PSYCHOPATHOLOGY
PSYCHOPATHOLOGY

Foundations for a Contemporary Understanding

3rd Edition

Edited by
James E. Maddux and Barbara A. Winstead

http://www.routledgementalhealth.com/psychopathology-9780415887908
# Contents

Editors vii
Contributors ix

## 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 Biological Bases of Psychopathology
   ROBERT F. SMITH 23

3 Cultural Dimensions of Psychopathology: The Social World’s Impact on Mental Disorders
   STEVEN REGESER LÓPEZ and PETER J. GUARNACCIA 45

4 The Role of Gender, Race, and Class in Psychopathology
   BARBARA A. WINSTEAD and JANIS SANCHEZ 69

5 Classification and Diagnosis: Historical Development and Contemporary Issues
   THOMAS A. WIDIGER 101

6 Psychological Assessment and Clinical Judgment
   HOWARD N. GARB, SCOTT O. LILIENFELD, and KATHERINE A. FOWLER 121

7 Psychotherapy Research
   REBECCA E. STEWART and DIANNE L. CHAMBLESS 145

## Part II  Common Problems of Adulthood

8 Anxiety Disorders
   S. LLOYD WILLIAMS 163

9 Mood Disorders
   LAUREN B. ALLOY, DENISE LABELLE, ELAINE BOLAND, KIM GOLDSTEIN, ABIGAIL JENKINS, BENJAMIN SHAPERO, SHIMRIT K. BLACK, and OLGA OBRAZTSOVA 195

10 Schizophrenia
   LISA KESTLER, ANNIE BOLLINI, KAREN HOCHMAN, VIJAY A. MITTAL and ELAINE WALKER 247

11 Personality Disorders
   JENNIFER RUTH PRESNALL and THOMAS A. WIDIGER 277

12 Sexual Dysfunctions and Disorders
   JENNIFER T. GOSSELIN 307
Contents

13 Somatoform and Dissociative Disorders 347
GEORG H. EIFERT, ELLEN MCCORMACK, and MICHAEL J. ZVOLENSKY

14 Substance Use Disorders 373
KEITH KLOSTERMANN and MICHELLE L. KELLEY

15 Mental Health and Aging 399
AMY FISKE, CAROLINE M. CILIBERTI, CHRISTINE E. GOULD, DANIELLE K. NADORFF, MICHAEL R. NADORFF, SARRA NAZEM, SARAH T. STAHL, and MEGAN M. CLEGGL-KRAYNOK

Part III Common Problems of Childhood and Adolescence

16 Developmental Psychopathology: Basic Principles 429
JANICE ZEMAN and CYNTHIA SUVEG

17 Externalizing Disorders 443
EVA R. KIMONIS and PAUL J. FRICK

18 Internalizing Disorders 473
THOMAS H. OLLENDICK and JANAY B. SANDER

19 Language, Learning, and Cognitive Disorders 499
REBECCA S. MARTÍNEZ, STACY E. WHITE, MICHELLE L. JOCHIM and LEAH M. NELLIS

20 Eating Disorders 517
TRACI MCFARLANE, KATHRYN TROTTIER, JANET POLIVY, C. PETER HERMAN, JESSICA ARSENAULT, and MICHELE BOIVIN

Index 553
A textbook about a topic should begin with a clear definition of that 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 (Gorenstein, 1984; Horwitz, 2002; Widiger, 1997, 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? The goal of this chapter is to address this issue. Addressing this issue in this opening chapter is important because the reader’s view of everything else 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 of this book.

Understanding various conceptions of psychopathology is important for a number of reasons. As medical philosopher Lawrie Reznek (1987) said, “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, 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 common and “commonsense” 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 commonsense 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 oft en done by developing an instrument or measure that attempts to quantify the phenomenon and then assigning 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 commonsense appeal and its scientific merits, this conception presents problems. It sounds relatively objective and scientific because it relies on well-established psychometric methods for developing measures of psychological phenomena and developing norms. Yet, this approach leaves much 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 ask ourselves “What is ‘intelligence’?” 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 no “true” definition of intelligence and no objective, scientific way of determining one. Intelligence is not a thing that exists inside 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 the words 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 is 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 (i.e., social and emotional intelligence), self-regulatory skills, artistic and musical abilities, and other abilities not measured by traditional tests of intelligence (e.g., Gardner, 1999). 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 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 (Kutchens & Kirk, 1997), 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.
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* (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association, 2000) incorporates this notion in its definition of mental disorder by stating that a mental disorder “is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more areas of functioning) or with significantly increased risk of suffering pain, death, disability, or an important loss of freedom” (p. xxxi).

Like the statistical deviance conception, this conception has commonsense appeal and is consistent with the way most laypersons use words such as pathology, disorder, and illness. 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 commonsense 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 or maladaptiveness depends on the situations in which the behavior is 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, 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 equals maladaptive” conception is that judgments of adaptiveness and maladaptiveness are logically unrelated to measures of statistical deviation. Of course, we often do find a strong relationship between the statistical abnormality of a behavior and its maladaptiveness. Many of the problems described in the *DSM–IV–TR* and in this textbook are both maladaptive and statistically rare. There are, however, major exceptions to this relationship.

First, psychological phenomena that deviate from the norm or the average are not all 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 almost always 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, 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 to 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, or situational opportunities to make positive changes (Bergner, 1997).

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

Another problem is that some conditions or patterns of behavior (e.g., pedophilia, 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.

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

In addition, the conception of psychopathology as a social norm violation is at times in conflict with the conception of psychopathology as a 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 United States who sought the right to vote were trying to change well-established social norms. Their actions were uncommon and therefore considered abnormal, but these people were far from psychologically unhealthy, at least not by today’s standards. Earlier in the 19th century, slaves who desired to escape from their owners were said to have drapetomania. Although still practiced in some parts of the world, slavery is almost universally viewed as socially deviant and pathological, and the desire to escape enslavement is considered to be as normal and healthy as the desire to live and breathe.

**Psychopathology as Dyscontrol or Dysregulation**

Some have argued that only those maladaptive patterns of behaving, thinking, and feeling that are not within the person’s ability to control or self-regulate should be considered psychopathologies or mental disorders (Klein, 1999; see also Widiger, this volume, for detailed discussion). 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 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 its draws an artificial line between “within control” (voluntary) and “out of control” (involuntary) that simply cannot be drawn. There may be some behaviors that person might engage in that most of us would agree are completely voluntary, deliberate, and intentional and other behaviors that a person might engage in that most of us would agree are completely involuntary, nondeliberate, 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 concluding that anything a person does 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, Siefier, & 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?

**Psychopathology as Harmful Dysfunction**

A more recent attempt at defining psychopathology is Wakefield’s (1992a, 1992b, 1993, 1997, 1999) *harmful dysfunction* (HD) conception. Presumably grounded in evolutionary psychology (Cosmides, Tooby, & Barkow, 1992), the HD conception 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. 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) reiterated this definition in writing that a mental disorder “satisfies two requirements: (1) it is negative or harmful according to cultural values; and (2) it is caused by a dysfunction (i.e., by a failure of some psychological mechanism to perform a natural function for which it was evolutionarily designed)” (p. 157). He and his colleagues also stated: “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).

However, the claim that identifying a failure of a “designed function” is a scientific judgment and not a value judgment is open to question. Wakefield’s claim that dysfunction can be defined in “purely factual scientific” (Wakefield, 1992a, p. 383) 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 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 catalog of mental mechanisms and their natural functions. Wakefield stated 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 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 Widiger, this volume).

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 stated, “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 revised HD conception simply offers another criterion that people (clinicians, scientists, and laypersons) might use to judge whether or not some behavior constitutes 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 are also 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 Widiger, this volume).

The DSM Definition of Mental Disorder

Any discussion of conceptions of psychopathology has to include a discussion of the most influential conception of all—that of 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, this volume, for a more detailed history of psychiatric classification and the DSM.)

Just as a textbook on psychopathology should begin by defining its key term, so should a taxonomy of mental disorders. To their credit, the authors of the DSM attempted to do that. 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–IV–TR (American Psychiatric Association, 2000):

In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. (p. xxxi)

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 or 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 a particular response to an event is "expectable" or "culturally sanctioned"? Who gets to determine this? How does one determine whether 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.

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 clearly 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. 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 (Keyes & Lopez, 2002; Widiger, this volume). 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 (Lubinski, 2000). 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" (1860, p. 14, quoted in Millon, 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 (Maddux & Mudell, 1999; Widiger & Trull, 2007; Widiger, this volume). 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, the most recent 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, Budzek, & Tamborski, 2009). In addition, the recent Emotional Cascade
Model of borderline personality disorder, although not presented explicitly as a dimensional model, is in almost every respect consistent with a dimension model (Selby & Joiner, 2009). The dimensional view of personality disorders is also supported by cross-cultural research (Alarcon, Foulks, & Vakkur, 1998).

Research on other problems 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 (Fossati, 2003; Fraley & Waller, 1998; Hankin, Kassel, Abela, 2005). 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 (Shaywitz, Escobar, Shaywitz, Fletcher, & Makuch, 1992; Shaywitz, Morris, & Shaywitz, 2008; Snowling, 2006). Research on attention deficit hyperactivity (Barkley, 2005), posttraumatic stress disorder (Anthony, Lonigan, & Hecht, 1999; Rosen & Lilienfeld, 2003; Ruscio, Ruscio, & Keane, 2002), and panic disorder (Eaton, Kessler, Wittchen, & Magee, 1994) demonstrates 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 recent study on depressive symptoms among children and adolescents found a dimensional structure for all of the DSM–IV symptoms of major depression (Hankin, Fraley, Lahey, & 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 “ungewonlich,” 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 as a classification 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; Kestler, Bollini, Hochman, Mittal, & Walker, this volume van Os, Verdoux, Maurice-Tison, Gay, Liarud, Salamon, & Bourgeois, 1999). 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). Finally, biological researchers continue to discover continuities between so-called normal and abnormal (or pathological) psychological conditions (Claridge, 1995; Livesley, Jang, & Vernon, 1998; Nettle, 2001; Smith, this volume).

Dimensional approaches, of course, are not without their limitations, including the greater difficulties they present in communication among professionals compared to categories and their greater complexity 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
Conceptions of Psychopathology • 13

traditional categorical schemes. (An extensive discussion of the pros and cons of categorical approaches are beyond the scope of this chapter. Detailed and information discussions can be found in other recent sources [e.g., Grove & Vrieze, 2010; Simonsen, 2010].)

Social Constructionism and Conceptions of Psychopathology

If we cannot come up with an objective and scientific conception of psychopathology and mental disorder, then is there some way left for 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, but rather to accept the fact that the problem has no solution—at least not a solution that can be arrived at 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 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 undergo 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, p. 234). 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 terms such as domestic violence (Muehlenhard & Kimes, 1999), child sexual abuse (Holmes & Slapp, 1998; Rind, Tromovitch, & Bauserman, 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. 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 & Kendler, 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 but 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 revealed 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 (Cross & Markus, 1999; Cushman, 1995; Hewitt, 2002) provide an example of this process at work. 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 & Guarnaccia, 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).

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 (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. 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—those 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 are derived from these values (Becker, 1963; Kirmeyer, 2005; Parker et al., 1995; Rosenblum & Travis, 1996). As McNamee and Gergen (1992) stated: “The mental health profession is not politically, morally, or valuationally 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, Vijayaragahavan, & 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 (2000) in Creating Mental Illness. According to Horwitz:

The emergence and persistence of an overly expansive disease model of mental illness was not accidental or arbitrary. The widespread creation of distinct mental diseases developed in specific historical circumstances and because of the interests of specific social groups…. By the time the DSM-III was developed in 1980, thinking of mental illnesses as discrete disease entities … offered mental health professionals many social, economic, and political advantages. In addition, applying disease frameworks to a wide variety of behaviors and to a large number of people benefited a number of specific social groups including not only clinicians but also research scientists, advocacy groups, and pharmaceutical companies, among others. The disease entities of diagnostic psychiatry arose because they were useful for the social practices of various groups, not because they provided a more accurate way of viewing mental disorders. (p. 16)

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” 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 more 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). 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”;

http://www.routledgementalhealth.com/psychopathology-9780415887908
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 stated:

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 stated:

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 American Psychiatric Association’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 posttraumatic 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), posttraumatic stress disorder (Herbert & Forman, 2010), personality disorder (Alarcon et al., 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. Between 1952 and 2000, the number of pages in the DSM increased from 86 to 943, and the number of mental disorders listed increased from 106 to 385. 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.

Consider some of the mental disorders listed in the DSM–IV (American Psychiatric Association, 1996). Cigarette smokers have “nicotine dependence.” If you drink large quantities of coffee, you may develop “caffeine intoxication” or “caffeine-induced sleep disorder.” If you have “a preoccupation with a defect in appearance” that causes “significant distress or impairment in … functioning” (p. 466), you have “body dysmorphic disorder.” A child whose academic achievement is “substantially below that expected for age, schooling, and level of intelligence” (p. 46) has a “learning disorder.” Toddlers who throw tantrums have “oppositional defiant disorder.” Not wanting sex often enough is “hypoactive sexual desire disorder.” Not wanting sex at all is “sexual aversion disorder.” Having sex but not having orgasms or having them too late or too soon is an “orgasmic disorder.” Failure (for men) to maintain “an adequate erection … that causes marked distress or interpersonal difficulty” (p. 504) is “male erectile disorder.” Failure (for women) to attain or maintain “an adequate lubrication or swelling response of sexual excitement” (p. 502) accompanied by distress is “female sexual arousal disorder.”

Consider also some of the new disorders proposed for DSM–5 (expected publication, May, 2013): hypersexual disorder, temper dysregulation disorders of childhood, hoarding disorder, skin picking disorder, psychosis risk syndrome, among others. Psychiatrist Allen Frances (2010), the chair of the DSM–IV task force, argued that these new “disorders” and other changes represent a further encroachment of the DSM into the realm of common problems in living. (See Widiger and the chapters in Part II of this volume for a more detailed discussion of the proposed changes for DSM–5.)

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.

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 continually 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

http://www.routledgementalhealth.com/psychopathology-9780415887908
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) stated:

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


http://www.routledgementalhealth.com/psychopathology-9780415887908


http://www.routledgementalhealth.com/psychopathology-9780415887908