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PSYCHOPATHOLOGY

Foundations for a Contemporary Understanding

EDITED BY JAMES E. MADDUX AND BARBARA A. WINSTEAD

FIFTH EDITION

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Psychopathology

Psychopathology, Fifth Edition is the most up-to-date text about the etiology and treatment of the most important psychological disorders.

The chapters are written by leading experts in the field of psychopathology who provide up-to-date information on theory, research, and clinical practice. The book is unique in its strong emphasis on critical thinking about psychopathology as represented by chapters on such topics as culture, race, gender, class, clinical judgment and decision-making, and alternatives to traditional categorical approaches to understanding psychopathology. The contributors have incorporated information about and from the World Health Organization's International Classification of Diseases along with information about and from the *DSM-5*.

As with the previous editions, this book remains a true textbook in psychopathology. Unlike the many weighty volumes that are intended as reference books, *Psychopathology, Fifth Edition* has been designed specifically to serve as a *textbook* on psychopathology for graduate students in clinical and counseling psychology programs and related programs such as social work. It will also serve as an extremely useful reference source for practitioners and researchers.

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Psychopathology

Foundations for a Contemporary Understanding

FIFTH EDITION

Edited by James E. Maddux and Barbara A. Winstead

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Preface

We are pleased to offer the fifth edition of *Psychopathology: Foundations for a Contemporary Understanding.* This book was created – and revised – with *students* in mind. The length, organization, and level and style of writing reflect this intention. We had – and still have – two major goals in mind.

1. Providing up-to-date information about theory and research on the etiology and treatment of the most important psychological disorders. Toward this end, we chose well-known researchers who would not only be aware of the cutting-edge research on their topics but who were also contributing to this cutting-edge research. This goal also demands frequent updating of information to reflect, as much as possible, the latest developments in the field.
2. Challenging students to *think critically* about psychopathology. We tried to accomplish this goal in two ways. First, we encouraged chapter authors to challenge traditional assumptions and theories concerning the topics about which they were writing. Second, and more important, we have included chapters that discuss in depth crucial and controversial issues facing the field of psychopathology, such as the definition of psychopathology, the influence of cultural and gender, the role of developmental processes, the validity of psychological testing, and the viability and utility of traditional psychiatric diagnosis. The first eight chapters in this book are devoted to such issues because we believe that a sophisticated understanding of psychopathology consists of much more than memorizing a list of disorders and their symptoms or memorizing the findings of numerous studies. It consists primarily of understanding *ideas* and *concepts* and understanding how to use those ideas and concepts to make sense of the research on specific disorders and the information found in formal diagnostic manuals.

Part I offers in-depth discussions of a number of important ideas, concepts, and theories which provide perspective on specific psychological disorders. The major reason for placing these general chapters in the first section before the disorders chapters is to give students a set of conceptual tools that will help them read more thoughtfully and critically the material on specific disorders.

Parts II and III deal with specific disorders of adulthood, childhood, and adolescence. We asked contributors to follow, as much as possible, a common format consisting of:

1. A definition and description of the disorder or disorders.
2. A brief history of the study of the disorder.
3. Theory and research on etiology.
4. Research on empirically supported interventions.

Editors must always make choices regarding what should be included in a textbook and what should not. A textbook that devoted a chapter to every disorder described in *the Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and the mental, behavioral, and neurodevelopmental disorders section of the *International Classification of Diseases and Related Problems* (*ICD*) would be unwieldy and impossible to cover in a single semester. Our choices regarding what to include and what to exclude were guided primarily by our experiences over several decades of teaching and training clinical psychology doctoral students regarding the kinds of psychological problems that these and students in related programs (e.g., counseling, social work) typically encounter in their training and in their subsequent clinical careers. We also wanted to be generally consistent with the nomenclature that appear in the *DSM*-5 and the new *ICD*-11.

We were pleased that the authors of 23 of the 24 chapters of the fourth edition agreed to revise their chapters for the fifth edition. This helps to assure continuity in content and style from the fourth edition to the fifth.

We continue to hope that instructors and students will find this approach to understanding psychopathology challenging and useful. We continue to learn much from our contributors in the process of editing their chapters, and we hope that students will learn as much as we have from reading what these outstanding contributors have produced.

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PART I

Thinking About Psychopathology

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Chapter 1

Conceptions of Psychopathology

A Social Constructionist Perspective

James E. Maddux, Jennifer T. Gosselin, and Barbara A. Winstead

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A textbook about a topic should begin with a clear definition of the topic. Unfortunately, for a textbook on psychopathology, this is a difficult if not impossible task. The definitions or conceptions of *psychopathology* and such related terms as *mental disorder* have been the subject of heated debate throughout the history of psychology and psychiatry, and the debate is not over (e.g., Gorenstein, 1984; Horwitz, 2002; Widiger, Chapter 6 in this volume). Despite its many variations, this debate has centered on a single overriding question: Are *psychopathology* and related terms such as *mental disorder* and *mental illness* scientific terms that can be defined objectively and by scientific criteria, or are they *social constructions* (Gergen, 1985) that are defined largely or entirely by societal and cultural values? Addressing these perspectives in this opening chapter is important because the reader's view of everything in the rest of this book will be influenced by his or her view on this issue.

This chapter deals with *conceptions* of psychopathology. A conception of psychopathology is not a *theory* of psychopathology (Wakefield, 1992a). A conception of psychopathology attempts to define the term – to delineate which human experiences are considered psychopathological and which are not. A conception of psychopathology does not try to *explain* the psychological phenomena that are considered pathological, but instead tells us which psychological phenomena are considered pathological and thus need to be explained. A *theory* of psychopathology, however, *is* an attempt to explain those psychological phenomena and experiences that have been identified by the conception as pathological. Theories and explanations for what is currently considered to be psychopathological human experience can be found in a number of other chapters, including all of those in Part II.

Understanding various conceptions of psychopathology is important for a number of reasons. As explained by medical philosopher Lawrie Reznek (1987), "Concepts carry consequences – classifying things one way rather than another has important implications for the way we behave towards such things" (p. 1). In speaking of the importance of the conception of *disease*, Reznek wrote:

> The classification of a condition as a disease carries many important consequences. We inform medical scientists that they should try to discover a cure for the condition. We inform benefactors that they should support such research. We direct medical care towards the condition, making it appropriate to treat the condition by medical means such as drug therapy, surgery, and so on. We inform our courts that it is inappropriate to hold people responsible for the manifestations of the condition. We set up early warning detection services aimed at detecting the condition in its early stages when it is still amenable to successful treatment. We serve notice to health insurance companies and national health services that they are liable to pay for the treatment of such a condition. Classifying a condition as a disease is no idle matter (p. 1).

If we substitute *psychopathology* or *mental disorder* for the word *disease* in this paragraph, its message still holds true. How we conceive of psychopathology and related terms has wide-ranging implications for individuals, medical and mental health professionals, government agencies and programs, legal proceedings, and society at large.

Conceptions of Psychopathology

A variety of conceptions of psychopathology have been offered over the years. Each has its merits and its deficiencies, but none suffices as a truly scientific definition.

Psychopathology as Statistical Deviance

A commonly used and "common sense" conception of psychopathology is that pathological psychological phenomena are those that are *abnormal* – statistically deviant or infrequent. Abnormal literally means "away from the norm." The word "norm" refers to what is typical or average. Thus, this conception views psychopathology as deviation from statistical psychological normality.

One of the merits of this conception is its common sense appeal. It makes sense to most people to use words such as *psychopathology* and *mental disorder* to refer only to behaviors or experiences that are infrequent (e.g., paranoid delusions, hearing voices) and not to those that are relatively common (e.g., shyness, a stressful day at work, grief following the death of a loved one).

A second merit to this conception is that it lends itself to accepted methods of measurement that give it at least a semblance of scientific respectability. The first step in employing this conception scientifically is to determine what is statistically normal (typical, average). The second step is to determine how far a particular psychological phenomenon or condition deviates from statistical normality. This is often done by developing an instrument or measure that attempts to quantify the phenomenon and then assigns numbers or scores to people's experiences or manifestations of the phenomenon. Once the measure is developed, *norms* are typically established so that an individual's score can be compared to the mean or average score of some group of people. Scores that are sufficiently far from average are considered to be indicative of "abnormal" or "pathological" psychological phenomena. This process describes most tests of intelligence and cognitive ability and many commonly used measures of personality and emotion (e.g., the Minnesota Multiphasic Personality Inventory).

Despite its common sense appeal and its scientific merits, this conception presents problems. Perhaps the most obvious issue is that we generally consider only one "side" of the deviation to be problematic (see "Psychopathology as Maladaptive Behavior" later in this chapter). In other words, Intellectual Disability is pathological, intellectual genius is not. Major Depressive Disorder is

pathological, unconstrained optimism is not. Another concern is that, despite its reliance on scientific and well-established psychometric methods for developing measures of psychological phenomena and developing norms, this approach still leaves room for subjectivity.

The first point at which subjectivity comes into play is in the *conceptual definition* of the construct for which a measure is developed. A measure of any psychological construct, such as intelligence, must begin with a conceptual definition. We have to answer the question "What is 'intelligence'?" before we can attempt to measure or study its causes and consequences. Of course, different people (including different psychologists) will come up with different answers to this question. How then can we scientifically and objectively determine which definition or conception is "true" or "correct"? The answer is that we cannot. Although we have tried-and-true methods for developing a reliable and valid (i.e., it consistently predicts what we want to predict) measure of a psychological construct once we have agreed on its conception or definition, we cannot use these same methods to determine which conception or definition is true or correct. The bottom line is that there is not a "true" definition of intelligence and no objective, scientific way of determining one. Intelligence is not a thing that exists inside of people and makes them behave in certain ways and that awaits our discovery of its "true" nature. Instead, it is an abstract idea that is defined by people as they use the words "intelligence" and "intelligent" to describe certain kinds of human behavior and the covert mental processes that supposedly precede or are at least concurrent with the behavior.

We usually can observe and describe patterns in the way most people use the words *intelligence* and *intelligent* to describe the behavior of themselves and others. The descriptions of the patterns then comprise the definitions of the words. If we examine the patterns of the use of *intelligence* and *intelligent,* we find that at the most basic level, they describe a variety of specific behaviors and abilities that society values and thus encourages; unintelligent behavior includes a variety of behaviors that society does not value and thus discourages. The fact that the definition of *intelligence* is grounded in societal values explains the recent expansion of the concept to include good interpersonal skills (e.g., social and emotional intelligence), self-regulatory skills, artistic and musical abilities, creativity, and other abilities not measured by traditional tests of intelligence. The meaning of *intelligence* has broadened because society has come to place increasing value on these other attributes and abilities, and this change in societal values has been the result of a dialogue or discourse among the people in society, both professionals and laypersons. One measure of intelligence may prove more reliable than another and more useful than another measure in predicting what we want to predict (e.g., academic achievement, income), but what we want to predict reflects what we value, and values are not derived scientifically.

Another point for the influence of subjectivity is in the determination of *how deviant* a psychological phenomenon must be from the norm to be considered abnormal or pathological. We can use objective, scientific methods to construct a measure such as an intelligence test and develop norms for the measure, but we are still left with the question of how far from normal an individual's score must be to be considered abnormal. This question cannot be answered by the science of psychometrics because the distance from the average that a person's score must be to be considered "abnormal" is a matter of debate, not a matter of fact. It is true that we often answer this question by relying on statistical conventions such as using one or two standard deviations from the average score as the line of division between normal and abnormal. Yet the decision to use that convention is itself subjective because a convention (from the Latin *convenire*, meaning "to come together"), is an agreement or contract made by people, not a truth or fact about the world. Why should one standard deviation from the norm designate "abnormality"? Why not two standard deviations? Why not half a standard deviation? Why not use percentages? The lines between normal and abnormal can be drawn at many different points using many different strategies. Each line of demarcation may be more or less useful for certain purposes, such as determining the criteria for eligibility for limited services and resources. Where the line is set also determines the prevalence of "abnormality" or "mental disorder" among the general population (Kutchins & Kirk, 1997; Frances, 2013), so it has great practical significance. But no such line is more or less "true" than the others, even when those others are based on statistical conventions.

We cannot use the procedures and methods of science to draw a definitive line of demarcation between normal and abnormal psychological functioning, just as we cannot use them to draw definitive lines of demarcation between "short" and "tall" people or "hot" and "cold" on a thermometer. No such lines exist in nature awaiting our discovery.

Psychopathology as Maladaptive (Dysfunctional) Behavior

Most of us think of psychopathology as behaviors and experiences that are not just statistically abnormal but also maladaptive (dysfunctional). *Normal* and *abnormal* are statistical terms, but *adaptive* and *maladaptive* refer not to statistical norms and deviations but to the effectiveness or ineffectiveness of a person's behavior. If a behavior "works" for the person – if the behavior helps the person deal with challenges, cope with stress, and accomplish his or her goals – then we say the behavior is more or less effective and adaptive. If the behavior does not "work" for the person in these ways, or if the behavior makes the problem or situation worse, we say it is more or less ineffective and maladaptive. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) (*DSM*-5) incorporates this notion in its definition of mental disorder by stating that mental disorders "are usually associated with significant distress or disability in social, occupational, or other important activities" (American Psychiatric Association [APA], 2013, p. 20).

Like the statistical deviance conception, this conception has common sense appeal and is consistent with the way most laypersons use words such as *pathology*, *disorder*, and *illness*. As we noted earlier, most people would find it odd to use these words to describe statistically infrequent high levels of intelligence, happiness, or psychological well-being. To say that someone is

"pathologically intelligent" or "pathologically well-adjusted" seems contradictory because it flies in the face of the common sense use of these words.

The major problem with the conception of psychopathology as maladaptive behavior is its inherent subjectivity. Like the distinction between normal and abnormal, the distinction between adaptive and maladaptive is fuzzy and arbitrary. We have no objective, scientific way of making a clear distinction. Very few human behaviors are in and of themselves either adaptive or maladaptive; instead, their adaptiveness and maladaptiveness depend on the situations in which they are enacted and on the judgment and values of the actor and the observers. Even behaviors that are statistically rare and therefore abnormal will be more or less adaptive under different conditions and more or less adaptive in the opinion of different observers and relative to different cultural norms. The extent to which a behavior or behavior pattern is viewed as more or less adaptive or maladaptive depends on a number of factors, such as the goals the person is trying to accomplish and the social norms and expectations in a given situation. What works in one situation might not work in another. What appears adaptive to one person might not appear so to another. What is usually adaptive in one culture might not be so in another (see López & Guarnaccia, Chapter 4 in this volume). Even so-called "normal" personality involves a good deal of occasionally maladaptive behavior, which you can find evidence for in your own life and the lives of friends and relatives. In addition, people given official "personality disorder" diagnoses by clinical psychologists and psychiatrists often can manage their lives effectively and do not always behave in maladaptive ways.

Another problem with the "psychopathological = maladaptive" conception is that judgments of adaptiveness and maladaptiveness are logically unrelated to measures of statistical deviation. Of course, often we do find a strong relationship between the statistical abnormality of a behavior and its maladaptiveness. Many of the problems described in the *DSM*-5 and in this textbook are both maladaptive and statistically rare. There are, however, major exceptions to this relationship.

First, not all psychological phenomena that deviate from the norm or the average are maladaptive. In fact, sometimes deviation from the norm is adaptive and healthy. For example, IQ scores of 130 and 70 are equally deviant from norm, but abnormally high intelligence is much more adaptive than abnormally low intelligence. Likewise, people who consistently score abnormally low on measures of anxiety and depression are probably happier and better adjusted than people who consistently score equally abnormally high on such measures.

Second, not all maladaptive psychological phenomena are statistically infrequent and vice versa. For example, shyness is almost always maladaptive to some extent because it often interferes with a person's ability to accomplish what he or she wants to accomplish in life and relationships, but shyness is very common and therefore is statistically frequent. The same is true of many of the problems with sexual functioning that are included in the *DSM* as "mental disorders" – they are almost always maladaptive to some extent because they create distress and problems in relationships, but they are relatively common (see Gosselin & Bombardier, Chapter 14 in this volume).

Psychopathology as Distress and Disability

Some conceptions of psychopathology invoke the notions of *subjective distress* and *disability*. Subjective distress refers to unpleasant and unwanted feelings, such as anxiety, sadness, and anger. Disability refers to a restriction in ability (Ossorio, 1985). People who seek mental health treatment usually are not getting what they want out of life, and many feel that they are unable to do what they need to do to accomplish their valued goals. They may feel inhibited or restricted by their situation, their fears or emotional turmoil, or by physical or other limitations. Individuals may lack the necessary self-efficacy beliefs (beliefs about personal abilities), physiological or biological components, self-regulatory skills, and/or situational opportunities to make positive changes (Bergner, 1997).

As noted previously, the *DSM* incorporates the notions of distress and disability into its definition of mental disorder. In fact, subjective distress and disability are simply two different but related ways of thinking about adaptiveness and maladaptiveness rather than alternative conceptions of psychopathology. Although the notions of subjective distress and disability may help refine our notion of maladaptiveness, they do nothing to resolve the subjectivity problem. Different people will define personal distress and personal disability in vastly different ways, as will different mental health professionals and different cultures. Likewise, people differ in their thresholds for how much distress or disability they can tolerate before seeking professional help. Thus, we are still left with the problem of how to determine normal and abnormal levels of distress and disability. As noted previously, the question "How much is too much?" cannot be answered using the objective methods of science.

Another problem is that some conditions or patterns of behavior (e.g., pedophilic disorder, antisocial personality disorder) that are considered psychopathological (at least officially, according to the *DSM*) are *not* characterized by subjective distress, other than the temporary distress that might result from social condemnation or conflicts with the law.

Psychopathology as Social Deviance

Psychopathology has also been conceived as behavior that deviates from social or cultural norms. This conception is simply a variation of the conception of psychopathology as statistical abnormality, only in this case judgments about deviations from normality are made informally by people using social and cultural rules and conventions rather than formally by psychological tests or measures.

This conception also is consistent to some extent with common sense and common parlance. We tend to view psychopathological or mentally disordered people as thinking, feeling, and doing things that most other people do not do (or do not want to do) and that are inconsistent with socially accepted and culturally sanctioned ways of thinking, feeling, and behaving. Several examples can be found in *DSM-5*'s category of paraphilic disorders.

The problem with this conception, as with the others, is its subjectivity. Norms for socially normal or acceptable behavior are not derived scientifically but instead are based on the values, beliefs, and historical practices of the culture, which determine who is accepted or rejected by a society or culture. Cultural values develop not through the implementation of scientific methods, but through numerous informal conversations and negotiations among the people and institutions of that culture. Social norms differ from one culture to another, and therefore what is psychologically abnormal in one culture may not be so in another (see López & Guarnaccia, Chapter 4 in this volume). Also, norms of a given culture change over time; therefore, conceptions of psychopathology will change over time, often very dramatically, as evidenced by American society's changes over the past several decades in attitudes toward sex, race, and gender. For example, psychiatrists in the 1800s classified masturbation, especially in children and women, as a disease, and it was treated in some cases by clitoridectomy (removal of the clitoris), which Western society today would consider barbaric (Reznek, 1987). Homosexuality was an official mental disorder in the *DSM* until 1973.

In addition, the conception of psychopathology as social norm violations is at times in conflict with the conception of psychopathology as maladaptive behavior. Sometimes violating social norms is healthy and adaptive for the individual and beneficial to society. In the 19th century, women and African-Americans in the US who sought the right to vote were trying to change well-established social norms. Their actions were uncommon and therefore "abnormal," but these people were far from psychologically unhealthy, at least not by today's standards. Earlier in the 19th century, slaves who desired to escape from their owners were said to have "drapetomania." Although still practiced in some parts of the world, slavery is almost universally viewed as socially deviant and pathological, and the desire to escape enslavement is considered to be as normal and healthy as the desire to live and breathe.

Psychopathology as "Dyscontrol" or "Dysregulation"

Some have argued that we should only consider as psychopathologies or mental disorders those maladaptive patterns of behaving, thinking, and feeling that are not within the person's ability to effectively control or self-regulate (e.g., Kirmayer & Young, 1999; Widiger & Sankis, 2000). The basic notion here is that if a person *voluntarily* behaves in maladaptive or self-destructive ways, then that person's behavior should not be viewed as in indication of or result of a mental disorder. Indeed, as does the notion of a physical or medical disorder, the term mental disorder seems to incorporate the notion that what is happening to the person is not within the person's control. The basic problem with this conception is that it draws an artificial line between "within control" (voluntary) and "out of control" (involuntary) that simply cannot be drawn. There are some behaviors that a person might engage in that most of us would agree are completely voluntary, deliberate, and intentional and some other behaviors that a person might engage in that most of us would agree are completely involuntary, non-deliberate, and unintentional. Such behaviors, however, are probably few and far between. The causes of human behavior are complex, to say the least, and environmental events can have such a powerful influence on any behavior that saying that anything that people do is completely or even mostly voluntary and intentional may be a stretch. In fact, considerable research suggests that most behaviors most of the time are automatic and therefore involuntary (Weinberger, Siefert, & Haggerty, 2010). Determining the degree to which a behavior is voluntary and within a person's control or involuntary and beyond a person's control is difficult, if not impossible. We also are left, once again, with the question of who gets to make this determination. The actor? The observer? The patient? The mental health professional? Although using theories of self-regulation can be highly useful in understanding the etiology and maintenance of those problems that get labeled as disorders (Sheppes, Suri, & Gross, 2015; Strauman, 2017), those theories cannot tell us which problems should be viewed as "disorders."

Psychopathology as Harmful Dysfunction

Wakefield's (1992a, 2010, 2013) *harmful dysfunction* (HD) conception, presumably grounded in evolutionary psychology (e.g., Cosmides, Tooby, & Barkow, 1992), acknowledges that the conception of mental disorder is influenced strongly by social and cultural values. It also proposes, however, a supposedly scientific, factual, and objective core that is not dependent on social and cultural values (Wakefield, 2010). In Wakefield's (1992a) words:

> a [mental] disorder is a harmful dysfunction wherein *harmful* is a value term based on social norms, and *dysfunction* is a scientific term referring to the failure of a mental mechanism to perform a natural function for which it was designed by evolution ... a disorder exists when the failure of a person's internal mechanisms to perform their function as designed by nature impinges harmfully on the person's well-being as defined by social values and meanings (p. 373).

One of the merits of this conception is that it acknowledges that the conception of mental disorders must include a reference to social norms; however, this conception also tries to anchor the concept of mental disorder in a scientific theory – the theory of evolution.

Wakefield (2006) has reiterated this definition in writing that a mental disorder "satisfies two requirements: (1) it is negative or harmful according to cultural values; and (2) it is caused by a dysfunction (i.e., by a failure of some psychological mechanism to perform a natural function for which it was evolutionarily designed)" (p. 157). He and his colleagues also write, "Problematic mismatches between designed human nature and current social desirability are not disorders ... [such as] adulterous longings, taste for fat and sugar, and male aggressiveness" (Wakefield, Horwitz, & Schmitz, 2006, p. 317).

One problem with this definition is that "evolution is not a directed process, and so there is no design for a particular characteristic" (Blashfield, Keeley, Flanagan, & Miles, 2014, p. 36). Another problem is that "mental functions may not be direct adaptions to the environment [but] exaptations, or characteristics that evolved for some other purpose but currently serve a particular function" (Blashfield et al., 2014, p. 36). In addition, the claim that identifying a failure of a "designed function" is a scientific judgment and not a value judgment is questionable. Wakefield's claim that dysfunction can be defined in "purely factual scientific" (Wakefield, 1992a, p. 383, 2010) terms rests on the assumption that the "designed functions" of human "mental mechanisms" have an objective and observable reality and, thus, that failure of the mechanism to execute its designed function can be objectively assessed. A basic problem with this notion is that although the physical inner workings of the body and brain can be observed and measured, "mental mechanisms" have no objective reality and thus cannot be observed directly – no more so than the "unconscious" forces (e.g., id, ego, superego) that provide the foundation for Freudian psychoanalytic theory.

Evolutionary theory provides a basis for explaining human behavior in terms of its contribution to reproductive fitness. A behavior is considered more functional if it increases the survival of those who share your genes in the next generation and the next and less functional if it does not. Evolutionary psychology cannot, however, provide a catalogue of "mental mechanisms" and their natural functions. Wakefield states that "discovering what in fact is natural or dysfunctional may be extraordinarily difficult" (1992b, p. 236). The problem with this statement is that, when applied to human behavior, "natural" and "dysfunctional" are not properties that can be "discovered"; they are value judgments. The judgment that a behavior represents a dysfunction relies on the observation that the behavior is excessive and/or inappropriate under certain conditions. Arguing that these behaviors represent failures of evolutionarily designed "mental mechanisms" (itself an untestable hypothesis because of the occult nature of "mental mechanisms") does not absolve us of the need to make value judgments about what is excessive, inappropriate, or harmful and under what circumstances (Leising, Rogers, & Ostner, 2009). These are value judgments based on social norms, not scientific "facts," an issue that we will explore in greater detail later in this chapter (see also Widiger, Chapter 6 this volume). Wakefield (2013) is correct that "the fuzziness of 'harm' and 'dysfunction' [does not] undermine the possibility of valuably picking out clear cases on both sides of the distinction" (p. 828). Nonetheless the enumerable unclear cases of both harmfulness and dysfunctionality leave a lot of room for human judgment, which will inevitably be influenced by social and professional norms.

Another problem with the HD conception is that it is a moving target. For example, Wakefield modified his original HD conception by saying that it is concerned not with what a mental disorder *is* but only with what most scientists *think* it is. For example, he states that "My comments were intended to argue, not that PTSD [posttraumatic stress disorder] is a disorder, but that the HD analysis is capable of explaining why the symptom picture in PTSD is *commonly judged* to be a disorder" (1999, p. 390, emphasis added). Wakefield's original goal was to "define mental disorders *prescriptively*" (Sadler, 1999, p. 433, emphasis added) and to "help us decide whether someone is mentally disordered or not" (Sadler, 1999, p. 434). His more recent view, however, "avoids making any prescriptive claims, instead focusing on explaining the conventional clinical use of the disorder concept" (Sadler, 1999, p. 433). Wakefield "has abandoned his original task to be prescriptive and has now settled for being *descriptive* only, for example, telling us why a disorder is judged to be one" (Sadler, 1999, p. 434, emphasis added).

Describing how people have agreed to define a concept is not the same as defining the concept in scientific terms, even if those people are scientists. Thus, Wakefield's HD conception simply offers a criterion that people (clinicians, scientists, and laypersons) might use to judge whether or not something is a "mental disorder." But consensus of opinion, even among scientists, is not scientific evidence. Therefore, no matter how accurately this criterion might describe how some or most people define "mental disorder," it is no more or no less scientific than other conceptions that also are based on how some people *agree* to define "mental disorder." It is no more scientific than the conceptions involving statistical infrequency, maladaptiveness, or social norm violations (see also Widiger, Chapter 6).

The DSM and ICD Definitions of Mental Disorder

Any discussion of conceptions of psychopathology has to include a discussion of the most influential conception of all – that of the *Diagnostic and Statistical Manual of Mental Disorders* (the *DSM*). First published in 1952 and revised and expanded five times since, the *DSM* provides the organizational structure for virtually every textbook (including this one) on abnormal psychology and psychopathology, as well as almost every professional book on the assessment and treatment of psychological problems. (See Widiger, Chapter 6, for a more detailed history of psychiatric classification, the *DSM*, and the *ICD*.)

Just as a textbook on psychopathology should begin by defining its key term, so should a taxonomy of mental disorders. The difficulties inherent in attempting to define psychopathology and related terms are clearly illustrated by the definition of "mental disorder" found in the latest edition of the *DSM*, the *DSM-5* (APA, 2013):

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above (p. 20).

All of the conceptions of psychopathology described previously can be found to some extent in this definition – statistical deviation (i.e., not "expectable"); maladaptiveness, including distress and disability; social norms violations; and some elements of the harmful dysfunction conception ("a dysfunction in the individual") although without the flavor of evolutionary theory. For this reason, it is a comprehensive, inclusive, and sophisticated conception and probably as good, if not better, than any proposed so far.

Nonetheless, it falls prey to the same problems with subjectivity as other conceptions. For example, what is the meaning of "clinically significant" and how should "clinical significance" be measured? Does clinical significance refer to statistical infrequency, maladaptiveness, or both? How much distress must a person experience or how much disability must a person exhibit before he/she is said to have a mental disorder? Who gets to judge the person's degree of distress or disability? How do we determine whether or not a particular response to an event is "expectable" or "culturally approved"? Who gets to determine this? How does one determine whether or not socially deviant behavior or conflicts "are primarily between the individual and society"? What exactly does this mean? What does it mean for a dysfunction to exist or occur "in the individual"? Certainly a biological dysfunction might be said to be literally "in the individual," but does it make sense to say the same of psychological and behavioral dysfunctions? Is it possible to say that a psychological or behavioral dysfunction can occur "in the individual" apart from the social, cultural, and interpersonal milieu in which the person is acting and being judged? Clearly, the *DSM*'s conception of mental disorder raises as many questions as do the conceptions it was meant to supplant.

The World Health Organization's (WHO) 11th edition of the *International Classification of Diseases and Related Health Problems* (*ICD-11*; WHO, 2018) includes a *Classification of Mental and Behavioural Disorders* that is highly similar in format and content to the *DSM-5*. In fact, the two systems have evolved in tandem over the past several decades. In the *ICD-11*,

> Mental, behavioural and neurodevelopmental disorders are syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning (WHO, 2018).

Although less wordy than the *DSM* definition, the *ICD* definition contains the same basic ideas and the same interpretive problems. What is missing is the statement that a mental disorder exists "in an individual" although the notion of an "underlying dysfunction" can be interpreted as meaning the same thing.

Categories Versus Dimensions

The difficulty inherent in the *DSM* conception of psychopathology and other attempts to distinguish between normal and abnormal or adaptive and maladaptive is that they are *categorical models* that attempt to describe guidelines for distinguishing between individuals who are normal or abnormal and for determining which specific abnormality or "disorder" a person has to the exclusion of other disorders. In other words, people either "have" a given disorder or they do not. An alternative model, overwhelmingly supported by research, is the *dimensional model*. In the dimensional model, normality and abnormality, as well as effective and ineffective psychological functioning, lie along a continuum; so-called psychological disorders are simply extreme variants of normal psychological phenomena and ordinary problems in living. Divisions along these continua between normal and abnormal or adaptive and maladaptive are arbitrary and artificial. The dimensional model is concerned not with classifying people or disorders but with identifying and measuring individual differences in psychological phenomena, such as emotion, mood, intelligence, and personal styles. Great differences among individuals on the dimensions of interest are expected, such as the differences we find on standardized tests of intelligence. As with intelligence, divisions between normality and abnormality may be demarcated for convenience or efficiency but are not to be viewed as indicative of true discontinuity among "types" of phenomena or "types" of people. Also, statistical deviation is not viewed as necessarily pathological, although extreme variants on either end of a dimension (e.g., introversion-extraversion, neuroticism, intelligence) may be maladaptive if they lead to inflexibility in functioning.