THE NATURE OF MENTAL DISORDERS

OPERATIONAL DEFINITION
Psychopathology, mental disorder, and mental illness have no strict, agreed-upon definition.

Major issue is whether mental disorders can be a scientific term or if they are instead only social constructs.

Which human experiences are pathological and which are not?

CONCEPTION OF DISEASE
"Classifying a condition as a disease is no idle matter."

Has consequences for:
- Researchers
- Benefactors
- Therapists
- Hospitals
- Courts
- Insurance companies
- People with that condition

Reznick (1987)
CONCEPTIONS OF PSYCHOPATHOLOGY

Psychopathology as
Statistical deviance
Maladaptive / dysfunctional behavior
Distress and disability
Social deviance
Harmful dysfunction
Dimensional
Social construction

STATISTICAL DEVIANCE

Psychopathology are those behaviors that are statistically deviant or infrequent

Has common-sense appeal

Lends itself to methods of measurement
Have to determine what is statistically “normal”
Then determine how far a condition deviates from the norm

STATISTICAL DEVIANCE

Seems objective and scientific due to reliance on psychometric methods

Still includes large amounts of subjectivity
Conceptual definition(s) of constructs
How deviant is too deviant?

Subjective influences have a number of consequences
MALADAPTIVE / DYSFUNCTIONAL BEHAVIOR

Refers to the effectiveness or ineffectiveness of a behavior in dealing with challenges or accomplish goals

Highly subjective
Adaptiveness of a behavior can be both situationally based and judgementally based
Cultural differences impact adaptive level

MALADAPTIVE / DYSFUNCTIONAL BEHAVIOR

Maladaptiveness is not logically related to statistical deviance
IQ scores of 130 and 70
Low depression or anxiety scores

Maladaptive behaviors are not all statistically infrequent and vice versa
Shyness
Sexual functioning

DISTRESS & DISABILITY

Very subjective, similar to maladaptive behavior
When is someone distressed?
When is someone disabled?

Pathological conditions may not always cause distress to the person with the condition
Personality disorders
SOCIAL DEVIANCE

Psychopathology is behavior that deviates from what is socially acceptable
Same as statistically deviant, but without the objectivity of stats
Norms are socially derived, not scientifically derived, and differ between cultures and time periods
Masturbation
Homosexuality

HARMFUL DYSFUNCTION

Acknowledges impact of social and cultural values, but proposes objectivity as well
_Harmful_ is based on social norms
_Dysfunction_ is scientific term for failure of an evolved mental mechanism

Pros and cons to this type of a definition

Wakefield ([1992, 1999])

HARMFUL DYSFUNCTION

Pros
Has both subjective and objective qualities
Grounded in a solid scientific theory (evolution by natural selection)

Cons
Mental mechanisms cannot be objectively measured, so we rely on value judgments
Changing conception of HD, from trying to define a mental disorder to describing how people define it
Why Classify Mental Disorders?

Classification systems provide us with a common nomenclature
Allows us to structure information
Allows us to communicate information
Social and political implications

The DSM-IV-TR

Lists symptoms of each disorder, information about etiology, prevalence, and cultural issues that may impact diagnosis
Uses a five axis model for diagnoses

Axis I: Primary clinical problem
Axis II: Personality disorders
Axis III: General medical conditions
Axis IV: Social and environmental stressors
Axis V: Global assessment of overall functioning
**DSM-IV Definition**

“...a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability, or with a significantly increased risk or suffering death, pain, disability or an important loss of freedom...must not be...expectable or culturally sanctioned...must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.”

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**Classifying Abnormal Behavior**

DSM classification has limitations

- What is “clinically significant”?
- How much distress is enough?
- Who says what is “culturally sanctioned”?
- What is a “behavioral, psychological, or biological dysfunction”?

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**Categories vs. Dimensions**

In the categorical models, psychopathology is either present or it is not (dichotomous)

In dimensional models, ”psychopathology” is simply the ends of a continuum of behavior
The Dimensional Model

“Psychological disorders” are extreme variants of normal phenomena and/or problems in living.

Not concerned with classifying disorders, but instead measuring differences in psychological phenomena:
- Emotion
- Mood
- Intelligence
- Personality
- etc.

The Dimensional Model

Statistical deviation is not always maladaptive, but can be if it leads to inflexibility.

Strongest evidence for dimensional model among personality disorders, but also:
- Attachment patterns
- Self-defeating behaviors
- Reading problems
- ADHD, PTSD, depression, schizophrenia, et al.

The Dimensional Model

Unfortunately, real-life often requires caseness or non-caseness:
- Insurance reimbursement
- Receiving services at school
- Disability status
- Inclusion in research studies

Creates tension between need for categories and lack of support for them.
The Dimensional Model

The DSM-IV, while saying that it recognizes the dimensional nature of mental disorders, works from a categorical framework.

“So-called categorical disorders…seem to merge imperceptibly both into one another and into normality…with no demonstrable natural boundaries.”

Boundaries and Comorbidity

The DSM strives to help clinicians differentiate disorders based on discrete characteristics.

Subjective nature of categorical disorders does not allow this to occur very frequently, so you see high rates of comorbidity or co-occurrence.

Why Use the DSM Categories?

Simplicity
- We naturally categorize things, and our typologies reflect this
- Dimensional models may be too complex or confusing to be clinically useful

Tradition / credibility
- Diagnosis is very much a part of medicine
- Loss of diagnosis may mean loss of credibility
**Why Use the DSM Categories?**

**Utility**
- Allows for communication between professionals
- Not as clinically useful, however, as it appears

**Validity**
- Biggest issue, as some research finds support for categorical model…but most support dimensional

**Cultural Influences**

Culture impacts presentation of disorders all over the globe

Can be due to language, religions, historical roots, and other factors

Taijin kyofusho in Japan
Ataque de nervios in Latin America

Some actions and behaviors are universally considered abnormal

**Social Constructionism**

If there can be no scientific definition of psychopathology, then what’s the solution?

**Psychopathology as a social construct**

Mental illness and psychopathology are products of our history and culture, not universal, scientific constructs
Social Constructionism

“Reality cannot be separated from the way a culture makes sense of it.”

Conceptions of psychopathology are influenced by sociocultural, political, professional, and economic forces.

Mental disorders are invented, but are not myths or not really there, just social constructs.

Why Construction?

Conceptions of mental illness developed from a medical model, which offered many benefits to many persons.

A dimensional model “did not demarcate clearly the well from the sick”

The DSM allowed psychiatry to essentially stake out its territory.

From Pattern to Disease

Observation of deviation from norm

Powerful group decides this deviation needs control, prevention, and/or treatment

Deviation is given a scientific-sounding, capitalized name / acronym

The now disorder takes on life of its own

People start thinking they have it

Healthcare providers start treating it

Scientists begin studying it
**FROM PATTERN TO DISEASE**

Similar to disease construction for *physical* diseases

"There are no illnesses or diseases in nature."

We consider medical disease something that precipitates death or failure to function

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**UP, UP, AND AWAY!**

The DSM has increasingly pathologized our lives

Nicotine dependence
Caffeine dependence
Hypoactive Sexual Disorder
Orgasmic Disorder
Erectile Dysfunction

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**HOW SHOULD WE CONSTRUCT?**

Robins & Guze (1970)

Purported disorder should be able to demonstrate a number of distinguishing characteristics

Cantwell (1996)

Candidate disorder differentiates from other disorders by any/all of: clinical descriptors, psychosocial, demographic, biological, genetic, or family environment factors, natural history, or response to treatment
HOW SHOULD WE CONSTRUCT?

DSM-IV definitions fall significantly short of both of these goals

Little support has been found for many of the diagnostic rules in the DSM
  X amount of weeks duration
  X of X symptoms

Even with strict definitions, the way you ask about them can have huge impact on whether or not someone has a “disorder”

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EPIDEMIOLOGY

How are mental disorders counted?

By using epidemiology - the study of the distribution of diseases, disorders, or health-related behaviors in a given population

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PREVALENCE

The number of active cases in a population during any given period of time
  Typically expressed as percentages

Can be expressed as point prevalence, one-year prevalence, and lifetime prevalence
**INCIDENCE**

Incidence is the number of new cases in a population over a given period of time.

Does not count preexisting cases, so it’s lower than prevalence.

**PREVALENCE IN ADULTS**

- Any mood disorder: One-Year (%) vs. Lifetime (%)
- Any anxiety disorder: One-Year (%) vs. Lifetime (%)
- Any substance abuse disorder: One-Year (%) vs. Lifetime (%)
- Any disorder: One-Year (%) vs. Lifetime (%)

**MOST COMMON DISORDERS**

- Major depressive disorder: One-Year Prevalence (%) vs. Lifetime Prevalence (%)
- Alcohol abuse: One-Year Prevalence (%) vs. Lifetime Prevalence (%)
- Specific phobia: One-Year Prevalence (%) vs. Lifetime Prevalence (%)
- Social phobia: One-Year Prevalence (%) vs. Lifetime Prevalence (%)
- Conduct disorder: One-Year Prevalence (%) vs. Lifetime Prevalence (%)

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SHOULD WE COUNT?

NIMH Epidemiologic Catchment Area study and National Comorbidity Study had widely different prevalence rates for common problems.

Level of impairment may be more useful, but only if linked to need for services.

Why do we need point prevalence rates, when other health areas often don’t?

Reiger et al. (1998), Spitzer (1998)

HOW TO DIAGNOSE?

The objective determines implementation of decision making tools:

1. To determine who needs what care
2. To determine what clinicians do in practice (service research)
3. To determine who had a “valid” disorder for research purposes

HOW TO DIAGNOSE, THEN?

Use the LEAD standard:

- Longitudinal,
- Expert, and making use of
- All available
- Data

This includes assessment over time, consultation, and use of multiple informants

Spitzer (1983)
**HOW TO DIAGNOSE, THEN?**

1. Determine nature of presenting problem (who needs help and why)
2. Evaluate developmental, cultural, and contextual factors impacting presentation
3. Ascertain level of impairment
4. Understand key aspects of problematic behavior pattern(s)
5. Determine presence of comorbidity or other factors that would influence treatment

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**Conclusions**

Accepting that psychopathology is a social construct does not rob it of its importance

Are these constructs less important because they are socially constructed?

- Poverty and wealth
- Beauty and truth
- Physical disease