelming. Take for example the so-called "mental status" exam. An accurate carrying-out of this exam requires, minimally, some cooperation from the patient. Some patients do not cooperate, or do so in such a way as to cast doubt on the validity and/or reliability of their answers. That is, they may neither be saying what they think nor answering the same way today they might tomorrow, and this lack of cooperation may or may not be part of a disease process.

Ascertaining this probability requires immense skill, and considerable familiarity with the patient being examined and with the circumstances that have brought him to the psychiatrist. An angry adolescent brought in by an equally angry parent is less likely to offer cooperation to the psychiatrist (who is perceived as the parent's ally) than a self-referred adult who is bothered by some intrapsychic stress and wants some relief.

In addition to considering such matters in doing a mental status exam, the psychiatrist will need enough flexibility and scope to be able to recognize the possibility that there may be a suspected mismatch between a given individual, who happens to be presenting as a patient, and a given social world. He will then have to consider whether that person is better off not trying to adjust to the environment. This would be the case if adjustment to

the situation is not the best outcome in the long run. The psychiatrist might make this assessment if the patient appears to be only temporarily in his present situation. For example, a patient who finds he cannot keep up with his workload may in fact be overworked by standards other than those of his present situation. He might be best off considering the possibility of changing jobs and thus reducing his workload, rather than trying to transform his character to the degree necessary to find that heavy workload tolerable. Or in another related example, there may be no good solution to a person who presents severe anxiety that appears to arise out of a conflict between his work and family demands. The problem here may not be so much social maladjustment—an inability to deal with the kinds of conflicts and pressures that other people appear to deal with—but rather a culturally determined conflict between changing definitions of what a man's role ought to include. Formerly, he would have been expected to earn a living and make progress in a job or career; now he is expected to do that in addition to spending more time with his children and helping at home. Here there is indeed social maladjustment, but it is not between an individual and society but between various facets of a complex and changing social environment.

Another case in which the psychiatrist may want to consider the possibility that "adjustment" between an individual and his environment is not possible, and where the problem is not entirely that of the patient, is when the patient is a child whose family is not able to take care of him. In such a

case, the psychiatrist may want to explore the possibility of finding another home for the child, perhaps temporarily with a relative or friend or perhaps on a more permanent basis.

The diagnostic category of social maladjustment, then, demands of the psychiatrist not only a familiarity with conventional diagnostic nosology, with psychopathology as it is conventionally construed, but an awareness of social developments as well. In some cases the psychiatrist will want to recognize the degree of stress in the patient, but instead of recommending therapy for the patient, may want to recommend therapy for a larger social system (a marital couple or a family) or may encourage the patient to think about rearranging his social world so as to change either one or another aspect of it, or to alter the degree of his involvement in a social sector that is coming into conflict with another important social sector.

Coping and Adaptation

Maladjustment is clearly in part a function of the complexity and possibly conflictual nature of one's social world; it is also, however, related to one's own means of coping with stress. When one examines the intrapsychic (and interpsychic) measures that people develop for coping with stress, one can begin to learn something about how people ordinarily manage the sorts of conflicts and crises that are thought to be more or less routine. Ordinary

management of stress involves not just intrapsychic maneuvers that are conventionally referred to as defense mechanisms, but other skills as well. As Engel has pointed out, “In recent years there has been a marked shift in the study of human adaptation from concern with intrapsychic defense mechanisms to much greater emphasis on the skills and supports required to meet typical life challenges.” Traditionally this has not been studied as intensively as neurosis or difficulties in living, but there are several studies worth noting. In Robert White’s *The Study of Lives*, there is a section by Theodore Kroeber called “Coping Functions of the Ego Mechanisms” that attempts to differentiate between the defensive (or unhealthy) and the coping (or healthy) aspects of various ego functions. For example, he says of the ego function of discrimination (the ability to separate one idea from another, or a feeling from an idea) that this has a healthy form when it involves objectivity, and an unhealthy form when it involves isolation. Both objectivity and isolation involve separation of feeling from idea, but the former is perhaps more voluntary, more flexible, more in the service of adaptation to some requirement of external reality.

A different approach, but one that is equally indebted to Freudian ideas of ego functions and what are referred to as defense mechanisms, is espoused by George Vaillant. He argues that one can arrange ego mechanisms in a hierarchy, with the more mature ones at one end and the more pathological at the other. Examples of those at the least healthy level include denial and

delusional projection. Examples of the healthiest mechanisms include sublimation, humor, anticipation, and altruism. There are, of course, an array of others between the two extremes.

Vaillant proposes that the more mature mechanisms are found more frequently in the more satisfied men in his study and also in those who are better adjusted to their social worlds (and on the average, more successful). He does not seem to be saying that mature ego functions necessarily lead to more successful adaptation to one's society, only that in his sample they happen to do so. This is a very difficult argument to defend, since the data are very difficult to untangle. But his general point of view is not uncommon in psychiatry: Maturity and health, as reflected in psychological functioning, accompany successful adjustment to one's social world. Vaillant does not have a simple-minded view of adjustment; rather he argues that success has objective and subjective aspects, the former connected with worldly success, and the latter with happiness or fulfillment; and he makes it clear throughout that his ultimate support is his data, which are the lives of the men in the study. Empirically, the men who scored best on the psychological measures (and the scorers worked without knowledge of the social status and success of the subjects) were also, on average, those who did better in worldly terms. Thus for Vaillant, social adjustment appears to be connected with psychological health.

This, of course, is the conventional view upon which the psychiatric nosology including the diagnostic category of social maladjustment is based. However, there are alternative ways of looking at the whole issue, ways that are equally rooted in Freudian and dynamic psychology. For example, Richard Coan attempts to analyze the notion of "optimal" personality functioning. He first provides an interesting review of the various concepts that have been described by different writers as characterizing the healthy or mature or normal person. He then argues that certain of these characteristics are incompatible, so that for a given individual to rank high on one of them, he would necessarily rank less high on another. To illustrate, one can examine a characteristic that many psychologists regard favorably: being open to experience, allowing one to experience the richness or fullness of events. Coan argues that this capacity cannot increase indefinitely without adversely affecting another highly thought of characteristic, namely the kind of stability of personality organization that provides freedom from distress. Similarly, he argues that other variables stand in opposition to one another: (1) an orientation toward harmony; (2) toward relatedness; (3) toward unity with other people and the world versus a sense of clear differentiation from others; (4) striving for autonomy, self-adequacy, mastery and individual achievement; and (5) an optimistic confident attitude toward the world versus a realistic appraisal of world conditions.

Coan's argument raises an interesting question. Perhaps the adjustment

concept (referring to a condition of being where one achieves a smooth existence, gets along well, and experiences a state of well-being in which negative emotional states occur infrequently) is not the same as the "healthy" or "optimum" concept. This in turn creates difficulties in our conception of social maladjustment, and we are then led, perhaps, to consider the possibility that a person might be socially maladjusted and yet, in one way or several ways, still moving toward a healthy or "optimum" state of existence. Or perhaps social maladjustment (the psychiatric nosological category) is compatible with achievement in any of several realms: in art, in finance, even in the psychological richness of one's life.

Part of the issue here is that of ascertaining what is the best dimension on which to array examples of social maladjustment. This whole issue would be clearer if psychiatry as a discipline were more certain about whether there is an illness-health dimension or whether what is called mental illness can be shown to be the opposite of what we might call health. Other possibly relevant dimensions are those of good and bad or even happiness and unhappiness. Until psychiatry has a more coherent view of how these different aspects of experience and behavior are related, questions concerning the definition of social maladjustment will seem bewildering.

Another aspect of the same problem comes into view when one realizes that people have greater or lesser abilities to find appropriate social niches

for themselves. If one can locate the appropriate social niche, in which one's deficits become advantages, then the question of maladjustment will never arise. In our pluralistic world, there are numerous social levels, any one of which might provide a comfortable habitation for a particular individual. We each have considerable choice about where we live, what work we do, whom we marry, which friends we have. These choices are never so numerous as perhaps they may appear, nor so varied as perhaps we wish, but nonetheless there are always real choices.

There is an interesting question that psychiatrists do not often ask but they well might consider: How do individuals manage to find a social world for themselves that allows them comfortable adaptation? This would be another vantage point on social maladjustment. Maladjustment can only arise, after all, when an individual has not made a successful choice of habitation. Psychiatrists are prone to think only in terms of coping styles, defense mechanisms, and personality structure, as though all of these functioned independently of social context once development has occurred. The prevailing assumption is that "development" occurs when a person is young, but when the person is "mature" he carries his personality around with him, applying his coping style to whatever social situation arises. Social psychologists and sociologists can contribute to psychiatry in this matter, since they are more likely to invest energy in articulating ways in which particular social networks provide support for, and give sustenance to,

particular personality constellations (while helping to discourage the expression of others). Sometimes psychiatrists recognize this mode of thought when they discuss stress and concede that almost anyone is vulnerable to certain forms and degrees of stress. Implicit in this view is the notion that stress is less in some situations and greater in others. Not much further thought is required to recognize the ways in which certain people inhabit realms that generate less stress than others, or even to recognize that what appears as "healthy" well-adjusted functioning in one context may not appear so in another. Psychiatrists who work with pairs or groups of people (for example, with families) are more ready to recognize this, since they often have rich clinical experience that forcefully brings home the fact that adjustment is always within a context, and that the context (of the marriage, or the family, for example) implicitly provides support for certain modes of functioning. Psychiatrists who work with marital couples always have vividly before them the fact that two individuals may have chosen each other mistakenly, that each individual might do better in a different marriage. But at the same time there is a pervasive trend in psychiatry toward insisting that a person who has difficulty in one marriage (or job, or social world) is likely to have difficulty in another. This is the strand of psychiatric thinking that overemphasizes the extent to which the individual carries his personality around with him, using it equally well in one situation or another. If psychiatrists stayed in closer touch with sociology they would be less prone to

make this mistake in emphasis. The difficulty is not, of course, that psychiatrists are mistaken, but simply that they do not give enough credence to another, different point of view.

Sociological Contributions

The concept of social maladjustments can be approached from a clinical or from a sociological point of view. A clinical approach would first consider, in a given patient, the degree of psychological discomfort. The patient comes into the psychiatrist's purview in part because of some form of psychic pain. This pain may be connected with cognitive inefficiency, with disturbances of bodily functionings, or with a vague kind of anhedonia that is not specifiable. But in the case of patients who are likely candidates for the category of social maladjustment, there is in addition some deviation in behavior from social norms. This deviation may be only apparent to the patient (and may, in fact, be illusory), or it may be so noticeable that various community representatives become involved in the referral, bringing the patient to the attention of the psychiatrist. If the deviations from social norms and mores are particularly flagrant, they may lead representatives of the community (whether they be people who live in close proximity to the identified patient or are rather more remote cohabitants of the patient's social world) to bring the patient to the attention of the psychiatrist against the patient's will, or at least against his conviction about what is best for him. In such a situation, the

psychiatrist may come to feel that he is, to a greater extent than usual, upholding the public interest, rather than (or in addition to) ministering to a particular mind diseased.

Thus, contemplating the use of the diagnostic category of social maladjustment may quickly lead the psychiatrist to a consideration of the social fabric and his part in maintaining it. Some sociologists argue that categories such as social maladjustment are in fact mainly attempts on the part of most of us to maintain some benchmarks against which we will compare ourselves favorably. If we have no standards about what is proper and improper behavior, then we are adrift in a sea of social relativity. But if we have some standards, which we enforce against others, then we gain a sense of solidity and substance. As Albert Cohen puts it, "each generation establishes benchmarks for measuring wickedness . . . and one determinant of where those marks are placed is interest in finding unfinished moral work that might provide opportunities for earning moral credit." For a psychiatrist, this may seem an unconventional point of view. But one of the disadvantages of the inclusiveness of the DSM-III is that it attempts to provide a category for everything a psychiatrist is likely to see in the office. This necessarily means, in some cases, that a psychiatrist will be attempting to assess cases where the social dimension of the difficulty is preeminent. Social maladjustment is the category that refers to such cases, and in order even to consider using such a category, the psychiatrist must be assessing not just a patient's own mental

state but the ways in which the patient’s behavior impact upon the lives of those around him, and, further, the ways in which those around the patient view the patient’s behavior. This involves assessment of social norm violation, and insofar as psychiatrists are involved in trying to change the behavior of their patients, they may well become involved in attempts to uphold social norms.

Now most psychiatrists will not, ordinarily, describe themselves in such terms. They will routinely and conventionally react with disapproval to suggestions that in some countries psychiatry may become an arm of the police establishment, used occasionally to suppress political dissent. And yet since the revolution in psychiatry wrought by Freud and his followers (a revolution that in part collapsed the distinctions between normal and pathological), all of psychiatry has become vulnerable to being embroiled in very similar situations.

In order for a psychiatrist to gain as clear a view as possible of this situation, some acquaintance with several aspects of sociological thought is desirable. One trend in current sociological theory that is particularly pertinent is referred to as labeling theory.

Labeling Theory

One specialty within sociology is the study of deviance. And within that

specialty, one theoretical point of view that has been particularly influential in the past twenty years or so is the labeling theory, or the labeling perspective. This perspective is used, of course, to discuss various forms of deviance, including the form of deviance ordinarily referred to as mental illness. From this perspective, what is seen as crucial is not the act committed by the patient, but rather the label that is applied to the act and then, by extension, to the actor (the patient). The interest focuses on how the label comes to be applied to some people and not to others. There is great attention paid to the fact that only a small proportion (the exact ratio is unknown) of deviant acts falling into any particular category come under the scrutiny of professionals in that field. In psychiatry, for example, only a small proportion of people who are unhappy or who do bizarre things come to see psychiatrists. Why do these few come, rather than others? How are they selected? What makes them, if you will, more open to the mental health professionals than others, more susceptible to having the mental illness label put on them?

These are the sorts of questions asked by those espousing the labeling perspective. Since psychiatrists are crucial in the process of making the “mentally ill” label stick, the practice of psychiatry is of particular interest to sociologists who find this point of view reasonable. However, many of the studies of mental illness from this perspective emphasize the hospitalization process, which, although of considerable importance, is far from being seen by psychiatrists as the action that provides meaning to their endeavors. Although

psychiatrists do think some people could benefit from hospitalization, they do not see committing them as their main justification for existence. In fact, the influential psychiatrists who write articles and books, who develop points of view that in turn win adherents, who help run training programs, are less interested in the process of hospitalization than in understanding what is going on with patients who are presented for treatment. And many of these patients are outpatients, not in a mental hospital or planning to spend time in one.

But even when hospitalization procedures are not the focus, labeling theorists still have ideas of potential interest to psychiatrists, since they consider the processes through which people first come to define themselves as having a mental illness, and because they often see therapy with a professional as a reasonable route to pursue. Thus, the data they gather inevitably becomes of interest to psychiatrists. Indeed, psychiatrists should take an interest in using the same methods generated by the more sociologically oriented researchers in order to study the question of how people who have entered therapy come to see themselves as either having benefited or as having remained the same. Rather than assuming, as we too often do, that there are patients with diseases to whom we apply various methods of therapy, which then either work (and produce cure) or do not work, we might instead become more sociological and reflect on how all of these nouns (patient, illness, therapy, cure) reflect very complicated social

interactions. Too often, perhaps, we tend to see them as so complicated that they cannot be studied, but the intricate studies that labeling theorists have carried out make clear that this is not the case.

Social Construction of Reality

Because psychiatrists are engaged in upholding ordinary reality, they need to become sensitive to their role in maintaining social reality, especially when they find themselves using diagnostic categories such as that of social maladjustment. In order to comprehend the intricacy of the whole process of defining social reality, some acquaintance with the tradition in sociology that explores this question is desirable. Too often psychiatry relies on a simple-minded notion of reality. The very concept of "reality-testing," which is presumably assessed in any psychiatric evaluation, reflects this sort of simple-mindedness. If the reality we each want to be in touch with were there in any simple sense, the entire question of whether we are indeed in touch with it would not be so vexing. Patients who fall into some of the residual categories in DSM-II or DSM-III force us to think more deeply about our ideas of reality, since often they are not psychotically impaired in their thinking but rather are engaged in some form of deviant reality that may or may not warrant psychiatric intervention. In practice, of course, psychiatrists recognize this, and they will usually only treat those who want to be treated, who want therefore to change. But psychiatrists do become implicated in working with

non-voluntary populations, and whenever that happens—whether with prison inmates, or with children, or with people who are being forced in more subtle ways to seek out psychiatric consultation by their families, relatives, or job associates—they run headlong into the dilemmas being discussing here. An acquaintance with the sociological literature on what is called the "social construction of reality" would at least serve to sensitize psychiatrists to many of these issues, issues that are relevant to assessment of patients who might fall into the category of social maladjustment.

Social Traps

Ever since Darwin, the term "adaptation" has accrued a variety of meanings within an evolutionary framework. That is, adaptive behavior tends toward survival, either of the species or of the individual. Diagnosing survival in the physical sense has never been acutely problematic for psychiatrists (though, in fact, defining "death" is a difficult matter for doctors in some situations). But ascertaining what psychological survival might be is not so easy.

Survival, of course, is a rather stark goal. Psychiatrists do not ordinarily see themselves as trying to ensure bare physical survival. Rather, they view themselves as promoting something more elusive, connected perhaps with happiness or fulfillment or authenticity (no good word exists for this elusive

state). However, in any attempt to assess the degree of social maladjustment present in any given individual, it would behoove psychiatrists to be at least aware of a developing field of study that intersects other more traditional fields. One landmark in this newly developing field is an article by Garrett Hardin called "The Tragedy of the Commons." Actually, his argument is not unknown within the somewhat esoteric branch of social psychology known as game theory (as outlined for example in the works of Anatol Rapaport and Thomas Schelling). What Hardin points out, in compelling terms, is that sometimes individuals pursue what they assume to be their own best self-interest, only to find that, in the long run, they become less and less happy, or even die (for lack of food). Much of the controversy generated by the field of ecology is fueled at least in part by an awareness of this dilemma. The example Hardin uses is that of a common grazing land to which each individual member of a community has free access for his animals. As long as not too many animals graze on the land, there is plenty of grass, which keeps on growing and replenishing itself without much effort on the part of the farmers. But if too many animals are allowed to graze on the land, then the grass will be eaten up and be unable to regenerate. This tragedy—whereby each individual citizen loses an entire flock for lack of grazing fodder—can be prevented only if it is foreseen and if some form of mutual regulation is arrived at, according to which, for example, each person is only allowed to pasture a limited number of animals on the commons.

Much of human society today is predicated on the existence of such control mechanisms. There is a limit to many supplies or goods, so that rationing the goods becomes, sooner or later, a problem. At present, this problem may not be so acute as to threaten humanity so far as food, oil, water, space, and air are concerned, but many people now foresee a time when all these resources will be in such scarce supply that some control mechanisms will have to exist for their allocation.

What is the relevance of all this to psychiatry? John Platt makes the connection, emphasizing that a social trap exists in the fact that "each individual . . . continues to do something for his individual advantage that collectively is damaging to the group as a whole." What psychiatrists need to keep in mind is the possibility that what looks like a coping mechanism in a given individual, insofar as it enables him to thrive in his own current social sphere, may not in the long run turn out to be optimal with regard to ensuring survival of either the individual or of the species. For example, the ability to commit oneself to both a family and a career may lead quickly to having children and to doing work that, while well rewarded in terms of money, is not truly productive in the sense of helping to create some worthwhile product that will in the long run help to ensure the survival of the species. Much work is not very productive (Paul Goodman's polemic of more than twenty years ago, *Growing Up Absurd*, probably puts the case as well as any). And there may be too many children already.

Obviously, a psychiatrist is no better suited by virtue of his training than anyone else to evaluate these issues. But having some awareness of them would probably help broaden a psychiatrist's perspective and at least make him more open to considering the possibility that a given course of action, while not adaptive in the sense of not being congruent with the social mores of the world the patient lives in, might in some other context be more beneficial, more valuable, more worthwhile. Making this judgment would not be easy, but being aware that such judgments are always being made would, at least, reduce the vulnerability of psychiatry to the charge that it is a conformist institution that specializes in simply adjusting people to a society that might not be worth adjusting to.

Psychiatrists do not often consider openly whether there is such a thing as over-adjustment. But sociologists raise this possibility in *The Organization Man* and *The Lonely Crowd* and literary and cultural critics have also explored this possibility. Psychiatrically inclined writers who explore this usually do so only in their less technical writings (as Erich Fromm did in his famous book *Escape from Freedom).*

The whole issue is brought into clear-cut relief when one considers a diagnostic category such as that of social maladjustment. For example, why is there no opposite category (social over-adjustment)? The fact that there are so many categories for people who cause troubles, and so few for people who

get along without making any fuss, is in itself a partial indictment of psychiatric nosology. The issue is not whether psychiatrists think people who get along are healthy; clearly no such opinion exists, and any immersion in the psychiatric literature will quickly bear this out. Psychiatrists, in fact, are more prone than most to see troubles everywhere, and whenever they take the time to work closely with ordinary people who have not sought out help, they conclude that even in such populations there is substantial illness or difficulty, well-hidden perhaps but nonetheless real. And yet, psychiatric nosology does not take this into account. Instead, the diagnostic manuals seem to restrict themselves almost entirely to consideration of what enters through the psychiatrist's door. And while this approach is convenient from the point of view of enabling a psychiatrist to find a category for most of the people he sees professionally, it does not encourage psychiatrists to think in terms of such problems as "over-adjustment."

Social Change

The whole question of social maladjustment becomes more complicated when one considers not only the question of an individual's adjustment to his social world, but also the phenomena of social change (more rapid now than ever before) and the fact that historically some societies have been known to thrive and then disappear. The whole complicated question of what enables a society to survive is far from clear, though of course there are many

speculations about this topic. For the psychiatrist who is engaged in daily work with patients, most of these speculations are not directly relevant. But a psychiatrist might do well to keep the matter in mind. The implication of social change and even the disappearance of a society is that any trait that helps a given individual survive today in his own society (traits that appear socially adaptive) may not help him tomorrow or in the next decade, and that further, it may be helping to create a situation that will eventually lead to the demise of the society.

The fact of rapid social change has frequent impact on the work that psychiatrists do, since they occasionally see patients who are having difficulties adjusting to a change in their environment. Some of these changes are common in certain life histories; for example, the change from having no children to having children, and then from having children to living without them. But even these normal changes have different meanings today than they did fifty years ago. For example, when children leave the parental home, they are more likely today to go farther away, given the ease of transportation and the desire for job mobility. Thus, the skills a parent needs in order to promote a smooth and healthy separation for his children may vary from one time period to another. Similarly, the pressures on women today are different from those that prevailed even as little as thirty years ago. Psychiatrists need to be aware of these changes if they are to assess accurately the nature of the difficulties a given patient is having with adjusting to some life change.

The other question of whether a given society is adaptively organized in the long run is more difficult to ascertain. There is no way to know at present whether our society is doing well or poorly, whether it is on a rising curve or a falling one. But it is worth keeping in mind that adaptation today may not mean adaptation tomorrow. Population geneticists stress the value of diversity in the gene pool for enhancing the ability of a given species to respond adaptively to environmental changes. Perhaps there is a metaphor here that is useful for considering social evolution. That is, perhaps a certain amount of diversity in social adjustment patterns is valuable, not because the diversity necessarily means that each individual is regarded as equally successful by his peers, but because having diversity present in the society makes it more likely that if and when conditions change, there may be individuals around who have developed patterns of living and thinking which will make them more capable of working out new ways of living, which in turn can be taught to their more conventional fellows. Such individuals are often labeled "geniuses." Being a genius—that is, being able to see things in different ways and to do things that turn out to be "better" than the things others do—is often accompanied by considerable eccentricity. The word "eccentricity" is an interesting one since it identifies a form of behavior that is clearly at variance with accepted social norms, and yet its connotations are not entirely unfavorable. There is a note of forgiving acceptance in our use of the term, which is probably altogether reasonable. For some people should be

allowed, even encouraged, to be different from their fellows; and psychiatrists need to be more attuned to this form of “adjustment” and to do more to promote it.

The essential questions to keep in mind, when addressing a given patient’s desires for change, are why does this person want to change, and is change really a good idea in this situation? Asking such questions, for example, would have helped avoid some of the controversy surrounding the American Psychiatric Association’s change of position with regard to homosexuality. Psychiatrists might have thought to themselves, in considering homosexuality, whether this kind of behavior really is harmful, and if so, to whom. They might have considered its adaptive characteristics; for example, it does not lead to reproduction, and thus acts as a population control. This is admittedly an unconventional way to think about homosexuality, but almost any deviation from the norm that might be labeled “maladaptive” may have beneficial aspects. Psychiatrists would do well to be more attuned to this possibility when considering the patients they are evaluating.

Psychiatrists could broaden their scope by studying sociological writing that emphasizes the adaptation required for anyone to work out any coherent orientation to life, even if it be called a “deviant” orientation. Many, though not all, “deviants” have adapted quite successfully to a subculture that happens to

be tangential to, or even in opposition to, the mainstream culture. Thus, what looks on the surface like maladaptive behavior (in terms of the mainstream culture) may, in fact, be adaptation in terms of a smaller culture. Psychiatrists working with children are often forced to recognize that a given child, who is identified by a school as "being in trouble," may on closer examination turn out to be rather well adapted to a peculiar family, which in turn makes smooth and easy adaptation to the school (with its different standards) quite difficult.

Second, psychiatrists could benefit from a familiarity with the thinking of those who are interested in the relationships between basic personality structure and social organization. Certain societies, especially more homogeneous ones than our own, often systematically reward certain kinds of personalities (the kind identified as "well adjusted"). But this is not to say that other personality types may not exist within that culture or that they could not make contributions to the larger culture by virtue of their "outsider" position. Keeping these matters in mind may not make the nosological task of the psychiatrist any easier, but it will help to ensure his sensitivity and flexibility in the use of the diagnostic categories.

A central difficulty is that adaptation is judged by success, and success is never a permanent fact but a contingent one. What appears to be success today may turn out to be failure tomorrow. In a larger context, a cultural

group or even a nation may be overrun by another cultural group or nation. Thus, the attributes that helped the tribe or nation prosper during one era may, in fact, one day contribute to its defeat in another. In our own case, if a nuclear disaster occurs, future historians (if there are any) may well speculate about how those traits that enabled western civilization to be so successful for centuries led to its demise. There is, of course, a certain vein of contemporary writing, some of it psychological and psychiatric, that assumes that our society is “mad” and that asserts that fitting into such a society is not a desirable goal. “Thus, a feeling of lack of fit between self and social structure is no longer perceived as pathological or even accidental. Such contemporary works hypothesize that what is positive in the self can never fit with society, which is, by its very nature, mad.” This position is certainly more extreme than what most psychiatrists would be comfortable with, but it is representative of one strand of contemporary thought about the relation between the individual and society. And such considerations are germane when considering the use of the diagnostic category of “social maladjustment.”

Developmental Psychology

We might legitimately wonder how it is that people who are raised by others manage to turn out in ways that are not consistent with the larger society. Part of the answer lies in the fact of social complexity; not every

family that raises children according to its own lights has beliefs and values congruent with those of the larger society. Another part of the answer is inherent in the human's potential for adaptation, the phenomenal plasticity that exists at birth. Animals whose behavioral repertoire is more clearly dictated by genetic factors have less capacity for maladaptation, since they are .born with the equipment necessary for carrying out their lives. People, on the other hand, are born with less of what they need, and must acquire many skills in order to be able to survive in their social and cultural context. Our phenomenal immaturity at birth is, of course, the reason we are able to learn so much after we are born. In a sense, immaturity is the capacity for adaptation. From the point of view of evolution, this is a tremendous strength, but there are costs; one of them is our capacity to develop in ways not directly encouraged by the society. Because we are so flexible at birth, we can learn any of a multitude of languages, depending on what is being spoken around us in our formative years. But by the same token, we are prey to various disorders that have communication and language difficulties at their source. Thus, adaptation and maladaptation are two sides of the same coin.

Within developmental psychology there is a wealth of information about how people develop. Much of this information illuminates some of the possible sources of maladaptation. Research conducted, for example, by Louis Sander and associates makes clear the exquisite delicacy of the mutual adaptation that occurs between parent and child during the early weeks and

months of life. In this process of mutual regulation, there are many possibilities for maladaptation. One of them arises when the parent's tempo does not match that of the child. This kind of mismatch between the capacities of the child and those of the parent may be more common than we think, and may in turn lead to more complicated kinds of maladaptation later.

Another rich source of ideas regarding maladaptation is the literature about marriages, since it often contains specific detailed examples of interactions between husband and wife, which illustrate the varied ways in which two people may work out adjustments to one another. All of these sources of data make clear that adaptation is a dynamic process that occurs either between individuals or between one person and a small group or a society.

At present this point of view is not easily accommodated within the psychiatric nosological system, but the existence of a category such as social maladaptation makes clear the necessity of considering such interconnections. Keeping this point of view in mind will help the psychiatrist assess the value of alternative therapeutic strategies. In some cases, individual therapy for the designated patient who is "maladapted" may be less appropriate than an attempt to change the nature of the system within which the patient functions. Thus, a psychiatrist might consider, in dealing with a younger patient, the possible value of working with the family as well, or he

might alternatively consider the value of advising the parents of the patient how to adjust themselves to their maladjusted child. A psychologist working in a school setting might consider some alteration in the school program. Such a change could provide a better environment for the needs of a particular child and thus eliminate the maladaptation that previously had appeared to be in the child but that was actually a feature of the relationship between a child and the school system.

Conclusion

The term “maladjustment” is such a general one that it might, in truth, be applied to nearly all the patients a typical psychiatrist is likely to see. Most people who are neurotic, character disordered,, and psychotic are likely to have a degree of maladjustment in some general sense. In addition, many of those who do not consult a psychiatrist could be considered maladjusted, in the sense that they are not perfectly adjusted either to the outer society or to their inner natures. If adjustment means no conflict, then maladjustment is everywhere.

This chapter has focused on a more limited form of maladjustment, one implied by the use of the diagnostic category of social maladjustment. However, the distinction between a category of social maladaptation and other categories of problems in living or illness is artificial. Making the

distinctions necessary to use this category in practice is difficult. However, there are several issues that appear relevant to the kinds of evaluations a psychiatrist would have to carry out in order to arrive at a diagnosis of social maladaptation. Many of these considerations involve nonpsychiatric data and theoretical orientations and approaches. That is as it should be, since the category of social maladjustment arises when there is a clear lack of harmony between an individual and society; and if the psychiatrist is to consider the matter from both ends—from the individual or intrapsychic end, and from the sociological or interpersonal end—then some familiarity with what are ordinarily considered sociological issues is necessary.

However, it bears remembering that a familiarity with such sociological notions as labeling theory and the social construction of reality does not necessarily make the psychiatrist's task an easy one. But in spite of the difficulties, it is possible to broaden one's scope and deepen one's imagination by being aware of larger existential problems, and this cannot but aid the therapist in his work.

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