“The editors have graced us with a reprise of their outstanding 4th edition of this textbook with chapters by almost all of the previous, very distinguished, experts. Attention to older adults and clinical judgment is particularly noteworthy, as is the attention to the current ICD and DSM diagnostic systems. It is concise, readily supplemented, and will not overwhelm students with dense and lengthy material. The book is a gem.”

—Barry A. Edelstein, PhD, Eberly Family Distinguished Professor, Department of Psychology, West Virginia University, USA

“As with previous editions, this volume is highly readable, well-organized, scholarly, and comprehensive. Maddux and Winstead have again produced an indispensable work for graduate-level education in understanding and treating mental illness. Written by acclaimed experts in that particular topic, each chapter follows a similar format which makes the material accessible to both students and instructors alike. More importantly, the authors present the up-to-date empirical work guiding research, assessments, and interventions. Updated to reflect both revisions to the DSM and advancements in the field, this is an essential textbook for training future mental health professionals.”

—Stephen M. Saunders, PhD, Professor and Chairperson, Department of Psychology, Marquette University, USA

### Praise for previous editions

“The challenge of not only describing, but also starting to explain, psychopathology is a daunting one, but Psychopathology does a superb job…Students’ understanding and appreciation for the key issues in psychopathology etiology, assessment, intervention, and research will increase tremendously by reading this text.”

—Bethany Teachman, PhD, Director, Program for Anxiety, Cognition, and Treatment; Associate Professor of Psychology, University of Virginia, USA

“This book will be of great value to mental health professionals across career stages…For all readers, the book’s clarity and insight on the nature of psychopathology itself, on clinical assessment, on cultural dimensions, and more will provide an invaluable resource.”

—Thomas Joiner, PhD, Author of Lonely at the Top and Why People Die by Suicide

“This textbook will be of great value to all students and health professionals in the field of psychology and psychiatry as it gives them access to the main issues of contemporary psychopathology and to updated data about specific disorders throughout the life-span.”

—Diane Purper Ouakil, Author of European Child and Adolescent Psychiatry
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.

James E. Maddux, PhD, is university professor emeritus in the Department of Psychology and Senior Scholar in the Center for the Advancement of Well-Being at George Mason University in Fairfax, Virginia.

Barbara A. Winstead, PhD, is professor of psychology in the Department of Psychology at Old Dominion University and in the Virginia Consortium Program in Clinical Psychology, Norfolk, Virginia.
# Contents

Contributors ix
Preface xiii

## PART I: THINKING ABOUT PSYCHOPATHOLOGY

1. Conceptions of Psychopathology: A Social Constructionist Perspective  
   James E. Maddux, Jennifer T. Gosselin, and Barbara A. Winstead 3

2. Psychopathology: A Neurobiological Perspective  
   Daniel Tranel, Molly A. Nikolas, and Kristian Markon 19

3. Developmental Psychopathology: Basic Principles  
   Janice Zemun, Cynthia Suveg, and Kara Braunstein West 57

   Steven Regeser López and Peter J. Guarnacciu 67

5. Gender, Race, and Class and Their Role in Psychopathology  
   Barbara A. Winstead and Janis Sanchez-Hucles 85

6. Classification and Diagnosis: Historical Development and Contemporary Issues  
   Thomas A. Widiger 109

7. Psychological Assessment and Clinical Judgment  
   Howard N. Gurl, Scott O. Lilienfeld, and Katherine A. Fowler 125

8. Psychotherapy Research  
   Rebecca E. Stewart and Dianne L. Chambless 141

## PART II: COMMON PROBLEMS OF ADULTHOOD

9. Anxiety Disorders and Obsessive-Compulsive and Related Disorders  
   Shari A. Steinman, Amber L. Billingsley, Ciera B. Edwards, Mira D. Snider, and Lauren S. Hallion 155

10. Trauma- and Stressor-Related Disorders  
    Lori A. Zollner, Belinda Graham, and Michele A. Bedard-Gilligan 173

11. Depressive Disorders and Bipolar and Related Disorders  
    Lauren B. Alley, Naoise Mac Giollabhui, Amber A. Graham, Allison Stumper, Corinne P. Bart, Erin E. Curley, Laura E. McLaughlin, Daniel P. Mortarity, and Tommy H. Ng 201

12. Schizophrenia Spectrum and Other Psychotic Disorders  
    Matilda Azis, Ivanka Reitanovic, Andrea Pelletier-Baldei, Hannah Trotman, Lisa Kestler, Annie Bollini, and Vijay A. Mittal 247

13. Personality Disorders  
    Cristina Crego and Thomas A. Widiger 281

14. Sexual Dysfunctions and Paraphilic Disorders  
    Jennifer T. Gosselin and Michael Bomberdier 305

15. Somatic Symptom and Related Disorders  
    Michael J. Zvolensky, Lorna Gay, Justin M. Shepherd, and Georg H. Eifert 341

16. Dissociative Disorders  
    Steven Jay Lynn, Scott O. Lilienfeld, Harold Merckelbich, Reel Maxwell, Dumle Aksen, Jessica Boltman, and Timo Giesbrecht 355
<table>
<thead>
<tr>
<th>Part</th>
<th>Title</th>
<th>Authors</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Substance-Related and Addictive Disorders</td>
<td>Keith Klostermann, Michelle L. Kelley, and Sarah Ehike</td>
<td>377</td>
</tr>
<tr>
<td>18</td>
<td>Mental Health and Aging</td>
<td>Amy Fiske, Ruifeng Cui, and Alexandria R. Ebert</td>
<td>399</td>
</tr>
<tr>
<td></td>
<td><strong>PART III: COMMON PROBLEMS OF CHILDHOOD AND ADOLESCENCE</strong></td>
<td></td>
<td>425</td>
</tr>
<tr>
<td>19</td>
<td>Externalizing Disorders of Childhood and Adolescence</td>
<td>Eva R. Kimonis, Paul J. Frick, and Georgette E. Fleming</td>
<td>427</td>
</tr>
<tr>
<td>20</td>
<td>Internalizing Disorders of Childhood and Adolescence</td>
<td>Janay B. Sander, Lindsay K. Rye, and Thomas H. Ollendick</td>
<td>459</td>
</tr>
<tr>
<td>21</td>
<td>Learning Disorders of Childhood and Adolescence</td>
<td>Rebecca S. Martinez and Leah M. Nellis</td>
<td>481</td>
</tr>
<tr>
<td>22</td>
<td>Eating Disorders</td>
<td>Danielle E. MacDonald, Traci McFarlane, and Kathryn Trottier</td>
<td>495</td>
</tr>
<tr>
<td>23</td>
<td>Gender Dysphoria</td>
<td>Jennifer T. Gosselin and Michael Bombardier</td>
<td>521</td>
</tr>
<tr>
<td>24</td>
<td>Autism Spectrum Disorders</td>
<td>Susan W. White and Caitlin M. Conner</td>
<td>537</td>
</tr>
<tr>
<td></td>
<td>Index</td>
<td></td>
<td>551</td>
</tr>
</tbody>
</table>
Contributors

Lauren B. Alloy, Department of Psychology, Temple University, Philadelphia, Pennsylvania

Damla Aksen, Psychology Department, Binghamton University, State University of New York, Binghamton, New York

Matilda Azis, Department of Psychology, Northwestern University, Evanston, Illinois

Jessica Baltman, The Reeds Center, New York

Corinne P. Bart, Department of Psychology, Temple University, Philadelphia, Pennsylvania

Michele A. Bedard-Gilligan, Department of Psychiatry and Behavioral Science, University of Washington, Seattle, Washington

Amber L. Billingsley, Department of Psychology, West Virginia University, Morgantown, West Virginia

Annie Bollini, Patient-Centered Outcomes Research Institute, Washington, DC

Michael Bombardier, Private Practice, Baltimore, Maryland

Kara Braunstein West, Clinical Psychology Doctoral Program, University of Georgia, Athens, Georgia

Dianne L. Chambless, Department of Psychology, University of Pennsylvania, Philadelphia, Pennsylvania

Caitlin M. Conner, Department of Psychiatry, University of Pittsburgh, Pittsburgh, Pennsylvania

Cristina Crego, Department of Psychology, University of Kentucky, Lexington, Kentucky

Ruifeng Cui, Department of Psychology, West Virginia University, Morgantown, West Virginia

Erin E. Curley, Department of Psychology, Temple University, Philadelphia, Pennsylvania

Alexandria R. Ebert, Department of Psychology, West Virginia University, Morgantown, West Virginia

Cierra B. Edwards, Department of Psychology, West Virginia University, Morgantown, West Virginia

Sarah Ehlke, Doctoral Candidate, Health Psychology Program, Old Dominion University, Norfolk, Virginia

Georg H. Eifert, Department of Psychology, Chapman University, Orange, California

Amy Fiske, Department of Psychology, West Virginia University, Morgantown, West Virginia

Georgette E. Fleming, School of Psychology, University of New South Wales, Sydney, Australia

Katherine A. Fowler, Division of Violence Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia

Paul J. Frick, Department of Psychology, Louisiana State University, Baton Rouge, Louisiana

Howard N. Garb, Wilford Hall Medical Center, Lackland Airforce Base, San Antonio, Texas

Lorra Garey, Department of Psychology, University of Houston, Houston, Texas
Timo Giesbrecht, Forensic Psychology Section, Faculty of Psychology and Neuroscience, Maastricht University, Maastricht, The Netherlands

Jennifer T. Gosselin, Salt Lake City, Utah

Amber A. Graham, Department of Psychology, Temple University, Philadelphia, Pennsylvania

Belinda Graham, Department of Experimental Psychology, University of Oxford, Oxford, England

Peter J. Guarnaccia, Institute for Health, Health Care Policy, and Aging Research, Rutgers, The State University of New Jersey, New Brunswick, New Jersey

Lauren S. Hallion, Department of Psychology, University of Pittsburgh, Pittsburgh, Pennsylvania

Michelle L. Kelley, Department of Psychology, Old Dominion University, Norfolk, Virginia

Lisa Kestler, Princeton, New Jersey

Eva R. Kimonis, School of Psychology, University of New South Wales, Sydney, Australia

Keith Klostermann, Department of Counseling and Clinical Psychology, Medaille College, Buffalo, New York

Scott O. Lilienfeld, Department of Psychology, Emory University, Atlanta, Georgia

Steven R. López, Department of Psychology, University of Southern California, Los Angeles, California

Steven J. Lynn, Department of Psychology, Binghamton University, The State University of New York, Binghamton, New York

Danielle E. MacDonald, Centre for Mental Health, University Health Network, Toronto, Ontario & Department of Psychiatry, University of Toronto, Toronto, Ontario

Naoise Mac Giollabhui, Department of Psychology, Temple University, Philadelphia, Pennsylvania

James E. Maddux, Department of Psychology & Center for the Advancement of Well-Being, George Mason University, Fairfax, Virginia

Kristian Markon, Department of Psychological and Brain Sciences, University of Iowa, Iowa City, Iowa

Rebecca S. Martinez, Department of Counseling and Educational Psychology, Indiana University, Bloomington, Indiana

Reed Maxwell, Cornell Weil Medical College, New York

Traci McFarlane, Centre for Mental Health, University Health Network, Toronto, Ontario & Department of Psychiatry, University of Toronto, Toronto, Ontario

Laura E. McLaughlin, Department of Psychology, Temple University, Philadelphia, Pennsylvania

Harald Merckelbach, Forensic Psychology Section, Faculty of Psychology and Neuroscience, Maastricht University, Maastricht, The Netherlands

Vijay A. Mittal, Department of Psychology, Northwestern University, Evanston, Illinois

Daniel P. Moriarity, Department of Psychology, Temple University, Philadelphia, Pennsylvania

Leah M. Nellis, Department of Communication Disorders and Counseling, School, and Educational Psychology, Indiana State University, Kokomo, Indiana
Tommy H. Ng, Department of Psychology, Temple University, Philadelphia, Pennsylvania.

Molly A. Nikolas, Department of Psychology, University of Iowa, Iowa City, Iowa

Thomas H. Ollendick, Department of Psychology, Virginia Polytechnic Institute and State University, Blacksburg, Virginia

Andrea Pelletier-Baldelli, Department of Psychiatry, University of North Carolina, Chapel Hill, North Carolina

Ivanka Ristanovic, Department of Psychology, Northwestern University, Evanston, Illinois

Lindsay K. Rye, Department of Educational Psychology, Ball State University, Muncie, Indiana

Janis Sanchez-Hucles, Department of Psychology, Old Dominion University, Norfolk, Virginia

Janay B. Sander, Department of Educational Psychology, Ball State University, Muncie, Indiana

Justin M. Shepherd, Department of Psychology, University of Houston, Houston, Texas

Mira D. Snider, Department of Psychology, West Virginia University, Morgantown, West Virginia

Shari A. Steinman, Department of Psychology, West Virginia University, Morgantown, West Virginia

Rebecca E. Stewart, Department of Psychiatry, University of Pennsylvania, Philadelphia, Pennsylvania

Allison Stumper, Department of Psychology, Temple University, Philadelphia, Pennsylvania

Cynthia Suveg, Department of Psychology, University of Georgia, Athens, Georgia

Daniel Tranel, Department of Neurology & Department of Psychological and Brain Sciences, University of Iowa, Iowa City, Iowa

Hanan Trotman, Department of Psychology, Mercer University, Macon, Georgia

Kathryn Trottier, Centre for Mental Health, University Health Network, Toronto, Ontario & Department of Psychiatry, University of Toronto, Toronto, Ontario

Susan W. White, Department of Psychology, University of Alabama, Tuscaloosa, Alabama

Thomas A. Widiger, Department of Psychology, University of Kentucky, Lexington, Kentucky

Barbara A. Winstead, Department of Psychology, Old Dominion University, Norfolk, Virginia

Janice Zeman, Department of Psychology, College of William and Mary, Williamsburg, Virginia

Lori A. Zoellner, Department of Psychology, University of Washington, Seattle, Washington

Michael J. Zvolensky, Department of Psychology, University of Houston, Houston, Texas
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.

James E. Maddux
George Mason University
Fairfax, Virginia

Barbara A. Winstead
Old Dominion University
Virginia Consortium Program in Clinical Psychology
Norfolk, Virginia

May 1, 2019
PART I

Thinking About Psychopathology
Chapter 1

Conceptions of Psychopathology

A Social Constructionist Perspective

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

Chapter contents

Conceptions of Psychopathology 4
Categories Versus Dimensions 9
Social Constructionism and Conceptions of Psychopathology 11
Summary and Conclusions 15
References 15
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 reframe 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 & Guar, 2015). 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 “dрапетомания.” 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., 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 ennumerable 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.
This notion is not new. As early as 1860, Henry Maudsley commented that “there is no boundary line between sanity and insanity; and the slightly exaggerated feeling which renders a man ‘peculiar’ in the world differs only in degree from that which places hundreds in asylums” (Maudsley, 1860, p. 14, as cited in Millon & Simonsen, 2010, p. 33).

Empirical evidence for the validity of a dimensional approach to psychological adjustment is strongest in the area of personality and personality disorders (Boudreaux, 2016; Krueger & Markon, 2014; Crego & Widiger, Chapter 13 in this volume; Widiger & Mullins-Sweatt, 2009). Factor analytic studies of personality problems among the general population and clinical populations with “personality disorders” demonstrate striking similarity between the two groups. In addition, these factor structures are not consistent with the DSM’s system of classifying disorders of personality into categories and support a dimensional view rather than a categorical view. For example, most evidence strongly suggests that psychopathic personality (or antisocial personality) and other externalizing disorders of adulthood display a dimensional structure, not a categorical structure (Edens, Marcus, Lilienfeld, & Poythress, 2006; Krueger, Markon, Patrick, & Iacono, 2005; Larsson, Andershed, & Lichtenstein, 2006). The same is true of narcissism and narcissistic personality disorder (Brown, Budzck, & Tamborski, 2009) and borderline personality disorder (Wright, Hopwood, & Zanarini, 2015). In addition, the recent emotional cascade model of borderline personality disorder, which highlights the interaction of emotional and behavioral dysregulation, although not presented explicitly as a dimensional model, is consistent with a dimension model (Selby & Joiner, 2009).

Research on other psychological phenomena supports the dimensional view. Studies of the varieties of normal emotional experiences (e.g., Carver, 2001; Oatley & Jenkins, 1992; Oatley, Keltner, & Jenkins, 2006) indicate that “clinical” emotional disorders are not discrete classes of emotional experience that are discontinuous from everyday emotional upsets and problems. Research on adult attachment patterns in relationships strongly suggests that dimensions are more accurate descriptions of such patterns than are categories (Fralay, Hudson, Heffernan, & Segal, 2015). Research on self-defeating behaviors has shown that they are extremely common and are not by themselves signs of abnormality or symptoms of “disorders” (Baumeister & Scher, 1988). Research on children’s reading problems indicates that “dyslexia” is not an all-or-none condition that children either have or do not have, but occurs in degrees without a natural break between “dyslexic” and “nondyslexic” children (Peterson, Pennington, Olson, & Wadsworth, 2014). Research indicates that attention deficit/hyperactivity (Barkley, 2005), post-traumatic stress disorder (Rosen & Lilienfeld, 2008; Ruscio, Ruscio, & Keane, 2002), anxiety disorders (Steinman et al., Chapter 9 in this volume), depression (Alloy et al., Chapter 11 in this volume), somatoform disorders (Zvolensky et al., Chapter 15 in this volume), sexual dysfunctions and disorders (Gosselin & Bombardier, Chapter 23 in this volume), impulsivity (Griffin, Lynam, & Samuel, 2017), pathological eating behavior (Luo, Donnellan, Burt, & Klump, 2016), and child conduct disorders (Salekin, 2015), psychosis (Kotov, Foti, Li, Bromet, Hajcak, & Ruggero, 2016) demonstrate this same dimensionality. Research on depression and schizophrenia indicates that these “disorders” are best viewed as loosely related clusters of dimensions of individual differences, not as disease-like syndromes (Claridge, 1995; Costello, 1993a, 1993b; Eisenberg et al., 2009; Flett, Vredenburg, & Krames, 1997). For example, a study on depressive symptoms among children and adolescents found a dimensional structure for all of the DSM-IV symptoms of major depression (Hankin, Fraley, Lahy, & Waldman, 2005).

The inventor of the term “schizophrenia,” Eugene Bleuler, viewed so-called pathological conditions as continuous with so-called “normal” conditions and noted the occurrence of “schizophrenic” symptoms among normal individuals (Gilman, 1988). In fact, Bleuler referred to the major symptom of “schizophrenia” (thought disorder) as simply “ungewöhnlich,” which in German means “unusual,” not “bizarre,” as it was translated in the first English version of Bleuler’s classic monograph (Gilman, 1988). Essentially, the creation of “schizophrenia” was “an artifact of the ideologies implicit in nineteenth century European and American medical nosologies” (Gilman, 1988, p. 204). Indeed, research indicates that the hallucinations and delusions exhibited by people diagnosed with a schizophrenic disorder are continuous with experiences and behaviors among the general population (Johns & van Os, 2001; Myin-Germeys, Krabbendam, & van Os, 2003; see also Azis et al., Chapter 12 in this volume). Recent research also suggests that dimensional measures of psychosis are better predictors of dysfunctional behavior, social adaptation, and occupational functioning than are categorical diagnoses (Rosenman, Korten, Medway, & Evans, 2003, as cited in Simonsen, 2010). Research on neuroticism strongly suggests that it provides the foundation for the development of anxiety and mood disorders and is best conceived as a dimension (Barlow, Sauer-Savala, Carl, Bullis, & Ellard, 2013). Research on general psychopathology factors (with internalizing and externalizing subfactors) (Martel et al., 2017) and research on hierarchical conceptions of psychopathology (Kotov et al., 2017; Lahay, Krueger, Rathouz, Waldman, & Zald, 2017) provide strong additional support for the dimensional view (Martel et al., 2017). Research indicates that dimensional measures of psychopathology are more reliable and valid than categorical measures (Markon, Chmielewski, & Miller, 2011). Research also strongly supports the validity and utility of structured and hiearchial conceptions of psychopathology that are based on the fundamental assumption that dimensions provide a more accurate way to conceptualize psychopathology than do categories (Waszczuk, Kotov, Ruggero, Gamez, & Watson, 2017; Lahay et al., 2017). The National Institute of Mental Health’s Research Domain Criteria (RDoC; REF), concerned primarily with the etiology of mental disorders, also conceive psychopathologies and their neurobiological influences as existing along continua (Cuthbert & Insel, 2013; Lilienfeld & Treadway, 2016). Finally, neuroscience research provides growing evidence that the activity of brain circuits is continuously distributed (Lilienfeld & Treadway, 2016). (See also Chapter 2 in this volume.)

Understanding the research supporting the dimensional approach is important because the vast majority of this research undermines the illness ideology’s assumption that we can make clear, scientifically-based distinctions between the psychologically well or healthy and the psychological ill or disordered. Inherent in the dimensional view is the assumption that these distinctions
are not natural demarcations that can be “discovered”; instead, they are created or constructed “by accretion and practical necessity, not because they [meet] some independent set of abstract and operationalized definitional criteria” (Frances & Widiger, 2012, p. 111).

Dimensional approaches, of course, are not without their limitations, including the greater difficulties they present in communication among professionals compared to categories, and the greater complexity of dimensional strategies for clinical use (Simonsen, 2010). In addition, researchers and clinicians have not reached a consensus on which dimensions to use (Simonsen, 2010). Finally, dimensional approaches do not solve the “subjectivity problem” noted previously because the decision regarding how far from the mean a person’s thoughts, feelings, or behavior must be to be considered “abnormal” remains a subjective one. Nonetheless, dimensional approaches have been gradually gaining great acceptance and will inevitably be integrated more and more into the traditional categorical schemes. [An extensive discussion of the pros and cons of categorical approaches are beyond the scope of this chapter. Detailed and informative discussions can be found in other sources (e.g., Grove & Vrieze, 2010; Simonsen, 2010; Clark et al., 2017)].

Dimensional conceptions of psychopathology did make some small inroads in the DSM-5, particularly in the new conception of “autism spectrum disorder” (that encompasses autistic disorder, Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified) and an appendix that describes an “alternative DSM-5 model for personality disorders” based largely on dimensional research on personality. It also incorporated severity as a dimension throughout the classification system (Clark et al., 2017). ICD-11 also includes a severity dimension for personality disorders, schizophrenia, and other psychotic disorders (Clark et al., 2017). Yet both documents remain essentially compendiums of categories.

Social Constructionism and Conceptions of Psychopathology

If we cannot come up with an objective and scientific conception of psychopathology and mental disorder, then what way is left to us to understand these terms? How then are we to conceive of psychopathology? The solution to this problem is not to develop yet another definition of psychopathology. The solution, instead, is to accept the fact that the problem has no solution—at least not a solution at which we can arrive by scientific means. We have to give up the goal of developing a scientific definition and accept the idea that psychopathology and related terms are not the kind of terms that can be defined through the processes that we usually think of as scientific. We have to stop struggling to develop a scientific conception of psychopathology and attempt instead to try to understand the struggle itself—why it occurs and what it means. We need to better understand how people go about trying to conceive of and define psychopathology, what they are trying to accomplish when they do this, and how and why these conceptions are the topic of continual debate and endure continual revision.

We start by accepting the idea that psychopathology and related concepts are abstract ideas that are not scientifically constructed but socially constructed. Social constructionism involves “elucidating the process by which people come to describe, explain, or otherwise account for the world in which they live” (Gergen, 1985, pp. 3–4). Social constructionism is concerned with “examining ways in which people understand the world, the social and political processes that influence how people define words and explain events, and the implications of these definitions and explanations—who benefits and who loses because of how we describe and understand the world” (Muehlenhard & Kimes, 1999, p. 234). From this point of view, words and concepts such as psychopathology and mental disorder “are products of particular historical and cultural understandings rather than ... universal and immutable categories of human experience” (Bohan, 1996, p. xvi).

Universal or “true” definitions of concepts do not exist because these definitions depend primarily on who gets to do the defining. The people who define them are usually people with power, and so these definitions reflect and promote their interests and values (Muehlenhard & Kimes, 1999). Therefore, “When less powerful people attempt to challenge existing power relationships and to promote social change, an initial battleground is often the words used to discuss these problems” (Muehlenhard & Kimes, 1999, p. 234). Because the interests of people and institutions are based on their values, debates over the definition of concepts often become clashes between deeply and implicitly held beliefs about the way the world works or should work and about the difference between right and wrong. Such clashes are evident in the debates over the definitions of domestic violence (Muehlenhard & Kimes, 1999), child sexual abuse (Holmes & Slapp, 1998; Rind, Tromovitch, & Bauseman, 1998), and other such terms.

The social constructionist perspective can be contrasted with the essentialist perspective. Essentialism assumes that there are natural categories and that all members of a given category share important characteristics (Rosenblum & Travis, 1996). For example, the essentialist perspective views our categories of race, sexual orientation, and social class as objective categories that are independent of social or cultural processes (Ho, Roberts, & Gelman, 2015). It views these categories as representing “empirically verifiable similarities among and differences between people” (Rosenblum & Travis, 1996, p. 2) and as “depict[ing] the inherent structure of the world in itself” (Zachar & Kendall, 2010, p. 128). In the social constructionist view, however, “reality cannot be separated from the way that a culture makes sense of it” (Rosenblum & Travis, 1996, p. 3). In social constructionism, such categories represent not what people are but rather the ways that people think about and attempt to make sense of differences among people. Social processes also determine what differences among people are more important than other differences (Rosenblum & Travis, 1996).

Thus, from the essentialist perspective, psychopathologies and mental disorders are natural entities whose true nature can be discovered and described. From the social constructionist perspective, however, they are abstract ideas that are defined by people
and thus reflect their values—cultural, professional, and personal. The meanings of these and other concepts are not reeled by the methods of science but are negotiated among the people and institutions of society who have an interest in their definitions. In fact, we typically refer to psychological terms as constructs for this very reason—that their meanings are constructed and negotiated rather than discovered or revealed. The ways in which conceptions of so basic a psychological construct as the “self” (Baumeister, 1987) and “self-esteem” (Hewitt, 2002) have changed over time and the different ways they are conceived by different cultures (e.g., Cushman, 1995; Hewitt, 2002; Cross & Markus, 1999) provide an example of this process at work. Other examples include the growing evidence that our conceptual categories of emotions do not reflect “distinct, dedicated neural essences [but] require a human perceiver for existence” (Barrett, 2017, p. 13) and growing evidence for the existence of an overarching general psychopathology factor (with subordinate internalizing and externalizing factors) (Martel et al., 2017). Thus “all categories of disorder, even physical disorder categories convincingly explored scientifically, are the product of human beings constructing meaningful systems for understanding their world” (Raskin & Lewandowski, 2000, p. 21). In addition, because “what it means to be a person is determined by cultural ways of talking about and conceptualizing personhood...identity and disorder are socially constructed, and there are as many disorder constructions as there are cultures” (Neimeyer & Raskin, 2000, pp. 6–7; see also López & Guarnera, Chapter 4 in this volume). Finally, “if people cannot reach the objective truth about what disorder really is, then viable constructions of disorder must compete with one another on the basis of their use and meaningfulness in particular clinical situations” (Raskin & Lewandowski, 2000, p. 26). In other words, the debate about defining mental disorders continues because people continue to manufacture and modify the definitions they find most useful.

From the social constructionist perspective, sociocultural, political, professional, and economic forces influence professional and lay conceptions of psychopathology. Our conceptions of psychological normality and abnormality are not facts about people but abstract ideas that are constructed through the implicit and explicit collaborations of theorists, researchers, professionals, their clients, and the culture in which all are embedded and that represent a shared view of the world and human nature. For this reason, “mental disorders” and the numerous diagnostic categories of the DSM were not “discovered” in the same manner that an archaeologist discovers a buried artifact or a medical researcher discovers a virus. Instead, they were invented (see Raskin & Lewandowski, 2000). By saying that mental disorders are invented, however, we do not mean that they are “myths” (Szasz, 1974) or that the distress of people who are labeled as mentally disordered is not real. Instead, we mean that these disorders do not “exist” and “have properties” in the same manner that artifacts and viruses do, even if they do have concomitant, complex biological processes. Therefore, a conception of psychopathology “does not simply describe and classify characteristics of groups of individuals, but...actively constructs a version of both normal and abnormal...which is then applied to individuals who end up being classified as normal or abnormal” (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995, p. 93).

Conceptions of psychopathology and the various categories of psychopathology are not mappings of psychological facts about people. Instead, they are social artifacts that serve the same sociocultural goals as do our conceptions of race, gender, social class, and sexual orientation—that of maintaining and expanding the power of certain individuals and institutions and maintaining social order, as defined by those in power (Beall, 1993; Parker et al., 1995; Rosenblum & Travis, 1996). As are these other social constructions, our concepts of psychological normality and abnormality are tied ultimately to social values—in particular, the values of society’s most powerful individuals, groups, and institutions—and the contextual rules for behavior derived from these values (Becker, 1963; Kirmayer, 2005; Parker et al., 1995; Rosenblum & Travis, 1996). As McNamee and Gergen (1992) state: “The mental health profession is not politically, morally, or instrumentally neutral. Their practices typically operate to sustain certain values, political arrangements, and hierarchies of privilege” (p. 2). Thus, the debate over the definition of psychopathology, the struggle over who gets to define it, and the continual revisions of the DSM are not aspects of a search for “truth.” Rather, they are debates over the definition of socially constructed abstractions and struggles for the personal, political, and economic power that derives from the authority to define these abstractions and thus to determine what and whom society views as normal and abnormal.

Millon (2010) has even suggested that the development of the DSM-IV was hampered by the reluctance of work groups to give up their rights over certain disorders once they were assigned them, even when it became clear that some disorders fit better with other work groups. In addition, over half of the members of the DSM-IV work groups (including every member of the work groups responsible for mood disorders and schizophrenia/psychotic disorders) had received financial support from pharmaceutical companies (Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006).

As David Patrick (2005) concluded about a definition of mental disorder offered by the British government in a recent mental health bill, “The concept of mental disorder is of dubious scientific value but it has substantial political utility for several groups who are sane by mutual consent” (p. 435).

These debates and struggles are described in detail by Allan Horwitz (2002) in Creating Mental Illness. According to Horwitz,
Psychiatrist Mitchell Wilson (1993) has offered a similar position. He has argued that the dimensional/continuity view of psychological wellness and illness posed a basic problem for psychiatry because it “did not demarcate clearly the well from the sick” (p. 402) and that “if conceived of psychosocially, psychiatric illness is not the province of medicine, because psychiatric problems are not truly medical but social, political, and legal” (p. 402). The purpose of DSM-III, according to Wilson, was to allow psychiatry a means of marking out its professional territory. Kirk and Kutchins (1992) reached the same conclusion following their thorough review of the papers, letters, and memos of the various DSM working groups.

The social construction of psychopathology works something like this. Someone observes a pattern of behaving, thinking, feeling, or desiring that deviates from some social norm or ideal or identifies a human weakness or imperfection that, as expected, is displayed with greater frequency or severity by some people than others. A group with influence and power decides that control, prevention, or “treatment” of this problem is desirable or profitable. The pattern is then given a scientific-sounding name, preferably of Greek or Latin origin. The new scientific name is capitalized. Eventually, the new term may be reduced to an acronym, such as OCD (Obsessive-Compulsive Disorder), ADHD (Attention-Deficit/Hyperactivity Disorder), and BDD (Body Dysmorphic Disorder). Once a condition is referred to as a “disorder” in a diagnostic manual, it becomes refined and treated as if it were a natural entity existing apart from judgments and evaluations of human beings (Hyman, 2010). The new disorder then takes on an existence all its own and becomes a disease-like entity. As news about “it” spreads, people begin thinking they have “it”; medical and mental health professionals begin diagnosing and treating “it”; and clinicians and clients begin demanding that health insurance policies cover the “treatment” of “it.” Once the “disorder” has been socially constructed and defined, the methods of science can be employed to study it, but the construction itself is a social process, not a scientific one. In fact, the more “it” is studied, the more everyone becomes convinced that “it” really is “something.”

Medical philosopher Lawrie Reznek (1987) has demonstrated that even our definition of physical disease is socially constructed. He writes:

Judging that some condition is a disease is to judge that the person with that condition is less able to lead a good or worthwhile life. And since this latter judgment is a normative one, to judge that some condition is a disease is to make a normative judgment. … This normative view of the concept of disease explains why cultures holding different values disagree over what are diseases … Whether some condition is a disease depends on where we choose to draw the line of normality, and this is not a line that we can discover … disease judgments, like moral judgments, are not factual ones (pp. 211–212).

Likewise, Sedgwick (1982) points out that human diseases are natural processes. They may harm humans, but they actually promote the “life” of other organisms. For example, a virus’s reproductive strategy may include spreading from human to human. Sedgwick writes:

There are no illnesses or diseases in nature. The fracture of a septuagenarian’s femur has, within the world of nature, no more significance than the snapping of an autumn leaf from its twig; and the invasion of a human organism by cholera-germs carries with it no more the stamp of ‘illness’ than does the souring of milk by other forms of bacteria. Out of his anthropocentric self-interest, man has chosen to consider as ‘illnesses’ or ‘diseases’ those natural circumstances which precipitate death (or the failure to function according to certain values) (p. 30).

If these statements are true of physical disease, they are certainly true of psychological “disease” or psychopathology. Like our conception of physical disease, our conceptions of psychopathology are social constructions that are grounded in sociocultural goals and values, particularly our assumptions about how people should live their lives and about what makes life worth living. This truth is illustrated clearly in the APA’s 1952 decision to include homosexuality in the first edition of the DSM and its 1973 decision to revoke its “disease” status (Kutchins & Kirk, 1997; Shorter, 1997). As stated by Wilson (1993), “The homosexuality controversy seemed to show that psychiatric diagnoses were clearly wrapped up in social constructions of deviance” (p. 404). This issue also was in the forefront of the debates over post-traumatic stress disorder, paraphilic rapism, and masochistic personality disorder (Kutchins & Kirk, 1997), as well as caffeine dependence, sexual compulsivity, low intensity orgasm, sibling rivalry, self-defeating personality, jet lag, pathological spending, and impaired sleep-related painful erections, all of which were proposed for inclusion in DSM-IV ( Widiger & Trull, 1991). Others have argued convincingly that schizophrenia (Gilman, 1988), addiction (Peele, 1995), post-traumatic stress disorder (Herbert & Forman, 2010), personality disorder (Alarcon, Foulks, & Vakkur, 1998), dissociative identity disorder (formerly multiple personality disorder) (Spanos, 1996), intellectual disability (Rapley, 2004) and both conduct disorder and oppositional defiant disorder (Mallet, 2007) also are socially constructed categories rather than disease entities.

With each revision, our most powerful professional conception of psychopathology, the DSM, has had more and more to say about how people should live their lives. The number of official mental disorders recognized by the APA has increased from six in the mid-19th century to close to 300 in the DSM-5 (Frances & Widiger, 2012). Between 1952 and 2013, the number of pages in the DSM increased from 130 (mostly appendices) to over 900. As the scope of “mental disorder” has expanded with each DSM revision, life has become increasingly pathologized, and the sheer number of people with diagnosable mental disorders has continued to grow. Moreover, mental health professionals have not been content to label only obviously and blatantly
dysfunctional patterns of behaving, thinking, and feeling as “mental disorders.” Instead, we have defined the scope of psychopathology to include many common problems in living (Frances, 2013) leading to a growing problem of “false positives” — people with relatively mild forms of common problems being given psychiatric diagnosis and treated with medications. As Wakefield (2016) states:

Diagnosis has clearly become untethered from medical reality when one out of five boys nationally is diagnosed with ADHD (Visser et al., 2014) and when antidepressant use has increased 400% in a decade, with nearly one-quarter of all women in their 40s and 50s taking antidepressants (Pratt, Brody, & Gu, 2011).

(Wakefield, 2016, p. 124).

Consider some of the “mental disorders” found in the DSM-5. Cigarette smokers have tobacco use disorder. If you try to quit, you are likely to develop the mental disorder tobacco withdrawal. If you drink large quantities of coffee, you may develop caffeine intoxication or caffeine-induced sleep disorder. What used to be known as simply “getting stoned” is the mental disorder cannabis intoxication — a mental disorder that afflicts millions of people every year — if not every day. If you have “a preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others” (APA, 2013, p. 242) that causes you significant distress of dysfunction, you may have body dysmorphic disorder. A child with “difficulties learning and using academic skills . . . that have persisted for at least six months, despite the provision of interventions that target those difficulties” (APA, 2013, p. 66) may have the mental disorder specific learning disorder. (There is no mention of the possibility that the targeted interventions may have been the wrong interventions.) Toddlers who throw tantrums may have oppositional defiant disorder. Women who are irritable or emotionally labile before their menstrual period may have premenstrual dysphoric disorder. People who eat gum or ice may have pica. Adults who are not interested in sex may have female sexual interest/arousal disorder or male hypoactive sexual desire disorder. Women who have sex but do not have orgasms that are frequent enough or intense enough may have a female orgasmic disorder. For men, ejaculating too early and too late are both signs of a mental disorder.

Consider also some of the new disorders that were proposed for DSM-5: hypersexual disorder, temper dysregulation disorders of childhood, hoarding disorder, skin picking disorder, psychosis risk syndrome, among others. Psychiatrist Allen Frances, the chair of the DSM-IV task force, has argued that these new “disorders” represent a further encroachment of the DSM into the realm of common problems in living (Frances, 2010). Nonetheless, hoarding disorder, disruptive mood dysregulation disorder (a renamed temper dysregulation disorder of childhood), and excoriation (skin-picking) disorder found their way into the DSM-5. A recent example of this encroachment was the decision to eliminate from DSM-5 the “bereavement exclusion rule” (in effect beginning with DSM-III) that stipulated that grief following the loss of a loved one should not be diagnosed as a major depressive disorder even if the person otherwise meets the diagnostic criteria (Zachar, First, & Kendler, 2017). By eliminating this rule, DSM-5 now allows us to pathologize grief. Several other conditions (e.g., Persistent Complex Bereavement Disorder, Internet Gaming Disorder) are listed as “conditions for further study” and therefore are likely to find their way into DSM-6. In fact, internet gaming disorder will make its first appearance as an official mental disorder in the new ICD-11.

In addition, “diagnostic fads” are sparked by each new edition. Frances notes four “epidemics” that were sparked by changes from DSM-III to DSM-IV: autism, attention deficit/hyperactivity disorder, childhood bipolar disorder, and paraphilia not otherwise specified (Frances, 2013). He also warns that DSM-5 threatens to provoke new epidemics of at least four new disorders that emerged in DSM-5: disruptive mood dysregulation disorder, binge-eating disorder, mild neurocognitive disorders, and “behavioral addictions” (Frances, 2013; see also Paris, 2013).

The past few years have witnessed media reports of epidemics of internet addiction, road rage, and “shopaholism.” Discussions of these new disorders have turned up at scientific meetings and in courtrooms. They are likely to find a home in a future revision of the DSM if the media, mental health professions, and society at large continue to collaborate in their construction and if “treating” them and writing books about them become lucrative (Beato, 2010).

The social constructionist perspective does not deny that human beings experience behavioral and emotional difficulties — sometimes very serious ones. It insists, however, that such experiences are not evidence for the existence of entities called “mental disorders” that can then be invoked as causes of those behavioral and emotional difficulties. The belief in the existence of these entities is the product of the all too human tendency to socially construct categories in an attempt to make sense of a confusing world. A growing body of research indicates that human emotions are not natural kinds “with boundaries that are carved in nature” (Barrett, 2006, p. 28). If this is true of emotions, then it must also be true of emotional disorders.

The socially constructed illness ideology and associated traditional psychiatric diagnostics schemes, also socially constructed, have led to the proliferation of “mental illnesses” and to the pathologization of human existence (e.g., Frances, 2013). Given these precursors, it comes as no surprise that a highly negative clinical psychology evolved during the 20th century. The increasing heft and weight of the DSM, which has been accompanied by its increasing influence over clinical psychology, provides evidence for this. As the socially constructed boundaries of “mental disorder” have expanded with each DSM revision, more relatively mundane human behaviors have become pathologized; as a result, the number of people with diagnosable “mental disorders” has continued to grow. This growth has occurred largely because mental health professionals have not been content to label only the obviously and blatantly dysfunctional patterns of behaving, thinking, and feeling as “mental disorders.” Instead, they (actually “we”) have gradually pathologized almost every conceivable human problem in living. As a result of the growing dominance of the illness ideology among both
professionals and the public, eventually everything that human beings think, feel, do, and desire that is not perfectly logical, adaptive, efficient, or “creates trouble in human life” (Paris, 2013, p. 43) will become a “mental disorder” (Frances, 2013; Paris, 2013). This is not surprising given that Frances notes that in his more than two decades of working on three DSMs, “never once did he recall an expert make a suggestion that would reduce the boundary of his pet disorder” (Frances & Widiger, 2012, p. 118). DSM-5 has made normality “an endangered species” partly because we live in a society that is “perfectionistic in its expectations and intolerant of what were previously considered to be normal and expectable distress and individual differences” (Frances & Widiger, 2012, p. 116), but also partly because pharmaceutical companies are constantly trying to increase the market for their drugs by encouraging the loosening and expanding of the boundaries of mental disorders described in the DSM (Frances, 2013; Paris, 2013). Essentially, DSM-5 “just continues a long-term trend of expansion into the realm of normality” (Paris, 2013, p. 183). As it does, “with ever-widening criteria for diagnosis, more and more people will fall within its net [and] many will receive medications they do not need” (Paris, 2013, p. 38).

We acknowledge that DSM-5 is an improvement over DSM-IV in its greater attention to alternative dimensional models for conceptualizing psychological problems and its greater attention to the importance of cultural considerations in determining whether or not a problematic pattern should be viewed as a “mental disorder.” Yet it remains steeped in the illness ideology for most of its 900 pages. For example, still included in the revised definition of mental disorder is the notion that a mental disorder is “a dysfunction in the individual” (p. 20) – an assumption that is inconsistent with almost every psychological and sociological conception of human functioning.

Summary and Conclusions

The debate over the conception or definition of psychopathology and related terms has been going on for decades, if not centuries, and will continue, just as we will always have debates over the definitions of truth, beauty, justice, and art. Our position is that psychopathology and mental disorder are not the kinds of terms whose “true” meanings can be discovered or defined objectively by employing the methods of science. They are social constructions – abstract ideas whose meanings are negotiated among the people and institutions of a culture and that reflect the values and power structure of that culture at a given time. Thus, the conception and definition of psychopathology always has been and always will be debated and always has been and always will be changing. It is not a static and concrete thing whose true nature can be discovered and described once and for all.

By saying that conceptions of psychopathology are socially constructed rather than scientifically derived, we are not proposing, however, that human psychological distress and suffering are not real or that the patterns of thinking, feeling, and behaving that society decides to label psychopathology cannot be studied objectively and scientifically. Instead, we are saying that it is time to acknowledge that science can no more determine the “proper” or “correct” conception of psychopathology and mental disorder than it can determine the “proper” and “correct” conception of other social constructions such as beauty, justice, race, and social class. We can nonetheless use science to study the phenomena that our culture refers to as psychopathological. We can use the methods of science to understand a culture’s conception of mental or psychological health and disorder, how this conception has evolved, and how it affects individuals and society. We also can use the methods of science to understand the origins of the patterns of thinking, feeling, and behaving that a culture considers psychopathological and to develop and test ways of modifying those patterns.

Psychology and psychiatry will not be diminished by acknowledging that their basic concepts are socially and not scientifically constructed – no more than medicine is diminished by acknowledging that the notions of health and illness are socially constructed (Reznik, 1987), nor economics by acknowledging that the notions of poverty and wealth are socially constructed. Likewise, the recent controversy in astronomy over how to define the term planet (Zachar & Kendler, 2010) does not make astronomy any less scientific. Science cannot provide us with “purely factual, scientific” definitions of these concepts. They are fluid and negotiated constructs, not fixed matters of fact.

As Lilienfeld and Marino (1995) have commented:

Removing the imprimatur of science . . . would simply make the value judgments underlying these decisions more explicit and open to criticism . . . heated disputes would almost surely arise concerning which conditions are deserving of attention from mental health professionals. Such disputes, however, would at least be settled on the legitimate basis of social values and exigencies, rather than on the basis of ill-defined criteria of doubtful scientific status (pp. 418–419).

References


Psychopathology constructs used in assessment, treatment, and research probably will become more biologically oriented, and less phenomenological or behavioral in nature. (See also Chapter 6, this volume.)

Whether or not this occurs is uncertain, however. Similar calls in the 1970s for a more biologically informed nosology formed the basis for the Research Diagnostic Criteria, DSM-III, and by extension, the DSM-5 (e.g., Blashfield, 1982) – the very same diagnostic systems that are now being criticized for not being biologically informed enough. Just as those approaches suffered from paradigmatic errors (e.g., overgeneralized assumptions that psychiatric illness consists of monogenic, discrete diseases), current approaches to “pure” biological classification will probably suffer from their own limitations.

Because the causes of psychopathology operate at multiple levels, from the molecular, neurobiological, and physiological, to the developmental, social, and cultural, a description or explanation of psychiatric illness focused solely on one level of explanation is unlikely to be productive (Kendler, 2012, 2014). Furthermore, because factors operating at different levels may dynamically influence one another, an authoritative description and classification of psychopathology (that is, developed by a formal body; such as the DSM, ICD, or RDoC) focused on one level exclusively will almost certainly be limiting in accounting for what is known and facilitating progress in theory and research. Science generally “finds a way” around such limitations, regardless of whether or not official nosology recognizes it; the burden is on those who develop formal nosologies to accommodate science in this regard, not the other way around (Markon, 2013).

Nevertheless, as research into causes of psychopathology progresses, and paths from molecular to cultural influences on mental illness are delineated more clearly, the constructs of focus will certainly shift as well. Although a focus on biological levels of description and explanation may not be sufficient for a comprehensive understanding of psychopathology, it is necessary. For this reason, the set of constructs used to discuss mental illness will likely diversify and increase in the future, if not in the precise manner articulated by initiatives such as RDoC, then perhaps along similar lines. The task for those who study psychopathology is to understand how to accommodate and integrate these different levels of explanation to produce a fuller account of mental disorder and illness.

Notes

1 Supported by NIMH P50 MH09425801, Grant #220020387 from the James S. McDonnell Foundation, and the Kiwanis Foundation.
2 This arrangement would apply to the typical left-verbal, right-nonverbal hemispheric specialization found in the vast majority (about 90–95%) of right-handed persons and also the majority (about 65–70%) of left-handed persons.
3 “Afferents” (inputs; think “arrive”) are neurons that carry information into or towards a particular structure; “efferents” (outputs; think “exit”) are neurons that carry information out of or from a particular structure.
4 We have used the term “ventromedial prefrontal cortex” (vmPFC) to designate the medial parts of the orbitofrontal cortex and the ventral parts of the mesial prefrontal cortices. These terms are not interchangeable, but they do overlap in their anatomical implications (see Naqvi, Tranel, & Bechara, 2006).

References


Beadle, J. N., Paradiso, S., & Tranel, D. Ventromedial prefrontal cortex is critical for helping others in situations that evoke empathy towards those who are suffering Frontiers in *Neurology* (in press).


References


A frequently employed explanation for the increased rates of mental health problems and disorders is the historical trauma that the Indian community experienced at the hands of European American colonizers. Gone (2014) draws on a 1901 war narrative of a female warrior, referred to as Watches All from a Northern Plains tribal group in Montana, to critically examine the historical trauma explanatory model. Although he acknowledges the considerable trauma experienced by Watches All and by many in the Indian community, Gone raises questions about the validity of historical trauma being the reason for current mental health problems. In addition, he points out that a focus on historical trauma diverts attention away from the structural inequalities that exist today in American Indian communities that contribute to many behavioral health problems. Gone concludes that “the construct of AI HT (American Indian historical trauma) appears to caricature and distort more than it illuminates and explains, and at probable cost to future AI promise and potential” (2014, p. 403).

**Summary and Conclusions**

Cultural psychopathology, the study of culture and the definition, experience, distribution, and course of psychological disorders, is now squarely “on the map.” Articles are being published in journals focused on the cultural dimensions of psychopathology as well as mainstream psychiatric and psychological journals. Substantive areas of psychopathology research are being shaped by cultural research. Efforts to integrate cultural concepts of distress with psychological and psychiatric constructs are well underway. Examples include studies of ataques de nervios and anxiety and affective disorders, and ataques and families’ conceptualization of serious mental illness. Guarnaccia and Rogler (1999) provide a program for moving some of this research forward. Kleinman’s important book, *Rethinking Psychiatry* (1988) got the message out that culture matters. As evidenced in the Surgeon General’s Report and the CPES, the message has been received; cultural research is providing an innovative and fresh perspective to our understanding of several important aspects of psychopathology.

For cultural researchers to build on the empirical and conceptual foundation that has been established, they need to continue to be critical of how culture is conceptualized and how such conceptualizations guide their research (See Kagawa Singer et al., 2013 for a recent statement on the conceptualization and measurement of culture in health research). Culture can no longer be treated solely as an independent variable or as a factor to be controlled for. Rather culture infuses the full social context of mental health research. Culture is important in all aspects of psychopathology research – the design and translation of instruments, the conceptual models that guide the research, the interpersonal interaction between researcher and research participants and clinician and patient, the definition and interpretation of symptom and syndromes, and the structure of the social world that surrounds a person’s mental health problems. Cultural psychopathology research requires a framework that incorporates culture in multifaceted ways. It is crucial that cultural research not obscure the importance of other social forces such as gender, class, poverty, and marginality that work in conjunction with culture to shape people’s everyday lives. The examination of both social and cultural processes is one way to help guard against superficial cultural analyses that ignore or minimize the powerful political economic inequalities that coexist with culture.

A corollary of the need for a broad framework for research is the need for approaches that integrate qualitative and quantitative methods. Cultural psychopathology research can serve as an important site for integrating ethnographic, observational, clinical, and epidemiological research approaches. Mental health problems cannot be fully understood through one lens. Ethnographic research provides insights into the meaning of mental health problems and how they are experienced in their sociocultural context. Observational research captures people's functioning in their daily lives. Clinical research can provide detailed descriptions of psychopathological processes and can contribute to developing treatments to alleviate suffering at the individual as well as social levels. Epidemiological research can identify who is most at risk for psychopathology and broaden perspectives to more generalized processes and populations. The integration of these perspectives, through new mixes of conceptual frameworks, methodologies, and in the composition of research teams, will make the cultural psychopathology research agenda succeed (Guarnaccia, 2009).

The ultimate goal of cultural psychopathology research is to alleviate suffering and improve people’s lives. This requires attention to the multiple levels of individual, family, community, and the broader social and political system. Our enhanced notion of culture leads to analysis of the expressions and sources of psychopathology at all of these levels. The mental health professions’ commitment to making a difference in peoples’ everyday lives argues for the development of treatment and prevention interventions at these multiple levels as well. The increasing cultural diversity of the US and the massive movements of people around the globe provide both an opportunity and imperative for cultural psychopathology research.


**References**


Cultural Dimensions of Psychopathology


CULTURAL DIMENSIONS OF PSYCHOPATHOLOGY | 83


produced complex findings on the effects of gender, race, and class on use of different services for mental health treatment. Research on the impact of gender, race, and class on therapy outcomes has shown that these statuses matter and that cultural adaptations to mental health interventions also improve outcomes. Research on quality and type of treatment and on pharmacotherapy suggests inequities in treatment and a need for better information about the connections between individual characteristics (including gender and race) and effectiveness of and reactions to psychotropic medications. In an era of establishing and promoting empirically supported treatments, we need to be mindful of the population being treated and we need to ask: Do therapies work equally well with different groups and can psychological interventions be improved by culturally based adaptations? Finally, we need to consider how best to seek greater understanding of the role of gender, race, and class in psychopathology and psychotherapy and we need to continue to focus on developing cultural competence in clinicians.

Very few studies actually meet the challenge of considering the intersection of gender, race, and class. Even where all of these sociodemographic variables are assessed, they are often analyzed as individual factors or possibly two-way interactions, and the possibilities of higher-order interactions are not pursued. Research that takes context into account, such as Chow et al.’s (2003) examination of mental health service use by diverse populations in low and high poverty communities and Kuno and Rothbard’s (2005) study of quality of care at community mental health centers in neighborhoods that vary by income and racial composition, demonstrate the value of doing more than collecting individual reports on sociodemographic variables. Snowden and Yamada (2005) acknowledge that we do not yet understand disparities in mental health care. They call for “more studies of treatment-seeking pathways that favor nonspecialty sources of assistance, improve trust and treatment receptiveness, eliminate stigma, and accommodate culturally distinctive beliefs about mental illness and mental health and styles of expressing mental health-related suffering” (pp. 160–161). A better understanding of interactions among gender, race, and class may require a more qualitative approach (Mullings & Schulz, 2006), partly because reporting of quantitative differences among groups may serve to further marginalize minority groups without helping us to understand them (Lopez, 2003).

Mullings and Schulz (2006) point out that “it is often difficult to pinpoint how the interaction, articulation, and simultaneity of race, class, and gender affect women and men in their daily lives, and the ways in which these forms of inequality interact in specific situation to condition health” (p. 6). They suggest that gender, race, and class should be viewed as social relationships rather than as characteristics of individuals. Building on this theme, Martin criticizes the supplement to the Surgeon General’s report and its assumption that:

> there is something concrete and real in the world (and increasingly in the brain) that corresponds one to one with the major psychiatric diagnosis. Identifying this real thing . . . is the proper first step in getting [patients] the proper treatment. Identifying observer bias and removing it will clear the way to more frequently correct diagnosis. But there are . . . troubling aspects of this view. First, what if the categories into which psychiatry divides disorders themselves already have cultural assumptions embedded in them, not fixed for all time . . . ? Second, what if our only route to the real is always through linguistic categories that are necessarily saturated with culturally constituted sets of meanings?

(Martin, 2006, p. 85)

These closing remarks remind us that gender, race, and class are more than sociodemographic characteristics. They constitute essential aspects of the lived experience of individuals who may come to us as clinicians in need of understanding and assistance. We must determine how to treat these individuals in culturally sensitive and appropriate ways.

### Notes


### References


the proposal to be credible, it is assigned to a review committee. Before a proposal is approved, it is posted for at least 30 days on the APA’s website, with an accompanying portal for providing feedback. The review committee will also formally request reviews by selected experts with respect to the proposal. Relevant professional and scientific societies may also be alerted. Proposed revisions have already been approved, albeit the changes have been largely minimal and confined to text discussion and/or minor changes to wording of criteria (e.g., the criteria for a hypomanic episode was revised to include the presence of another medical condition as an exclusion criterion, as well as the effect of a substance; APA, 2018).

It is also possible, if not likely, that once ICD-11 becomes official, there will be corresponding revisions proposed for DSM-5. Each country, including the United States, is obligated to have a nomenclature that closely conforms with the ICD and is not fundamentally inconsistent (First, Reed, Hyman, & Saxena, 2015). There might then be some pressure or impetus for DSM-5 to be revised to incorporate the significant changes that have occurred for ICD-11 (e.g., perhaps include a complex PTSD diagnosis, a compulsive sexual behavior diagnosis, and/or shift the personality disorders toward a dimensional trait model).

Conclusions

Nobody was fully satisfied with, or lacked valid criticisms of, DSM-IV-TR. DSM-5 generated considerable criticism and controversy (Decker, 2010; Frances, 2013; Greenburg, 2013). ICD-11 includes quite a few significant and potentially controversial revisions, albeit did not generate as much attention as DSM-5. Zilboorg’s (1941) suggestion that budding 19th-century theorists and researchers cut their first teeth by providing a new classification of mental disorders still applies, although the rite of passage today is to provide a critique of the DSM.

Nobody, however, appears to suggest that all official diagnostic nomenclatures be abandoned. The benefits do appear to outweigh the costs (Salmon et al., 1917). Everybody finds fault with this language, but there is at least the ability to communicate disagreement. Communication among researchers, theorists, and clinicians of common or different theoretical persuasions would be much worse in the absence of this common language. In addition, the DSM-5 is perhaps to be commended for resisting the pressure of neurobiological psychiatry to favor this theoretical model to the detriment of all other theoretical perspectives. DSM-5 will be considerably more user-friendly for the psychodynamic, cognitive-behavioral, and interpersonal-systems clinicians and researchers than the RDoC system of NIMH.

Nevertheless, as an official diagnostic nomenclature, DSM-5 and ICD-11 are exceedingly powerful documents with a considerable impact on how psychopathology is not only diagnosed, but also understood and treated. Persons think in terms of their language, and DSM-5 and ICD-11 will govern the manner in which clinicians think about psychopathology for many years to come, for better or for worse.

References


predictors and criteria are almost always superior to or at least equal to clinical judgment (Dawes et al., 1989; Grove & Meehl, 1996).

Statistical prediction rules have been used for a wide array of tasks. Substantial progress has been made in forensic settings to predict violence and criminal recidivism (Monahan & Skeem, 2016). In mental health settings, statistical prediction has been valuable for identifying psychotherapy clients who are at risk for failure and whose case needs to be re-evaluated (Boswell et al., 2015). It has also been used to predict psychosis with the goal of being able to prevent psychotic breaks (Cannon et al., 2008), though further advances are needed for this task. Another example involves the prediction of diagnoses. Because structured interviews typically yield more reliable and valid diagnoses than most diagnoses made in clinical practice, statistical prediction rules have been used to predict structured interview diagnoses. These statistical prediction rules are less expensive and less time-consuming to use than structured interviews (Youngstrom, Halverson, Youngstrom, Lindhiem, & Findling, 2018). Statistical prediction rules are also being developed to improve treatment selection (Cohen & DeRubeis, 2018). New approaches for statistical analysis (e.g., machine learning) are being applied in mental health settings (e.g., Kessler et al., 2015; Walsh, Ribeiro, & Franklin, 2017). Finally, in military settings, statistical prediction is being used to identify trainees who are at risk for mental health or behavioral problems, so that they can be interviewed and appropriate referrals can be made (Garb, Wood, & Baker, 2018).

Conclusions
Assessing psychopathology is an activity fraught with potential error and bias. However, by attending to research findings, psychologists can avoid using test scores that are invalid, and they can become familiar with the strengths and weaknesses of clinical judgment. In this way, errors that are potentially detrimental to clients can be avoided.

Some psychologists argue that although scientific research is important, we should also rely on clinical experience to determine if an assessment instrument is valuable. Indeed, some even argue that when research and clinical experience conflict, we should place a higher premium on the latter. Psychologists are frequently encouraged to use the Rorschach test and other projective techniques because they seem to provide rich clinical data (e.g., Karon, 2000). However, clinical experience can be fallible for a host of reasons, including biased feedback, illusory correlation, confirmation bias, and deterministic reasoning (Croskerry, 2017; Dawes et al., 1989; Garb, 1998). Scientific methods are not panaceas, but they are more likely than either clinical experience or intuition to yield answers that approximate the truth. Specifically, such methods are the best available safeguards against error, such as confirmation bias, and our best hope for resolving controversies. Research techniques, such as double-blind designs and control groups, are essential tools that researchers have developed to protect themselves and others from being misled (Lilienfeld, 2002, 2010). As McFall (1991) noted:

[There is a] commonly offered rationalization that science doesn’t have all the answers yet, and until it does, we must do the best we can to muddle along, relying on our clinical experience, judgment, creativity, and intuition (cf., Matarazzo, 1990). Of course, this argument reflects the mistaken notion that science is a set of answers, rather than a set of processes or methods by which to arrive at answers. Where there are lots of unknowns – and clinical psychology certainly has more than its share – it is all the more imperative to adhere as strictly as possible to the scientific approach. Does anyone seriously believe that a reliance on intuition and other unscientific methods is going to hasten advances in knowledge?

(pp. 76–77)

Finally, as noted by McFall (cited in Trull & Prinstein, 2012, p. 65), one feature that should distinguish clinical and counseling psychologists from most other mental health professionals is their scientific training (see also Baker, McFall, & Shoham, 2009). To ignore research findings because they make us feel uncomfortable is to neglect our most distinctive and positive attribute: our training in, and our willingness to be guided by, science.

Notes
1 The views expressed in this chapter are those of the authors and do not reflect the official views or policy of the Department of Defense or its Components.
2 We use the term “provisional diagnoses” because formal diagnoses of psychiatric disorders should not be made on the basis of the MMPI-2 alone.

References


The prospect for rigorously controlled outcome research on long-term psychodynamic psychotherapy is less hopeful, although there is some progress in this regard. The Division 12 Committee now lists the 18-month mentalization treatment for bipolar personality disorder as having modest research support (Bateman & Fonagy, 2009). With regards to trials of long(ER) term psychodynamic psychotherapy, certainly, patients cannot ethically be kept in control conditions for years. Accordingly, the remaining approach to controlled research (see section on Research Designs, earlier) would require very large studies in which long-term dynamic psychotherapy is compared with another active treatment. Such research would be extremely expensive, and few patients or public health systems would be able to afford access to this treatment even if it proved effective, making the public health significance low. In addition, drop-out rates in long-term treatment research are very high, threatening the internal validity of the research. Perhaps for these reasons, most United States funding agencies are reluctant to support research on long-term therapy. As a result, psychodynamic therapists who focus on long-term treatment may rely upon case reports based on clinical experience and upon uncontrolled research (e.g., Leichsenring & Rabung, 2008) to inform the theory and practice of this form of therapy.

Conclusions

We began this chapter with a statement that psychopathology research serves psychotherapy research. We end with the observation that psychotherapy research serves psychopathology research. That is, there is a reciprocal feedback loop between these two forms of research that is mutually beneficial. For example, cognitive theory of panic disorder stresses the importance of frightening misinterpretations of bodily sensations to the development and maintenance of this problem (Clark, 1986). Treatment aimed at changing these cognitions has proved to be highly effective (see Siev & Chambless, 2007 for a meta-analytic review), and, closing the feedback loop, Teachman, Marker, and Clerkin (2010) have determined that changing beliefs about bodily sensations is critical to the efficacy of cognitive therapy for panic disorder. Thus, psychopathology research informs treatment, and treatment research informs the understanding of the psychopathology of this disorder and the mechanisms underlying effective treatment.

The reciprocal feedback loop can also identify when something is wrong with either the theory or the treatment. For example, it was originally postulated that the "sine qua non of marriage was the quid pro quo" (see Gottman, 1998, p. 181). In other words, in happy couples there was an equitable exchange of positive behaviors. This theory led to the use of contingency contracting in marital behavioral therapy, wherein spouses were trained to contract for a desired behavior on the part of their partner by agreeing to reciprocate by doing something that their partner wanted. However, systematic research on couples' interactions revealed that this was precisely the wrong thing to do. In fact, insistence on the equitable exchange of behaviors actually characterized unhappy marriages. Thus, the increased knowledge about marital satisfaction led to improvements in marital therapy, namely the removal of contingency contracting as a basic intervention.

On the basis of these and many other such examples, we argue that progress in applied clinical psychology occurs when treatments are based on a solid understanding of the psychopathology of a given disorder, and when those treatments are rigorously evaluated not only for their efficacy and effectiveness but also for the causal factors underlying their benefits. In this fashion, treatments may be honed more precisely to concentrate on the critical elements in outcome, making psychotherapeutic interventions more efficient and more effective.

References


How Can We Increase Dissemination and Implementation of Evidence-Based Treatments?

Although anxiety disorders are highly treatable, the WHO estimates that only half of individuals with an anxiety disorder or OCD will receive treatment (Kohn, Saxen, Levav, & Saraceno, 2004). Common barriers to receiving treatment include a lack of access to care (specifically to therapists trained in evidence-based treatment), lack of knowledge (about anxiety or OCRDs, or about treatment options), perceived stigma, and financial costs of treatment (Baker, McFall, & Shoham, 2008; Corrigan, 2004; Kessler et al., 2001; Saxena, Thornicroft, Knapp, & Whiteford, 2007). Research on the most effective ways to increase dissemination and implementation, as well as testing new delivery models of treatment (e.g., via smartphones, the internet) can reduce the suffering of individuals with anxiety disorders and OCRDs.

References


Begum, M., & Corrigan, P. W. (2014). Common barriers to receiving treatment include a lack of access to care (specifically to therapists trained in evidence-based treatment), lack of knowledge (about anxiety or OCRDs, or about treatment options), perceived stigma, and financial costs of treatment (Baker, McFall, & Shoham, 2008; Corrigan, 2004; Kessler et al., 2001; Saxena, Thornicroft, Knapp, & Whiteford, 2007). Research on the most effective ways to increase dissemination and implementation, as well as testing new delivery models of treatment (e.g., via smartphones, the internet) can reduce the suffering of individuals with anxiety disorders and OCRDs.


domains together is now crucial. Only through an integration of understanding of etiological factors, natural recovery, and therapeutic recovery across biopsychosocial levels of analysis will the field move forward and ultimately improve trauma survivors’ lives. This multi-level approach will guide the next generation of researchers seeking to identify at-risk individuals, mitigate long-term impact, guide our early intervention development, and develop more effective and targeted treatments. The field of trauma and stressor-related disorders has multiple grand challenges that will guide research and clinical endeavors for years to come.

Acknowledgments

This chapter was supported in part by R01MH066347 (PI: Zoellner). We would like to thank Lindsay Kramer for her help with the references in this chapter.

References


is likely that a full understanding of the causes of mood disorders will require even further integration of cognitive, behavioral, psychosocial, and neurobiological mechanisms in the future.

References


References


form of psychopathology that has captured his or her immediate attention. It can be difficult to obtain insurance coverage for the treatment of a personality disorder due to the inaccurate assumption that they are not in fact treatable. This is regrettable because some maladaptive personality traits (e.g., borderline and antisocial) have substantial social and public health care costs.

Section III of DSM-5, for emerging models and measures, and the forthcoming ICD-11 include five-domain trait models that are closely aligned, both conceptually and empirically, with the five-factor model of general personality structure. The FFM and these dimensional maladaptive trait models offer a compelling alternative to the categorical diagnosis of personality disorders provided in Section II of DSM-5. Advantages of understanding personality disorders in terms of these dimensional trait models are the provision of more specific descriptions of individual patients (including adaptive as well as maladaptive personality functioning), the avoidance of arbitrary categorical distinctions, and the ability to bring to bear the extensive amount of research on the heritability, temperament, development, and course of general personality functioning of the FFM to an understanding of personality disorders.

References


simply be a lesser form of sadism; and (3) a wider concern regarding the medicalization of criminal behavior (Beech, Miner, & Thornton, 2016). According to Frances and First (2011), “a rapist is not someone who has a mental disorder and psychiatric commitment of rapists is not justified,” arguing for longer prison sentences instead (p. 558). An additional concern is the potential misuse of a “mental illness” as a legal defense for rape (Halpern, 2011). Labeling illegal behaviors as disorders is also a slippery slope; Hinderliter (2010) rhetorically asks if “Embezzlement Disorder” and “Insider Trading Disorder” will be included in a future DSM. A counterpoint is that if simply released into the community after a relatively short prison sentence based on inadequate sentencing laws, without any required ongoing psychiatric treatment, the rapist has a substantial risk of reoffending. A diagnosis may assist in civil commitment cases, and the paraphilia not otherwise specified (NOS) category has already been used extensively in the courtroom for this purpose (Beech & Harkins, 2012; Frances & First, 2011). While the debate continues, the inclusion of “paraphilic coercive disorder” is unlikely to be accepted as a new disorder in future editions of the DSM, with legitimate reasons.

Another debate that may resurface for the DSM-6 is the proposed disorder of “hypersexuality,” which was rejected for the DSM-5, despite a promising DSM field trial (Reid et al., 2012). The decision to leave hypersexual disorder out of DSM-5 was likely complicated by two competing conceptualizations of hypersexual behavior. While some theorists (e.g., Kafka, 2010) viewed hypersexual disorder as a sexual disorder and argued that it belongs in the same category with paraphilias and sexual dysfunctions, others argued that hypersexual disorder is a behavioral addiction, more akin to pathological gambling (Beech, Miner, & Thornton, 2016). Given that internet gaming disorder is already listed under Conditions for Further Study in the DSM-5 and was included in the recently released ICD-11, it is conceivable that excessive use of internet pornography could be listed in this section in the future (Griffiths, 2012). The proposal to rename pedophilia pedohelophilia and divide it into hebephilia (attraction to pubescent children ages 11–14) and pedophilia (attraction to prepubescent children under age 11) for the DSM-5 was also rejected, but this issue may come up again (Balon, 2013; Blanchard, 2013). One concern about this proposal is that it may be considered overly inclusive or as potentially increasing the false positive rate of diagnosis (First, 2010).

### Concluding Remarks

Sexual dysfunctions and paraphilic disorders reflect distinct phenomena, although they both share a degree of social stigma and social dogma. Sexual behavior is often either held to an impossible standard of perfect performance and pleasure, or is stigmatized when considered deviant in our society. Historically and socioculturally, for men, sex has been viewed as an important sign of manhood, and as such, “physicians, academics, and charlatans have regularly offered purportedly revolutionary cures (e.g., rhinoceros horn, Spanish flies, mandrake root, and a host of herbolological methods) to safeguard men’s sexual performance, on the basis of the accepted knowledge of their era” (Berry, 2013a, p. 22). The current emphasis on sexual function in our society can be easily identified through internet ads for “male enhancement” or through the many erectile dysfunction ads on television. The scope of these media campaigns has already begun to broaden to include women. While some may argue that there is an over-emphasis on sex in our current society, it is unlikely that the profitable industries involving sex—from pornography to pharmaceuticals—will curb their endeavors. It follows that the issue of sexual behavior will continue to find itself at the crossroads of society, culture, social activism, religion, the law, medicine, and psychology.

### References


JENNIFER T. GOSSELIN AND MICHAEL BOMBARDIER


Conclusions

Somatic symptoms, complaints, and concerns are very common in the general population. These problems are costly to the individuals concerned in terms of distress and financial expense as well as to society in terms of lost productivity and health care costs. Compared to other common psychological dysfunctions (e.g., anxiety and depression), our conceptual understanding of somatic symptom and related disorders is poor, and we lack comprehensive integrative models.

One factor that has impeded a better understanding of the somatic symptom disorders is the unsatisfactory and somewhat arbitrary nature of the DSM classifications. The “comorbidity” of somatic symptom disorders with anxiety disorders and depression is an indication that they share underlying psychopathological processes, particularly in relation to anxiety, as noted previously (Aikens, Zvolensky, & Eifert, 2001). A practical consequence for researchers and clinicians is to focus not on the individual disorders but on identifying the common functions of symptoms in persons with different somatic problems (Eifert, 1996; Kirmayer & Sartorious, 2009).

The complex relationships between the physical and psychological aspects of somatic symptom disorders have led to much confusion. We caution against an over-reliance upon medical diagnostic procedures and medical theory. At the same time, research and clinical work would benefit from a more balanced approach that focuses not just on finding or excluding somatic abnormalities but also on combining current medical knowledge and diagnostic techniques with the psychological assessments of a patient’s behavior, cognitive processes, and social relationships (cf. Fink, 1996; Löwe et al., 2008). In our observational work with cardiac patients, we observed how a simple reliance on one source of information (medical or psychological) was inadequate for developing individualized treatment strategies for many patients. Instead, the combination of medical and psychological information yielded insight that was critical for recommending and designing the most appropriate treatment for the individual patient.

Perhaps one of the most compelling conclusions from the research reviewed in this chapter is that somatic symptom disorders cannot be adequately understood, assessed, and treated from a single perspective. Both the classification and research could be improved by adopting a multidisciplinary approach and an integrated biopsychosocial perspective. For example, Mayou, Bass, and Sharpe (1995) proposed a multidimensional classification of patients with functional somatic symptoms along five dimensions: (1) number and type of somatic symptoms; (2) mental state (mood and psychiatric disorder); (3) cognitions (e.g., symptom misinterpretations, disease conviction); (4) behavioral and functional impairment (illness behavior, avoidance, use of health services); and (5) pathophysiological disturbance (organic diseases, physiological mechanisms such as hyperventilation). As described in the section on health anxiety, Löwe and colleagues (2008) present an alternate diagnostic system that focuses on the presence of behaviors, some of which are abnormal illness behaviors. They propose that individuals should be assessed for: (1) dysfunctional cognitions; (2) excessive healthcare use; (3) selective attention to bodily signals; (4) persistent attribution of symptoms to undiagnosed conditions; (5) avoidance and decreased activity; and (6) functional impairments due to somatization. These criteria are behavioral and would be of more immediate relevance for treatment than diagnosing according to physiological phenomena that we cannot observe or measure. Rather than attempting to find the “correct diagnosis,” we recommend assessment along the crucial dimensions involved in the regulation of maladaptive illness behavior and devising treatment programs based on such assessments rather than diagnosing according to the number and type of physical complaints.

A multicausal perspective suggests several potentially fruitful lines for future psychological research into somatic disorders such as an increased focus on information processing behavior (attention, attribution, and memory) and environmental contingencies for illness behavior (e.g., social, occupational, medical). An interdisciplinary approach such as psychoneuroimmunology, which examines the interaction between mental and physical health processes, may help clarify particular aspects of the nature of the interface between pathophysiological changes and individual responses to such changes as exemplified in some chronic pain research (cf. Flor et al., 1990; Bjurström, Giron, & Griffis, 2016). Although the past emphasis on the problems of patients with no demonstrable physical pathology was worthwhile and to a lesser extent deserves continued attention, the gray area of persons with some organic pathology, bodily symptoms, and psychological distress deserves greater recognition and needs to be investigated more carefully.

Improving our conceptual understanding of these problems should lead to more effective interventions. The need for better theories and treatments is even more pressing for those somatic problems that have been particularly neglected in the past such as conversion problems. The relative success of recent cognitive-behavioral treatment and ACT programs for persons with unexplained physical symptoms, health anxiety, or chronic pain is promising. These treatment successes may help change the common perception of health-care providers that people with such problems are just a “pain in the neck” and invariably difficult, or even impossible, to treat.

References


reduce the frequency of nightmares, address other unusual sleep-related problems (e.g., narcolepsy), and promote cognitive control and affect regulation should also be a high treatment and research priority.

**Conclusion**

Dissociative disorders exact an enormous personal, societal, and economic burden. Accordingly, it is heartening that concerted empirical and theoretical efforts have promoted better understanding of these puzzling conditions. Although controversies persist regarding the specific role of trauma in dissociation, spirited debates have generated empirically grounded alternative hypotheses (e.g., role of fantasy, hyperassociation) regarding the mediators and moderators of dissociative disorders that are subject to empirical test. It is also encouraging that some proponents of the SCM and PTM agree that a multi-pronged investigatory approach that considers multiple determinants of dissociative disorders is the best way forward. Moreover, researchers are avidly pursuing promising avenues of investigation of dissociation such as the role of sleep in producing depersonalization/derealization and other dissociative phenomena. Better understanding of the antecedents and risk factors for dissociation will, we anticipate, shape the contours of more sophisticated and refined science-based approaches to the treatment of dissociation. We further anticipate that tension between competing perspectives will continue to generate provocative questions, healthy debate, and ultimately a more comprehensive and nuanced understanding of dissociative disorders and their treatment.

**References**


Learning drink refusal

Behavioral contracting and establishment of a consequences and reward method for adhering to the goals.

Self-analytics of drinking and prevention.

In the US, the idea that substance abusers can control their drinking or drug use remains a controversial and highly debated topic. However, controlled drinking interventions are less controversial in other parts of the world (e.g., The Netherlands, Australia), and have been used effectively in other countries (e.g., Dawe & Richmond, 1997). The debate regarding controlled drinking as an acceptable treatment goal has raged for over 25 years. Some investigators have noted that controlled drinking can be efficacious (Heather, 1995; Kahler, 1995), whereas others have argued that alcohol-dependent individuals cannot maintain control over drinking and, as such, controlled drinking is not an acceptable treatment objective (Donovan & Wells, 2007).

Conclusion

Substance use disorders are among the most pressing and intransigent mental health problems facing society today. Concerns about abuse of alcohol, tobacco, and other psychoactive substances date as far back as Biblical times: "He shall separate himself from wine and strong drink, and shall drink no vinegar of wine, or vinegar of strong drink, neither shall he drink any liquor of grapes, nor eat moist grapes, or dried" (Numbers 6:3). Despite such a long history, scientific scrutiny of these problems is a fairly recent phenomenon. However, a large and evolving body of literature about the epidemiology, etiology, neurobiology, and treatment of addictive behavior has accumulated. These and other aspects of addictive behavior continue to be the focus of extensive clinical and experimental research.

The study of substance use and misuse has been marked by extensive controversy and heated debate. These conflicts have been fueled by a fundamental disagreement among scientists, clinicians, social policy makers, and the public about whether to view addiction as a disease in need of medical treatment, a sin in need of punishment and containment, or learned behaviors that can be modified by contingencies. The debate has important implications for research, treatment, and social policy. Unfortunately, the beliefs about what constitutes effective treatment are often not supported by the empirical research. Those who view alcoholism and other drug use as diseases are ethically and, in some instances, morally opposed to the use of controlled use treatments, which they view as irresponsible. Drug users fill our criminal justice system, while treatment providers lament the criminalization of these “diseases.” Yet, proponents of legalization of drugs, who are in the minority, note that legalization will help contain many of the social ills associated with substance use. Others see such a stance as irresponsible and immoral because it would increase the exposure of those with a genetic propensity for addiction to the substances that would activate the addictive process. In turn, they believe that such policies would contribute to greater social decay. Because the emotional, legal, and economic stakes in the debate are so high, no end to the debate is in sight.

Discussion Questions

1. What are the advantages and limitations of viewing addictive behavior as diseases? As learned behaviors? As immoral and sinful?
2. Should harm reduction approaches to treatment (e.g., controlled drinking, methadone maintenance) be made more widely available in treatment programs?
3. What would be the advantages and disadvantages of legalizing certain illicit substances, such as cannabis?
4. What are some of the barriers to implementation of medical assisted therapies for substance use disorder?

Acknowledgement

The authors wish to acknowledge William Fals-Stewart for his contributions to earlier versions of this chapter.

References


Psychopathology in Late Life

There is evidence of both similarities and differences in psychopathology in late life relative to earlier ages. Contrary to popular stereotype, late life is associated with lower prevalence of many types of psychopathology, including anxiety disorders, major depressive disorder, bipolar disorder, schizophrenia, alcohol use disorders, and some types of personality disorders. There is longitudinal evidence of attenuation of symptom severity or even remission for most of these disorders. These outcomes are consistent with the improved emotion regulation that has been documented in late life. It is also possible, however, that lower rates of disorder in late life may be a methodological artifact rather than reflecting a true age-related decline. Symptom presentation of many of the disorders differs in older adults compared to younger adults, such that diagnostic rubrics established to describe disorders in younger populations may not capture these disorders when they appear in older populations. In some cases, symptoms may attenuate slightly, such that diagnostic criteria are no longer met, but remain problematic for the patient. For example, sub-threshold depressive and anxiety symptoms are common in late life. Further, selective mortality may explain some of the apparent decline in prevalence of some of these disorders (bipolar, major depressive disorder, substance use disorders, schizophrenia). More research, including longitudinal designs, is needed to tease apart alternative explanations.

In contrast to the disorders that appear to decline in prevalence with age, there are several disorders that increase in prevalence with age, including dementia, sleep disorders, and select personality disorders. Biological changes associated with aging, which are associated with increased likelihood of executive dysfunction and other cognitive deficits, may explain not only dementia but also other disorders that are linked to cognitive functioning, such as OCPD. Age-related changes in the circadian rhythm have been implicated in increased rates of insomnia. Of note, however, is that biological aging is not always associated with increases in disorder; e.g., changes in metabolism with age can lead to reductions in problem drinking. In addition, behavioral and environmental factors may contribute to increased prevalence of certain disorders in late life. For example, schedule flexibility in old age and sleep-related behaviors may perpetuate insomnia; habituation to painful or provocative experiences may increase risk of high lethality suicidal behavior; and social role changes may precipitate change in alcohol use.

The assessment of psychopathology in older adults can be challenging, owing to differences in symptom presentation and comorbid physical illnesses. Age-specific measures are available for some but not all disorders. Many of the same treatments that have demonstrated efficacy in adult populations have also been shown to work in older adults, and several treatments have been developed specifically for older adults. Nonetheless, outcome research within this age group is scarce.

Increasingly, longitudinal research has begun to reshape our understanding of psychopathology in late life. Additional longitudinal research is needed to elucidate the trajectories of psychopathology across the lifespan. Future research focused on older adults who do not manifest psychopathology in spite of risk factors could be particularly helpful in uncovering protective factors. Finally, assessment and treatment outcome research with a focus on older adults is needed. Considering the impending expansion of the older adult population, this type of research could not be more timely.

References


An individualized approach to intervention that is consistent with the treatment principles outlined above and is delivered in the child’s natural environment.

MST involves an initial comprehensive assessment that seeks to understand the level and severity of the child or adolescent’s presenting problems and to understand how these problems may be related to factors in the child’s familial, peer, and cultural environment. Information from this assessment is used to outline an individualized treatment plan based on the specific needs of the child and his or her family. Unlike the individual interventions described previously, MST is not manualized and does not emphasize the use of specific techniques. Instead, it emphasizes several principles that follow from its orientation to intervention. These principles include the following:

- The identified problems in the child are understood within the child’s familial, peer, and cultural context.
- Therapeutic contacts emphasize positive (strength-oriented) levers for change.
- Interventions promote responsible behavior among family members.
- Interventions are present focused and action oriented, targeting specific and well-defined problems.
- Interventions target sequences of behavior within and between multiple systems.
- Interventions must be developmentally appropriate.
- Interventions are designed to require daily or weekly effort by family members.
- Intervention effectiveness must be evaluated continuously from multiple perspectives.
- Interventions are designed to promote maintenance of therapeutic change by empowering caregivers.

A critical component of MST is a system of intensive supervision for the therapists implementing the treatment to determine how these principles should be implemented to meet the needs of each individual case and to ensure that the principles are followed throughout the intervention (Henggeler et al., 2009b; Schoenwald, 2016). One of the important contributions of MST to the treatment outcome literature is its demonstration that individualized interventions can be rigorously evaluated through controlled treatment outcome studies.

Several randomized trials have found that adolescent offenders who receive MST exhibit lower rates of delinquent behavior, substance use, recidivism, and incarceration following treatment compared to adolescents receiving standard community care (e.g., individual counseling) (Henggeler & Schaeffer, 2016; Henggeler & Sheidow, 2012). A follow-up study of one of the first randomized trials of MST for adolescent offenders (Borduin et al., 1995) found lower rates of recidivism 22 years after treatment initiation among seriously delinquent juveniles who received MST relative to those assigned to individual therapy (Sawyer & Borduin, 2011). The positive effect of MST on even severe antisocial behavior appears to be due in part to the program’s ability to improve family relations, increase caregivers’ use of positive discipline techniques, and reduce deviant peer group affiliation (Henggeler, 2011; Henggeler & Sheidow, 2012). Preliminary research suggests that MST does not reduce the antisocial behaviors of adolescents with CU traits to levels equivalent to adolescents without CU traits (Manders et al., 2013; see also Masi et al., 2013). Moreover, results are mixed on its ability to significantly reduce CU traits relative to treatment as usual (Butler et al., 2011; Manders et al., 2013).

**Overall Summary**

Externalizing disorders are one of the most common reasons children are referred to mental health clinics for treatment. Children with disorders such as ADHD, ODD, and CD often cause significant disruption to those around them, particularly parents and teachers who are most likely to refer them for treatment. Further, children with these problems are at increased risk for a number of longer term problems in adjustment, such as delinquency, substance abuse, and depression, particularly when problems begin early in life and with high initial severity. Fortunately, there is a large body of research on externalizing disorders, which has led to great advances in our understanding of their causes and the development of effective interventions to treat them in childhood. Unfortunately, this research is often not translated well into practice and, as a result, many children with these disorders do not receive state-of-the-art treatment. This research-to-practice gap may be the result of practitioners failing to remain current on this research or not being trained in the most current theories and approaches to treatment; to research not being conducted or presented in a way that is useful to practicing psychologists; or to a combination of the two. In any case, the quality of services provided to children with disruptive behaviors depends heavily on advances in research and our ability to translate these findings into widely used applications. The focus of this chapter was to summarize research on children with externalizing disorders in a way that promotes such a translation.

**Note**

1 A “specifier” is used to define variants of a disorder, which may have implications for treatment planning. Specifiers are not always mutually exclusive, and more than one specifier can be given.
References


Summary
The research on child and adolescent depression offers a number of exciting and promising findings. Treatment research is ongoing, including new directions involving biological and interpersonal factors. Although efficacious treatments exist, both pharmacological and psychosocial (primarily CBT, IPT-A, and attachment-based family therapy), not all children are being helped by these interventions. Furthermore, the issue of comorbidity has not been adequately addressed nor has the role of culture and ethnicity. The protective factors and risk factors associated with different cultural and ethnic practices have yet to be examined in standard research and clinical practice. These could be pivotal factors in understanding and treating childhood depression in our increasingly diverse society.

Future Directions
The internalizing disorders of children and adolescents represent a major challenge to practicing clinicians and researchers. Anxiety and affective disorders are highly prevalent in childhood and adolescence. Their effects are distressing in the short run and can be long lasting and devastating as adolescents emerge into adulthood.

Although we have attempted to illustrate a developmental psychopathology perspective when examining these disorders, it is evident that more research is needed to fully understand these problems. Many studies continue to look at single causal pathways and direct, linear outcomes. As we have suggested, it may be more productive to posit that several very different pathways can lead to any one outcome such as depression or anxiety (i.e., the developmental principle of equifinality) and that any one pathway can lead to diverse outcomes (i.e., the principle of multifinality). Thus, a risk factor such as child sexual abuse can and frequently does lead to multiple outcomes, whether an internalizing disorder or an externalizing disorder. Tracking this developmental process is complex and challenging but necessary. This effort will benefit greatly from carefully planned, multi-site, longitudinal studies (Weisz, Sandler, Durlak, & Anton, 2005).

Our treatment and prevention programs must move away from a “one size fits all” mentality to address the complexity of each child or adolescent, and the bio-psychosocial context. Children and adolescents become depressed or anxious through a variety of pathways, and they express these disorders in a variety of ways. We need to take this complexity into consideration in designing, implementing, and evaluating our interventions. Although current empirically supported or evidence-based interventions work with most (i.e., 50–70%) of the children and adolescents and families who come into our practices and research clinics, we must do better. An approach that is individualized and prescriptive, and one that is based in developmental theory and grounded in established principles of behavior change (e.g., exposure, cognitive change, interpersonal relationships), is likely to be most effective, although such remains to be carefully documented.

Note
1 These and other online measures are available from the American Psychiatric Association website: www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures (accessed May 7, 2015).

References


Reinecke, M., Curry, J., & March, J. (2009). Findings from the Treatment for Adolescents with Depression Study (TADS): What have we learned? What do we need to know? Journal of Clinical Child and Adolescent Psychology, 38(6), 761–767. doi: 10.1080/15374410903258991


an opportunity to give input into school programming and services, and to plan direct services that seek to reinforce and generalize the school-based efforts. For students with more severe learning disabilities (i.e., intellectual disability) practitioners can also play a vital part in ensuring their client receives the school-based services and supports they need to successfully transition into employment, supported or independent living, and/or further education after exiting the school system.

**Assist Parents and Families to Support Clients with Learning Disorders**

Psychologists can help their clients and their clients’ families develop the skills and supports needed to successfully advocate in the school system. For example, they may work directly with clients on self-monitoring study strategies, and on developing the social skills for asking for help when they need it. Psychologists can work with parents on skills and strategies to advocate for their children and communicate their needs and desires to school personnel successfully. Parents sometimes experience guilt or denial when their child is identified with one of the learning disorders described in this chapter. Helping parents understand the importance of consistency and routine in the home as well as following through with school recommendations for the home can help parents more effectively support their child who has a learning disorder.

**Notes**

1. A sixth provision in IDEA 2004 is the Procedural Safeguard, which educates parents about their rights within the special education system and protect parents and their children when disagreements about identification and placement arise between schools and parents.
2. Some students who do not qualify for special education services under IDEA 2004 may qualify for special education provisions under Section 504, which is a part of the Rehabilitation Act of 1973, which is civil rights legislation that prohibits discrimination based on disability.

**References**


unrecognized, such as binge-eating disorder, have become codified in our diagnostic manuals. We have come a long way in identifying important risk factors for eating disorders, and establishing that eating disorders are serious mental health disorders and not simply “diets gone wrong” has done much to increase understanding and reduce stigma. Furthermore, recent efforts to dispel harmful racial and gender stereotypes about eating disorders have helped to increase awareness that eating disorders are problems that can affect anyone. Finally, although there remains work to be done, we now have several evidence-based treatments that are helpful for many people. Not unlike Bruch’s seminal writings, many of the advancements that have been made in the past 40 years have begun with clinical observations. These observations have often inspired important research questions and have led to innovative ideas and findings, which have then been incorporated back into clinical practice.

References


Regardless of whether gender dysphoria is retained as a disorder in the future, clinical, medical, and legal practices should promote acceptance, empathy, and empowerment to gender non-conforming individuals.

**Note**

1 Acknowledgements: The authors would like to thank Diana Schellenberg for providing incisive commentary and invaluable suggestions on an earlier draft of this chapter.

**References**


Books for Clients and Families

A Parent’s Guide to Asperger Syndrome, & High-Functioning Autism by Sally Ozonoff, Geraldine Dawson, and James McPartland
Asperger’s from the Inside Out: A Supportive and Practical Guide for Anyone with Asperger’s Syndrome by Michael John Carley
Asper Girls by Rudy Simone
Autism Spectrum Disorders: The Complete Guide to Understanding Autism, Asperger’s Syndrome, Pervasive Developmental Disorders, and Other ASDs, by Chantal Secile-Kira
Safety Skills for Asperger Women by Liane Holliday Willey
Ten Things Every Child with Autism Wishes You Knew by Ellen Notbohm
The Asperkid’s (Secret) Book of Social Rules: The Handbook of Not-so-obvious Social Guidelines for Tweens and Teens with Asperger Syndrome by Jennifer Cook O’Toole
The Autistic Brain: Thinking across the Spectrum by Temple Grandin and Richard Panek
The Complete Guide to Asperger’s Syndrome by Tony Attwood
The Hidden Curriculum: Practical Solutions for Understanding Unstated Rules in Social Situations by Brenda Smith Myles, Melissa L. Trautman, and Ronda L. Schelvan
The Scientist of Making Friends by Elizabeth Laugeson
The Thinking Person’s Guide to Autism edited by Shannon Des Roches Rosa, Jennifer Byrne Myers, Liz Ditz, Emily Willingham, and Carol Greenburg
Thinking in Picture: My Life with Autism by Temple Grandin

Online Resources

Centers for Disease Control (CDC) www.cdc.gov/ncbddd/autism/research.html
Organization for Autism Research www.researchautism.org/
Autism Speaks www.autismSpeaks.org/
Spectrum (autism research news magazine) www.spectrumnews.org/
Autistic Self Advocacy Network http://autisticadvocacy.org/
The Global and Regional Asperger Syndrome Partnership (GRASP) http://grasp.org

References


