

# Conceptions of Psychopathology: A Social Constructionist Perspective

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A textbook about a subject should begin with a clear definition of the subject. Unfortunately, in the case of a textbook on psychopathology, definition is difficult if not impossible. The definitions or conceptions of *psychopathology* and related terms such as *mental disorder* have been the focus of heated debate throughout the history of psychology and psychiatry, and the debate is far from over (e.g., Gorenstein, 1984; Horwitz, 2002; Widiger, 1997). Despite many variations, the 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 entirely by societal and cultural values? The goal of this chapter is to address this question. Addressing it early is important because readers' views of everything they read in the rest of this book will be influenced by their views on this question.

A conception of psychopathology is not a theory of psychopathology (Wakefield, 1992a). A conception of psychopathology provides one definition of the term—it delineates 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 what psychological phenomena are considered pathological and thus need to be explained. A theory of psychopathology, however, provides an explanation of those psychological phenomena and experiences that have been identified by the conception as pathological. This chapter deals with conceptions of psychopathology. Theories and explanations can be found in a number of other chapters, including all of those in part II.

Understanding various conceptions of psychopathology is important for many 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 the term psychopathology or mental disorder for the word *disease* in this paragraph, Reznek's 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.

## TRADITIONAL CONCEPTIONS OF PSYCHOPATHOLOGY

Various 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 common sense conception of psychopathology is that pathological psychological phenomena are those that are abnormal or statistically deviant or infrequent. *Abnormal* literally means away from the norm. The word *norm* refers to what is typical or average. Thus, in this conception, psychopathology is viewed as deviation from psychological normality.

One of the merits of this conception is its commonsense appeal. It makes sense to most people to use terms 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, sadness following the death of a loved one).

A second benefit of 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 using 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 step is often accomplished 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 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.

Subjectivity first comes into play 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 offer 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 proven methods for developing a reliable and valid (i.e., it 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. There is no one 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 concurrent with the behavior.

We usually can observe and describe patterns in the way most people use the words intelligence and intelligent to describe their own behavior and that of 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 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, self-regulatory skills, artistic and musical abilities, 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 that change in values is the result of a dialogue or discourse among the people in society, both professionals and laypersons. One measure of intelligence may be more reliable than 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 scientifically derived.

Subjectivity also influences 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 (see the chapter on cognitive abilities in childhood). Yet the decision to use that convention is itself subjective. 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 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 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 behavior and experience 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 is effective for the person—if the behavior helps the person deal with challenge, cope with stress, and accomplish his or her goals—then we say the behavior is more or less adaptive. If the behavior does not help in these ways, or if the behavior makes the problem or situation worse, we say it is more or less maladaptive.

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. The distinction between adaptive and maladaptive, like the distinction between normal and abnormal, is fuzzy and often 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; their adaptiveness and maladaptiveness depends on the situations in which they are enacted and on the judgment and values of the observer. Even behaviors that are statistically rare and therefore abnormal are more or less adaptive under different conditions and more or less adaptive in the opinion of different observers. 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 of 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. Even so-called normal personality involves a good deal of occasionally maladaptive behavior, for which you can find evidence in your own life and the lives of friends and relatives. In addition, people given personality disorder diagnoses by clinical psychologists and psychiatrists often can manage their lives effectively and do not always behave in disordered ways.

Another problem with the psychopathological-equals-maladaptive conception is that determinations 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 *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association [APA], 2000) and in this textbook are both maladaptive and statistically rare. There are, however, major exceptions to this relationship. First, psychological phenomena that deviate from normal or average are not all maladaptive. In fact, sometimes deviation from normal is adaptive and healthy. For example, IQ scores of 130 and 70 are equally deviant from normal, 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, maladaptive psychological phenomena are not all statistically infrequent and vice versa. For example, shyness is very common and therefore is statistically frequent, but 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. This is not

to say that shyness is pathological but only that it makes it difficult for some people to live full and happy lives. The same is true of many of the problems with sexual functioning that are included in the DSM as mental disorders.

## 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 are not getting what they want out of life, and many feel that they are unable to do what they would like to do. They may feel inhibited or restricted by their situation, their fears or emotional turmoil, or by physical or other limitations. The individual may lack the necessary self-efficacy beliefs (beliefs about personal abilities), physiological or biological components, and/or situational opportunities to make positive changes (Bergner, 1997).

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 define personal distress and personal disability in vastly different ways, as do different mental health professionals and those in different cultures. Likewise, people differ in how much distress or disability they can tolerate. 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., sexual fetichisms, 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

Another conception views psychopathology as behavior that deviates from social or cultural norms. This conception is simply a variation of the conception of psychopathology as abnormality, except that in this case judgments about deviations from normality are made informally by people rather than formally according to 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 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 scientifically derived 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 book). Also, norms of a given culture change over time; therefore, conceptions of psychopathology also 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 19<sup>th</sup> 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 abnormal, but these people were far from psychologically unhealthy, at least by today's standards. Earlier in the 19<sup>th</sup> century, slaves who desired to escape from their owners were said to have "drapetomania." Today slavery itself, although still practiced in some parts of the world, is seen 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.

## CONTEMPORARY CONCEPTIONS: 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 (e.g., 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 approach is that it acknowledges that the conception of mental disorders must include a reference to social norms; however, this conception also tries to ground the concept of mental disorder in a scientific theory—that is, the theory of evolution.

Wakefield (1999) recently has reiterated this definition in writing that "a disorder attribution requires both a scientific judgment that there exists a failure of designed function and a value judgment that the design failure harms the individual" (p. 374). 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 psychoanalysis.

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 an evolutionarily designed mental mechanisms (itself an untestable hypothesis because of the occult nature of mental mechanisms) does not relieve us of the need to make value judgments about what is excessive or inappropriate in what circumstances. These value judgments are based on social norms, not on scientific facts, an issue that we will explore in greater detail later in this chapter.

Another problem with the HD conception is that it is a moving target. Recently, Wakefield modified the HD conception by saying that it refers not to what a mental disorder is but only to 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).

According to Sadler (1999), Wakefield's original goal was to "define mental disorders prescriptively [and to] help us decide whether someone is mentally disordered or not. [However, his current view] avoids making any prescriptive claims, instead focusing on explaining the conventional clinical use of the disorder concept [and he] 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" (pp. 433–434).

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 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, this book.)

## CONTEMPORARY CONCEPTIONS: 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. The DSM documents "what is currently understood by most scientists, theorists, researchers, and clinicians to be the predominant forms of psychopathology" (Widiger, this book). 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 book, 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 is clearly

illustrated by the definition of mental disorder found in the latest edition of the DSM, the DSM-IV-TR (APA, 2000):

*... 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 original 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 as, if not better than, any proposed so far. Nonetheless, it contains 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 people experience or how much disability must people exhibit before they are said to have a mental disorder? Who judges a person's degree of distress or disability? How do we determine whether a particular response to an event is expectable or culturally sanctioned? Who determines 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 sociocultural and interpersonal milieu in which the person is acting? 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 in which individuals are determined either to have or not have a disorder. 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 book). 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 (e.g., Lubinski, 2000). Great differences among individuals on the dimensions of interest are expected, such as the



differences we find on formal tests of intelligence. As with intelligence, divisions made 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.

Empirical evidence for the validity of a dimensional approach to psychological adjustment is strongest in the area of personality and personality disorders (Coker & Widiger, this book; Costello, 1996; Maddux & Mundell, 2005). 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 (Maddux & Mundell, 2005). The dimensional view of personality disorders also is 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., Oatley & Jenkins, 1992) indicates 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 useful descriptions of such patterns than are categories (Fraley & Waller, 1998). 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 rather, the condition occurs in degrees without a natural break between dyslexic and nondyslexic children (Shaywitz, Escobar, Shaywitz, Fletcher, & Makuch, 1992). Research on attention deficit/hyperactivity (Barkley, 1997) and posttraumatic stress disorder (Anthony, Lonigan, & Hecht, 1999) 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; Persons, 1986). The coiner of the term *schizophrenia*, Eugen 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, p. 204). (See also Walker, Bollini, Hochman, & Kestler, this book.) Finally, biological researchers continue to discover continuities between so-called normal and abnormal (or pathological) psychological conditions (Claridge, 1995; Livesley, Jang, & Vernon, 1998).

## SOCIAL CONSTRUCTIONISM AND CONCEPTIONS OF PSYCHOPATHOLOGY

If we cannot derive 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 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 cannot 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 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 instead are socially constructed. To do this is to engage in social constructionism, which 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” (Gergen, 1985, pp. 3–4). 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 on who does 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 *domestic violence* (Muehlenhard & Kimes, 1999), *child sexual abuse* (Holmes & Slapp, 1998; Rind, Tromovich, & 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). 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 such basic psychological constructs 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., 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, p. 6–7). 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 archeologist discovers a buried artifact or a medical researcher discovers a virus. Instead, they were invented (see Raskin & Lewandowski, 2000, in Neimeyer & Raskin). 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 derived from these values (Becker, 1963; Parker et al., 1995; Rosenblum & Travis, 1996). As McNamee and Gergen (1992) state: "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 defines 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.

These debates and struggles are described in detail by Allan Horwitz in *Creating Mental Illness* (2002). 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" (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 DMS-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). The new disorder then takes on an existence all its own and becomes a disease-like entity. As news about the disorder 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 used 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" is a valid "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 (p. 211). . . . 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. (p. 212) . . . disease judgments, like moral judgments, are not factual ones.*

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. (See also López & Guarnaccia, this book, and Widiger, this book.) 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 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), personality disorder (Alarcon et al., 1998), and dissociative identity disorder (formerly multiple personality disorder) (Spanos, 1996) 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 and about what makes life worth living. The number of pages increased from 86 in 1952 to almost 900 in 1994, and the number of mental disorders increased from 106 to 297. 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 found in the DSM-IV. 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 a 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.

The past few years have witnessed media reports of epidemics of internet addiction, road rage, pathological stock market day trading, and "shopaholism." Discussions of these new disorders have turned up at scientific meetings and in courtrooms. They are likely to find a

home in the next 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.

Those adopting the social constructionist perspective do not deny that human beings experience behavioral and emotional difficulties, sometimes very serious ones. They insist, however, that such experiences are not evidence for the existence of entities called mental disorders that then explain 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 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 using 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 psychopathological 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—any more than medicine is diminished by acknowledging that the notions of health and illness are socially constructed (Reznek, 1987), nor economics by acknowledging that the notions of poverty and wealth are socially constructed. Science cannot provide us with purely factual scientific definitions of these concepts. They are fluid and negotiated matters of value, not fixed matters of fact.

As Lilienfeld and Marino (1995) have said:

*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)*

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## Classification and Diagnosis: Historical Development and Contemporary Issues

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Aberrant, dysfunctional, and maladaptive thinking, feeling, behaving, and relating are of substantial concern to many different professions, the members of which will hold an equally diverse array of beliefs regarding etiology, pathology, and intervention. It is imperative that these persons be able to communicate meaningfully with one another. The primary purpose of an official diagnostic nomenclature is to provide this common language of communication (Kendell, 1975; Sartorius et al., 1993).

Official diagnostic nomenclatures, however, can be exceedingly powerful, impacting significantly many important social, forensic, clinical, and other professional decisions (Schwartz & Wiggins, 2002). Persons think in terms of their language, and the predominant languages of psychopathology are the fourth edition of the American Psychiatric Association's (1994, 2000) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and the tenth edition of the World Health Organization's *International Classification of Diseases* (ICD-10; 1992). As such, these nomenclatures have a substantial impact on how clinicians, social agencies, and the general public conceptualize psychopathology.

These two languages, however, are not the final word. Interpreting DSM-IV or ICD-10 as conclusively validated nomenclatures exaggerates the extent of their empirical support (Frances, Pincus, Widiger, Davis, & First, 1990). On the other hand, DSM-IV and ICD-10 are not lacking in credible or compelling empirical support. DSM-IV and ICD-10 contain many flaws but they are also well-reasoned, scientifically researched, and well-documented nomenclatures that describe what is currently understood by most scientists, theorists, researchers, and clinicians to be the predominant variants of psychopathology (Nathan & Langenbucher, 1999; Widiger & Trull, 1993). This chapter will overview the DSM-IV diagnostic nomenclature, beginning with historical background, followed by a discussion of major issues facing future revisions.

## HISTORICAL BACKGROUND

The impetus for the development of an official diagnostic nomenclature was the crippling confusion generated by its absence (Widiger, 2001). "For a long time confusion reigned. Every self-respecting alienist [the 19<sup>th</sup> century term for a psychiatrist], and certainly every professor, had his own classification" (Kendell, 1975, p. 87). The production of a new system for classifying psychopathology became a right of passage in the nineteenth century for the young, aspiring professor.

*To produce a well-ordered classification almost seems to have become the unspoken ambition of every psychiatrist of industry and promise, as it is the ambition of a good tenor to strike a high C. This classificatory ambition was so conspicuous that the composer Berlioz was prompted to remark that after their studies have been completed a rhetorician writes a tragedy and a psychiatrist a classification. (Zilboorg, 1941, p. 450)*

In 1908 the American Bureau of the Census asked the American Medico-Psychological Association (which subsequently altered its title in 1921 to the American Psychiatric Association) to develop a standard nosology to facilitate the obtainment of national statistics. This committee affirmed the need for a uniform system.

*The present condition with respect to the classification of mental diseases is chaotic. Some states use no well-defined classification. In others the classifications used are similar in many respects but differ enough to prevent accurate comparisons. Some states have adopted a uniform system, while others leave the matter entirely to the individual hospitals. This condition of affairs discredits the science. (Salmon, Copp, May, Abbot, & Cotton, 1917, pp. 255-256)*

The American Medico-Psychological Association, in collaboration with the National Committee for Mental Hygiene, issued a nosology in 1918, titled *Statistical Manual for the Use of Institutions for the Insane* (Grob, 1991; Menninger, 1963). This nomenclature, however, failed to gain wide acceptance. It included only 22 diagnoses, which were confined largely to psychoses with a presumably neurochemical pathology. "In the late twenties, each large teaching center employed a system of its own origination, no one of which met more than the immediate needs of the local institution" (American Psychiatric Association [APA], 1952, p. v). A conference was held at the New York Academy of Medicine in 1928 to develop a more authoritative and uniformly accepted manual. The resulting nomenclature was modeled after the *Statistical Manual* but it was distributed to hospitals within the American Medical Association's *Standard Classified Nomenclature of Disease*. Many hospitals used this system, but it eventually proved to be inadequate when the attention of the profession expanded well beyond psychotic disorders during World War II.

## ICD-6 and DSM-I

The Navy, Army, and Veterans Administration developed their own, largely independent nomenclatures during World War II mainly because of the inadequacies of the *Standard Classified*. "Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists, found themselves operating within the limits of a nomenclature specifically not designed for 90% of the cases handled" (APA, 1952, p. vi). The World Health Organization (WHO) accepted the authority in 1948 to produce the 6<sup>th</sup> edition of the *International Statistical Classification of Diseases, Injuries, and Causes of Death* (ICD). ICD-6 was the first to include

a section devoted to mental disorders (Kendell, 1975; Kramer, Sartorius, Jablensky, & Gulbinat, 1979), perhaps in recognition of the many psychological casualties of World War II and the increasing impact of mental health professions. The United States Public Health Service commissioned a committee, chaired by George Raines (with representations from a variety of professions and public health agencies), to develop a variant of the mental disorders section of ICD-6 for use within the United States. The United States, as a member of the WHO, was obliged to use ICD-6, but modifications could be made to maximize its acceptance and utility for use within the United States. The resulting nomenclature resembled closely the Veterans Administration system developed by Brigadier General William Menninger (brother to Karl Menninger, 1963). Responsibility for publishing and distributing this nosology was given to the American Psychiatric Association (1952) under the title *Diagnostic and Statistical Manual. Mental Disorders* (hereafter referred to as DSM-I).

DSM-I was generally successful in obtaining acceptance, mainly because of its expanded coverage, including somatoform disorders, stress reactions, and personality disorders. However, the New York State Department of Mental Hygiene, which had been influential in the development of the *Standard Nomenclature*, continued for some time to use its own classification. DSM-I also included narrative descriptions of each disorder to facilitate understanding and more consistent applications. Nevertheless, fundamental criticisms regarding the reliability and validity of psychiatric diagnoses were also raised (e.g., Zigler & Phillips, 1961). For example, a widely cited reliability study by Ward, Beck, Mendelson, Mock, and Erbaugh (1962) concluded that most of the poor agreement among psychiatrists' diagnoses was due largely to inadequacies of DSM-I.

ICD-6 was less successful. The "mental disorders section [of ICD-6] failed to gain [international] acceptance and eleven years later was found to be in official use only in Finland, New Zealand, Peru, Thailand, and the United Kingdom" (Kendell, 1975, p. 91). The WHO therefore commissioned a review by the English psychiatrist Erwin Stengel. Stengel (1959) reiterated the importance of establishing an official nomenclature:

*A serious obstacle to progress in psychiatry is difficulty of communication. Everybody who has followed the literature and listened to discussions concerning mental illness soon discovers that psychiatrists, even those apparently sharing the same basic orientation, often do not speak the same language. They either use different terms for the same concepts, or the same term for different concepts, usually without being aware of it. It is sometimes argued that this is inevitable in the present state of psychiatric knowledge, but it is doubtful whether this is a valid excuse. (Stengel, 1959, p. 601)*

Stengel attributed the failure of clinicians to accept the mental disorders section of ICD-6 to the presence of theoretical biases, cynicism regarding any psychiatric diagnoses (some theoretical perspectives opposed the use of any diagnostic terms), and the presence of abstract, highly inferential diagnostic criteria that hindered consistent, uniform applications by different clinicians.

## ICD-8 and DSM-II

Work began on ICD-8 soon after Stengel's (1959) report (ICD-6 had been revised to ICD-7 in 1955, but there were no revisions to the mental disorders). Considerable effort was made to develop a system that would be used by all of the member countries of the WHO. The final edition of ICD-8 was approved by the WHO in 1966 and became effective in 1968. A companion glossary, in the spirit of Stengel's (1959) recommendations, was to be published

conjointly, but work did not begin on the glossary until 1967 and it was not completed until 1972. "This delay greatly reduced [its] usefulness, and also [its] authority" (Kendell, 1975, p. 95). In 1965, the American Psychiatric Association appointed a committee, chaired by Ernest M. Gruenberg, to revise DSM-I to be compatible with ICD-8 and yet also be suitable for use within the United States. The final version was approved in 1967, with publication in 1968.

The diagnosis of mental disorders, however, was receiving substantial criticism during this time (e.g., Rosenhan, 1973; Szasz, 1961). A fundamental problem continued to be the absence of empirical support for the reliability, let alone the validity, of its diagnoses (e.g., Blashfield & Draguns, 1976). Researchers, however, took to heart the recommendations of Stengel (1959) by developing more specific and explicit criterion sets (Blashfield, 1984). The most influential of these efforts was produced by a group of neurobiologically oriented psychiatrists at Washington University in St. Louis. Their criterion sets generated so much interest that they were published separately in what has become one of the most widely cited papers in psychiatry (i.e., Feighner et al., 1972). Research has since indicated that mental disorders can be diagnosed reliably and do provide valid information regarding etiology, pathology, course, and treatment (Nathan & Langenbucher, 1999).

## ICD-9 and DSM-III

By the time Feighner et al. (1972) was published, work was nearing completion on the ninth edition of the ICD. The authors of ICD-9 had decided to include a glossary that would provide more precise descriptions of each disorder, but it was apparent that ICD-9 would not include the more specific and explicit criterion sets used in research (Kendell, 1975). In 1974, the American Psychiatric Association appointed a task force, chaired by Robert Spitzer, to revise DSM-II in a manner that would be compatible with ICD-9 but would also incorporate many of the current innovations in diagnosis. DSM-III was published in 1980 and was remarkably innovative, including (a) a multiaxial diagnostic system (most mental disorders were diagnosed on Axis I, personality and specific developmental disorders were diagnosed on Axis II, medical disorders on Axis III, psychosocial stressors on Axis IV, and level of functioning on Axis V), (b) specific and explicit criterion sets for all but one of the disorders (schizoaffective), (c) a substantially expanded text discussion of each disorder to facilitate diagnosis (e.g., age at onset, course, complications, sex ratio, and familial pattern), and (d) removal of terms (e.g., neurosis) that appeared to favor a particular theoretical model for the disorder's etiology or pathology (Spitzer, Williams, & Skodol, 1980).

## DSM-III-R

A disadvantage of DSM-III was that errors in criterion sets were as specific and explicit as the diagnostic criterion sets, and a number of such errors were soon apparent (e.g., panic disorder could not be diagnosed in the presence of a major depression). "Criteria were not entirely clear, were inconsistent across categories, or were even contradictory" (APA, 1987, p. xvii). The American Psychiatric Association therefore authorized the development of a revision to DSM-III to correct these errors. Fundamental revisions were to be tabled until work began on ICD-10. However, it might have been unrealistic to expect the authors of DSM-III-R to confine their efforts to refinement and clarification, given the impact, success, and importance of DSM-III.

*The impact of DSM-III has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians and researchers for*

*communicating about the disorders for which they have professional responsibility. Recent major textbooks of psychiatry and other textbooks that discuss psychopathology have either made extensive reference to DSM-III or largely adopted its terminology and concepts. (APA, 1987, p. xviii)*

It was not difficult to find persons who wanted to be involved in the development of DSM-III-R and most persons who were (or were not) involved wanted to have a significant impact. More persons were involved in making corrections to DSM-III than were used in its original construction, and, not surprisingly, there were many proposals for additions, revisions, and deletions. Four of the diagnoses approved for inclusion by the authors of DSM-III-R (i.e., narcissistic personality disorder, self-defeating personality disorder, late luteal phase dysphoric disorder, and paraphiliac rapism) generated so much controversy that a special ad hoc committee was appointed by the Board of Trustees of the American Psychiatric Association to reconsider their inclusion. A concern common to all four was that their inclusion might result in harm to women. For example, paraphiliac rapism might be used to mitigate criminal responsibility for rape and self-defeating personality disorder might be used to blame female victims for having been abused. Another concern was the lack of sufficient empirical support to address or offset these concerns. A compromise was eventually reached in which the two personality disorders and late luteal phase dysphoric disorder were included in an appendix (Endicott, 2000; Widiger, 1995); paraphiliac rapism was deleted entirely.

## ICD-10 and DSM-IV

By the time work was completed on DSM-III-R, work had already begun on ICD-10. The decision of the authors of DSM-III to develop an alternative to ICD-9 was instrumental in developing a highly innovative manual (Kendell, 1991; Spitzer et al., 1980). However, its innovations were also at the cost of decreasing compatibility with the ICD-9 nomenclature that was used throughout the rest of the world, which is problematic to the stated purpose of providing a common language of communication. In May of 1988 the American Psychiatric Association appointed a DSM-IV task force, chaired by Allen Frances (Frances, Widiger, & Pincus, 1989). Mandates for DSM-IV included better coordination with ICD-10 and improved documentation of empirical support.

The DSM-IV committee aspired to use a more conservative threshold for the inclusion of new diagnoses and to have decisions that were guided more explicitly by the scientific literature (Nathan & Langenbucher, 1999). Frances et al. (1989) suggested that "the major innovation of DSM-IV will not be in its having surprising new content but rather will reside in the systematic and explicit method by which DSM-IV will be constructed and documented" (p. 10). Proposals for additions, deletions, or revisions were guided by 175 literature reviews that used a specific format that maximized the potential for critical review, containing (for example) a method section that documented explicitly the criteria for including and excluding studies and the process by which the literature had been reviewed. Each of these reviews has since been published in three volumes of a DSM-IV Sourcebook (Widiger et al., 1994, 1996, 1997). Testable questions that could be addressed with existing data sets were also explored in thirty-six studies, which emphasized the aggregation of multiple data sets from independent researchers, and twelve field trials were conducted to provide reliability and validity data on proposed revisions. The results of the thirty-six studies and twelve field trials were published in the fourth volume of the DSM-IV Sourcebook (Widiger et al., 1998). Critical reviews of these 223 projects were obtained by sending initial drafts to advisors or consultants to a working group, by presenting drafts at relevant conferences, and by submitting drafts to peer-reviewed journals (Widiger, Frances, Pincus, Davis, & First, 1991).

## DSM-IV-TR

One of the innovations of DSM-III was the inclusion of a relatively detailed text discussion of each disorder, including information on age of onset, gender, course, and familial pattern (Spitzer et al., 1980). This text was expanded in DSM-IV to include cultural and ethnic group variation, variation across age, and laboratory and physical exam findings (Frances, First, & Pincus, 1995). Largely excluded from the text is information concerning etiology, pathology, and treatment as this material was considered to be too theoretically specific and more suitable for academic texts. Nevertheless, it had also become apparent that DSM-IV was being used as a textbook, and the material on age, course, prevalence, and family history was quickly becoming outdated as new information was being gathered.

Therefore, in 1997, the American Psychiatric Association appointed a DSM-IV Text Revision work group, chaired by Michael First (editor of the text and criterion sets for DSM-IV) and Harold Pincus (Vice-Chair for DSM-IV) to update the text material. No substantive changes in the criterion sets were considered, nor were any new additions, subtypes, deletions, or other changes in the status of any diagnoses implemented. In addition, each of the proposed revisions to the text had to be supported by a systematic literature review that was critiqued by a considerable number of advisors. The DSM-IV Text Revision (DSM-IV-TR) was published in 2000 (APA, 2000).

## ICD-11 and DSM-V

DSM-I, DSM-II, DSM-III, and DSM-IV were each coordinated, at least in timing, with an edition of the ICD (ICD-6, ICD-8, ICD-9, and ICD-10, respectively). If this coordination were to continue, DSM-V would begin in tandem with the development of ICD-11. However, the WHO experienced substantial difficulty completing all of the sections of the ICD (Kendell, 1991). The mental disorders section of ICD-10 was published in 1992, but to this day has still not been implemented officially within the United States. The WHO is unlikely to attempt again to revise the entire ICD. Future revisions will be confined to individual sections of the manual, each being revised on its own schedule. Revisions to the mental disorders section of the ICD may in fact be coordinated with the development of DSM-V (rather than vice versa) partly because of the recognized success of the recent editions of the DSM.

In 1999, a conference jointly sponsored by the National Institute of Mental Health (NIMH) and the American Psychiatric Association was held to identify the research that would most likely be informative for the authors of DSM-V (McQueen, 2000). Substantive issues emphasized by research planning work groups developed from this conference included (but were not limited to) cross-cultural issues, gender differences, developmental differences, the distinction between Axis I and Axis II, the definition of mental disorder, the threshold for diagnosis, the use of laboratory findings in diagnosis, the impact of neuroscience, and dimensional models of psychopathology (e.g., Alarcon et al., 2002; First et al., 2002; Lehman et al., 2002; Rounsaville et al., 2002). A series of more specific international conferences are likely to follow, leading up to a DSM-V task force that may not be formed until approximately 2005, with an anticipated publication of DSM-V in approximately 2010.

## CONTINUING ISSUES FOR DSM-V

The issues considered by the DSM-V research planning work groups (McQueen, 2002) will not necessarily be new or unique to DSM-V. In fact, some of them concern fundamental issues

that have been raised throughout the history of the diagnosis of mental disorders (Blashfield, 1984; Kendell, 1975; Zilboorg, 1941). Six issues worth highlighting in particular are (1) the definition of mental disorder and threshold for diagnosis, (2) multiple diagnoses (i.e., excessive diagnostic co-occurrence), (3) categorical versus dimensional models of classification, (4) culture and values, (5) gender, and (6) the inclusion of laboratory tests within diagnostic criterion sets. Each of these issues will be discussed briefly in turn.

## Definition of Mental Disorder and Threshold for Diagnosis

The boundaries of the diagnostic manual have been increasing with each edition, and there has been vocal concern that much of this expansion represents an encroachment into normal problems of living (Caplan, 1995; Folette & Houts, 1996). Diagnoses proposed for DSM-IV were ultimately included within an appendix primarily because they might be below an appropriate threshold for diagnosis, such as mixed anxiety-depressive disorder, age-related cognitive decline, and minor depressive disorder (Widiger & Coker, 2003). A difficult task facing the authors of DSM-V will be establishing a meaningful boundary between abnormal and normal psychological functioning. (See Maddux, Gosselin, & Winstead, this book, for a more detailed discussion of this issue.)

The extract that follows provides the definition of mental disorder presented in DSM-IV-TR (APA, 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 original 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. (American Psychiatric Association, 2000, p. xxxi)*

This definition was the result of an effort by the authors of DSM-III to develop specific and explicit criteria for deciding whether a behavior pattern (homosexuality in particular) should be classified as a mental disorder (Spitzer & Williams, 1982). The intense controversy over homosexuality has largely abated, but the issues raised in this historical debate continue to apply.

For example, in order to be diagnosed with pedophilia, DSM-III-R (APA, 1987) required only that an adult have recurrent intense urges and fantasies involving sexual activity with a prepubescent child over a period of at least six months and have acted on them (or be markedly distressed by them). Every adult who engaged in a sexual activity with a child for longer than six months would meet these diagnostic criteria. The authors of DSM-IV were therefore concerned that DSM-III-R was not providing adequate guidance for determining when deviant sexual behavior is the result of a mental disorder. Deviant behavior alone has not traditionally been considered sufficient for a diagnosis (Gorenstein, 1984). Presumably, some persons can engage in deviant, aberrant, and even heinous activities without being compelled to do so by the presence of psychopathology. The authors of DSM-IV, therefore, added the requirement that "the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 1994, p. 523).

*Require Presence of Pathology?* Spitzer and Wakefield (1999), however, have argued that the impairment criteria included in DSM-IV are inadequate. They concurred with a concern raised by the National Law Center for Children and Families that DSM-IV might contribute to a normalization of pedophilic and other paraphilic behavior by allowing the diagnoses not to be applied if the persons who have engaged in these acts are not themselves distressed by their behavior or do not otherwise experience impairment. In response, Frances et al. (1995) had argued that pedophilic sexual "behaviors are inherently problematic because they involve a nonconsenting person (exhibitionism, voyeurism, frotteurism) or a child (pedophilia) and may lead to arrest and incarceration" (p. 319). Therefore, any person who engaged in an illegal sexual act (for longer than six months) would be exhibiting a clinically significant social impairment and would therefore meet the DSM-IV threshold for diagnosis. However, using the illegality of an act as a diagnostic criterion presents three problems. First, it undermines the original rationale for the inclusion of the impairment criterion (i.e., to distinguish immoral or illegal acts from abnormal or disordered acts). Second, it provides no meaningful basis for determining when deviant sexual acts or fantasies are or are not due to a mental disorder. Third, it is inconsistent with the stated definition of a mental disorder that indicates that neither deviance nor conflicts with the law are sufficient to warrant a diagnosis (see previous APA definition). Spitzer and Wakefield argued that the distinction between disordered and nondisordered abuse of children requires an assessment for the presence of an underlying, internal pathology (e.g., irrational cognitive schema or neurochemical dysregulation).

Wakefield (1997) has provided examples of other criterion sets from DSM-IV less politically or socially controversial than pedophilia, which he has argued have also failed to make a necessary distinction between maladaptive problems in living and true psychopathology due to the reliance within the criterion sets on indicators of distress or impairment rather than references to pathology. For example, the DSM-IV criterion set for major depressive disorder currently excludes most instances of depressive reactions to the loss of a loved one (i.e., uncomplicated bereavement). Depression after the loss of a loved one can be considered a mental disorder, though, if "the symptoms persist for longer than two months" (APA, 1994, p. 327). Allowing two months to grieve before one is diagnosed with a mental disorder might be as arbitrary and meaningless as allowing a person to engage in a sexually deviant act only for six months before the behavior is diagnosed as a paraphilia. Similar concerns have been raised by Regier et al. (1998) regarding the diagnosis of common anxiety and mood disorders. They suggested that the prevalence rates for many of the anxiety, mood, and other mental disorders obtained by the NIMH Epidemiologic Catchment Area program (ECA) and the National Comorbidity Survey (NCS) were excessive. "Based on the high prevalence rates identified in both the ECA and NCS, it is reasonable to hypothesize that some syndromes in the community represent transient homeostatic responses to internal or external stimuli that do not represent true psychopathologic disorders" (Regier et al., 1998, p. 114).

The inclusion of pathology within diagnostic criterion sets (e.g., irrational cognitive schemas, unconscious defense mechanisms, or neurochemical dysregulations) would be consistent with the definition of mental disorder provided in DSM-IV, which states that the syndrome "must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (APA, 2000, p. xxxi; see previous APA definition). However, a limitation of this proposal is that there is currently little agreement over the specific pathology that should be required for any particular disorder. There is insufficient empirical support to give preference to one particular cognitive, interpersonal, neurochemical, psychodynamic, or other theoretical model of pathology. The precise nature of this pathology could be left undefined or characterized simply as an "internal dysfunction" (Wakefield, Pottick, & Kirk, 2002), but an assessment of an unspecified pathology is unlikely to be reliable. Clinicians will have



very different opinions concerning the nature of the internal dysfunction and quite different thresholds for its attribution.

The assumption that the expansion of the nomenclature is subsuming normal problems in living is itself questionable. Persons critical of the nomenclature have decried the substantial expansion of the diagnostic manual over the past 50 years (e.g., Caplan, 1995; Folletté & Houts, 1996; Kutchins & Kirk, 1997). It would have been more surprising, however, to find that scientific research and increased knowledge have failed to lead to the recognition of more instances of psychopathology (Wakefield, 1998). In fact, the current manual might still be inadequate in its coverage despite the expansion. Quite often, the most common diagnosis in general clinical practice is not otherwise-specified (NOS; Clark, Watson, & Reynolds, 1995). The NOS diagnosis is provided when a clinician has determined that psychopathology is present but the symptomatology fails to meet criteria for any one of the existing disorders. Clinicians providing the diagnosis of NOS for anxiety, mood, personality, and other disorders is a testament to the inadequate coverage currently provided (although perhaps one could argue as well that this is a testament to a tendency of clinicians to diagnose normal problems in living as being instances of mental disorder).

The inclusion of pathology within diagnostic criterion sets may even fail to result in a more conservative threshold for diagnosis. Irrational cognitive schemas and neurochemical dysregulations (Prigerson et al., 1999) might be found in the ostensibly normal cases of bereavement described by Regier et al. (1998) and Wakefield (1997). Pathology might also be present in the absence of any impairment or distress (Lehman et al., 2002). Optimal psychological functioning, as in the case of optimal physical functioning, might represent an ideal that is achieved by only a small minority of the population. The rejection of a high prevalence rate of psychopathology may reflect the best of intentions, such as concerns regarding the stigmatization of mental disorder diagnoses (Kutchins & Kirk, 1997) or the potential impact on funding for treatment (Regier et al., 1998). These social and political concerns, however, could also hinder a more dispassionate and accurate recognition of the true rate of a broad range of psychopathology within the population (Widiger & Sankis, 2000).

***Harmful Dysfunction or Dyscontrolled Maladaptivity?*** Wakefield (1992) has developed an alternative harmful dysfunction definition of mental disorder where dysfunction is a failure of an internal mechanism to perform a naturally selected function (e.g., the capacity to experience feelings of guilt in a person with antisocial personality disorder) and harm is a value judgment that the design failure is harmful to the individual (e.g., failure to learn from mistakes results in repeated punishments, arrests, loss of employment, and eventual impoverishment). Wakefield's model has received substantial attention and is being considered for inclusion in DSM-V (Rounsaville et al., 2002). However, the model has also received compelling criticism (e.g., Bergner, 1997; Kirmayer & Young, 1999; Lilienfeld & Marino, 1999). A fundamental limitation is its girding within evolutionary theory, thereby limiting its relevance and usefulness to alternative models of etiology and pathology (Bergner, 1997). Wakefield's model might even be inconsistent with some sociobiological models of psychopathology. Cultural evolution may at times outstrip the pace of biological evolution, rendering some designed functions that were originally adaptive within earlier time periods maladaptive in many current environments (Lilienfeld & Marino, 1999; Widiger & Sankis, 2000). For example, "the existence in humans of a preparedness mechanism for developing a fear of snakes may be a relic not well designed to deal with urban living, which currently contains hostile forces far more dangerous to human survival (e.g., cars, electrical outlets) but for which humans lack evolved mechanisms of fear preparedness" (Buss, Haselton, Shackelford, Bleske, & Wakefield, 1998, p. 538).

Missing from Wakefield's (1992) definition of mental disorder is any reference to dyscontrol. Harm within Wakefield's conceptualization of mental disorder is concerned with the presence of impairment, dysfunction with the presence of pathology. Mental disorders, however, are perhaps better understood as dyscontrolled impairments in psychological functioning (Kirmayer & Young, 1999; Klein, 1999; Widiger & Trull, 1991). "Involuntary impairment remains the key inference" (Klein, 1999, p. 424). Dyscontrol is one of the fundamental features of mental disorder emphasized in Bergner's (1997) significant restriction and Widiger and Sankis' (2000) dyscontrolled maladaptivity definitions of mental disorder.

Fundamental to the concept of a mental disorder is the presence of impairments to feelings, thoughts, or behaviors over which a normal (healthy) person is believed to have adequate control. To the extent that a person willfully, intentionally, freely, or voluntarily engages in harmful sexual acts, drug usage, gambling, or child abuse, the person is not considered to have a mental disorder. Persons seek professional intervention in large part to obtain the insights, techniques, skills, or other tools (e.g., medications) that increase their ability to better control their mood, thoughts, or behavior. In sum, impairment and dyscontrol might provide the optimal means with which to identify a meaningful boundary between, or an important parameter for quantifying, normal and abnormal psychological functioning, if these constructs are more precisely defined, calibrated, and assessed. (See also Maddux, Gosselin, & Winstead, this book.)

## Multiple Diagnoses

The difficulty in delineating a point of demarcation between normal and abnormal psychological functioning is paralleled by an equally fundamental problem of differentiating individual mental disorders from one another. "DSM-IV is a categorical classification that divides mental disorders into types based on criterion sets with defining features" (APA, 2000, p. xxxi). The intention of the diagnostic manual is to help the clinician determine which particular disorder is present, the diagnosis of which would purportedly indicate the presence of a specific pathology that would explain the occurrence of the symptoms and suggest a specific treatment that would ameliorate the patient's suffering (Kendell, 1975; Frances et al., 1995).

It is evident, however, that DSM-IV routinely fails in the goal of guiding the clinician to the presence of one specific disorder. Despite the best efforts of those who have been the primary authors of each revision, multiple diagnoses are the norm (Clark et al., 1995). It is rare for a patient to meet the DSM-IV-TR diagnostic criteria for just one mental disorder. The number of multiple diagnoses is even higher when one includes lifetime as well as current functioning and it might be remarkably high if all of the disorders within DSM-IV-TR are in fact considered. Excluded from prior epidemiologic studies have been many disorders (e.g., personality disorders and specific substance abuse disorders) that might increase even further the occurrence of multiple diagnoses (Widiger & Sankis, 2000).

In general medicine, the presence of multiple diagnoses would logically suggest the presence of multiple disorders (i.e., comorbidity). However, the frequency with which psychiatric patients routinely meet diagnostic criteria for three, four, five, and even more mental disorders has raised questions concerning the validity of this straightforward understanding. "The greatest challenge that the extensive comorbidity data pose to the current nosological system concerns the validity of the diagnostic categories themselves—do these disorders constitute distinct clinical entities?" (Mineka, Watson, & Clark, 1998, p. 380). Diagnostic comorbidity has become so prevalent that some argue for an abandonment of the term *comorbidity* in favor of a term (e.g., co-occurrence) that does not imply the presence of distinct clinical entities (Lilienfeld, Waldman, & Israel, 1994). There are instances in which the presence of multiple

diagnoses do suggest the presence of distinct yet comorbid psychopathologies, but in many instances the presence of co-occurring diagnoses does appear to suggest the presence of an etiology or pathology that is shared by the purportedly distinct disorders (Widiger & Clark, 2000).

## Categorical and Dimensional Models of Classification

There has been substantial interest in identifying a specific gene (or other form of specific etiology) for each mental disorder, modeled after the success obtained with some physical disorders. "As the rare Mendelian disorders such as cystic fibrosis and Huntington's disease are solved, the entire genetics community is, with great excitement, turning its attention to complex disorders . . . [and] psychiatric illnesses are fully and unquestionably viewed as part of the next challenge in mainstream genetics" (Hyman, 1998, p. 38). However, the complex disorders of psychopathology appear unlikely to have specific etiologies or even specific genetic etiologies (McGue & Bouchard, 1998), and initial successes in identifying specific genes have typically failed to replicate (Portin & Alanen, 1997). For example, up to 85% of the susceptibility to schizophrenia appears to be attributable to genetic contributions, but the extensive genome scan studies of schizophrenia currently "do not support the hypothesis that a single gene causes a large increase in the risk of schizophrenia" (Levinson et al., 1998, p. 741).

Categorical disease models are being challenged . . . by the recent data indicating that individuals may carry a genetic risk factor to develop a disorder that can be measured premorbidly . . . and that may or may not ultimately be expressed as the full form of the disorder, depending on the occurrence of a variety of factors" (Andreasen, 1997, p. 1587). There continues to be a hope of demarcating "a clear-cut, natural, qualitative subgroup" of psychopathology (Lenzenweger, 1999, p. 186), but it might be unrealistic to expect maladaptive cognitions, affects, and behaviors, or any particular constellation of symptoms, to have a specific etiology. Not only would this etiology have to have provided a uniquely and specifically important contribution to their development (Meehl, 1977), but the phenomenology of the disorder would also have to have been largely resilient to the potential impact of other genetic and environmental influences. The symptomatology of most mental disorders appears to be, in contrast, responsive to a wide variety of neurochemical, interpersonal, cognitive, and other mediating variables. Mental disorders are most likely the result of polygenetic dispositions and multiple, interacting etiologies (Rutter, 1997).

Many researchers are now turning their attention to the identification of underlying spectra of dysfunction that cut across the existing diagnostic categories. For example, Brown, Chorpita, and Barlow (1998) conducted a series of confirmatory factor analyses of the symptomatology evident among 350 anxiety and mood disorder patients. Their results confirmed the presence of latent dimensions of pathology (e.g., abnormal levels of positive affectivity and arousal), some of which cut across the mood and anxiety disorders (e.g., negative affectivity or neuroticism). In an extensive longitudinal epidemiological study, Krueger, Caspi, Moffitt, and Silva (1998) assessed a range of symptomatology in a large, unselected birth cohort in New Zealand at ages 18 and 21. Using structural equation modeling to examine cross-sectional and longitudinal co-occurrence patterns, they identified the presence of "stable, underlying 'core psychopathological processes'" (Krueger et al., 1998, p. 216). More specifically, Krueger et al. suggested that a broad domain of internalization (neuroticism or negative affectivity) underlies the mood and anxiety disorder diagnostic categories and a complementary factor of externalization (low constraint, disinhibition) underlies the disruptive behavior and substance use disorder diagnostic categories. Krueger (1999) obtained similar results in a confirmatory factor analysis of the patterns of co-occurrence among the diagnoses included within the NCS and concluded that "comorbidity results from common, underlying core psychopathological processes" (p. 921).

Lynam and Widiger (2001) aggregated the diagnostic co-occurrence among the personality disorder diagnoses obtained in fifteen previous studies. "Although high comorbidity presents a fundamental challenge to the validity of the categorical approach, it is easily accommodated within a dimensional model that views the categories as configurations of basic dimensions of personality" (Lynam & Widiger, 2001, p. 403). They indicated that when personality disorders are understood in terms of the domains and facets of the dimensional Five-Factor Model of general personality functioning, the apparent comorbidity is readily explained. A Five-Factor Model understanding of the personality disorders is presented in Coker and Widiger (this book).

A model for the future diagnosis of all mental disorders might be provided by one of the oldest and best validated diagnoses, mental retardation, a disorder for which much is known of its etiology, pathology, and classification. The point of demarcation for its diagnosis is an arbitrary, quantitative distinction along the normally distributed levels of the multivariate domain of intelligence. Mental retardation is diagnosed primarily on the basis of having an intelligence quotient (IQ) of 70 or below (APA, 2000). There are persons with an IQ less than 70 for whom a qualitatively distinct disorder is evident. However, this disorder is not mental retardation, it is a physical disorder (e.g., Down syndrome) that can be traced to a specific biological event (i.e., trisomy 21). Intelligence is itself distributed as a continuous variable. In addition, "in approximately 30%–40% of individuals seen in clinical settings, no clear etiology for the Mental Retardation can be determined despite extensive evaluation efforts" (APA, 2000, p. 45). Intelligence is the result of a complex array of multiple genetic, fetal and infant development, and environmental influences (Neisser et al., 1996). There are no discrete breaks in the distribution of intelligence that would provide an absolute distinction between normal intelligence and abnormal intelligence.

## Culture and Values

It is the intention of the authors of ICD-10 to provide a universal diagnostic system, but diagnostic criteria and constructs can have quite different implications and meanings across different cultures. DSM-IV addresses cultural issues in three ways. First, the text of DSM-IV provides a discussion of how each disorder is known to vary in its presentation across different cultures. Second, an appendix of culture-bound syndromes describes disorders that are currently thought to be specific to a particular culture. Third, an additional appendix provides a culturally informed diagnostic formulation that considers the cultural identity of the individual and the culture-specific explanations of the person's presenting complaints (Mezzich et al., 1997).

There is both a strong and a weak cross-cultural critique of current scientific understanding of psychopathology. The weak critique does not question the validity of a concept of mental disorder but does argue that social and cultural processes affect and potentially bias the "science of psychopathology and diagnosis: a) by determining the selection of persons and behaviors as suitable material for analysis; b) by emphasizing what aspects of this material will be handled as relevant from a [clinical] standpoint; c) by shaping the language of diagnosis, including that of descriptive psychopathology; d) by masking the symptoms of any putative 'universal' disorder; e) by biasing the observer and would-be diagnostician; and f) by determining the goals and endpoints of treatment" (Fabrega, 1994, p. 262). These concerns are not weak in the sense that they are trivial or inconsequential but they are relatively weak in that they do not necessarily dispute the fundamental validity of a concept of a mental disorder or the science of psychopathology. The strong critique, in contrast, is that the construct of mental disorder is itself a culture-bound belief that reflects the local biases of western society, and that the science of psychopathology is valid only in the sense that it is an accepted belief system of a particular culture (Lewis-Fernandez & Kleinman, 1995).

The concept of mental disorder does include a value judgment that there should be necessary, adequate, or optimal psychological functioning (Wakefield, 1992). However, this value judgment is also a fundamental component of the construct of physical disorder (Widiger, 2002). In a world in which there were no impairments or threats to physical functioning, the construct of a physical disorder would have no meaning except as an interesting thought experiment. Meaningful and valid scientific research on the etiology, pathology, and treatment of physical disorders occurs because in the world as it currently exists there are impairments and threats to physical functioning. It is provocative and intriguing to conceive of a world in which physical health and survival would or should not be valued or preferred over illness, suffering, and death, but this form of existence is unlikely to emerge anytime in the near future. Placing a value on adequate or optimal physical functioning might be a natural result of evolution within a world in which there are threats to functioning and survival. Likewise, in the world as it currently exists, there are impairments and threats to adequate psychological functioning. It is provocative and intriguing to conceive of a society (or world) in which psychological health would or should not be valued or preferred, but this form of existence is also unlikely to emerge anytime in the near future. Placing a value on adequate, necessary, or optimal psychological functioning might be inherent to and a natural result of existing in this world. Any particular definition of what would constitute adequate, necessary, or optimal psychological functioning would likely be biased to some extent by local cultural values, but this situation is perhaps best understood as only the failing of one particular conceptualization of mental disorder (i.e., a weak rather than a strong critique). Valuing adequate, necessary, or optimal psychological functioning could itself still be a logical and natural result of existing in a world in which there are threats to psychological functioning, just as placing a value on adequate, necessary, or optimal physical functioning would be a logical and natural result of existing in a world in which there are threats to physical functioning (Widiger, 2002).

Different societies, cultures, and even persons within a particular culture will disagree as to what constitutes optimal or pathological biological and psychological functioning (Lopez & Guarnaccia, 2000; this book). An important and difficult issue is how best to understand the differences between cultures with respect to what constitutes dysfunction and pathology (Alarcon et al., 2002). For example, simply because diagnostic criterion sets are applied reliably across different cultures does not necessarily indicate that the constructs themselves are valid or meaningful within these cultures (Lewis-Fernandez & Kleinman, 1995). A reliably diagnosed criterion set can be developed for an entirely illusory diagnostic construct. On the other hand, it is perhaps equally unclear why it would be necessary for the establishment of a disorder's construct validity to obtain cross-cultural (i.e., universal) acceptance. Lewis-Fernandez and Kleinman argue that it is necessary "to produce a comprehensive nosology that is both internationally and locally valid" (p. 435). A universally accepted diagnostic system will have an international social utility and consensus validity (Kessler, 1999), but it is also apparent that belief systems vary in their veridicality. Recognition of and appreciation for alternative belief systems is important for adequate functioning within an international community, but respect for alternative belief systems does not necessarily imply that all belief systems are equally valid (Widiger, 2002).

Kirmayer, Young, and Hayton (1995) illustrate well many of the complexities of cross-cultural research. For example, a woman's housebound behavior might be diagnosed as agoraphobic within western cultures but considered normative (or even virtuous) within a Muslim culture; submissive behavior that is diagnosed as pathologic dependency within western societies might be considered normative within the Japanese culture. However, simply because a behavior pattern is valued, accepted, encouraged, or even statistically normative within a particular culture does not necessarily mean it is conducive to healthy psychological functioning.

"In societies where ritual plays an important role in religious life . . . such societies may predispose individuals to obsessive-compulsive symptoms and mask the disorder when present" (Kirmayer et al., 1995, p. 507). "The congruence between religious belief and practice and obsessive-compulsive symptoms also probably contributes to relatively low rates of insight into the irrationality of the symptoms" (Kirmayer et al., p. 508). Behaviors diagnosed as disordered within one culture might be normative within another, but what is accepted, allowed, encouraged, or even statistically normative within a culture might still be pathological. On the other hand, it is equally important not to assume that what is believed to be associated with maladaptive (or adaptive) functioning in one culture should also be considered to be maladaptive (or adaptive) within all other cultures (Alarcon et al., 2002). "This possible tension between cultural styles and health consequences is in urgent need of further research" (Kirmayer et al., p. 517), and it is important for this research to go beyond simply identifying differences in behaviors, belief systems, and values across different cultures. This research also needs to address the fundamental question of whether differences in beliefs actually question the validity of any universal conceptualization of psychopathology or suggest instead simply different perspectives on a common, universal issue. (See Lopez & Guarnaccia, this book, for a more detailed discussion of culture and psychopathology.)

## Gender

Differential sex prevalence rates can be highly controversial as gender differences can reflect wider social, political controversies (Eagly, 1995). The diagnoses that generated the most controversy in the development of the recent editions of the DSM were problematic largely because of their questionable application to women (Ross, Frances, & Widiger, 1995). The basic charge was that the DSM is fundamentally flawed through its imposition of patriarchal or masculine biases of what does or should constitute psychopathology (e.g., Caplan, 1991, 1995). In perhaps one of the more widely cited critiques, Kaplan (1983) argued that "our diagnostic system, like the society it serves, is male centered" (p. 791) and that "masculine-biased assumptions about what behaviors are healthy and what behaviors are crazy are codified in diagnostic criteria" (p. 786). Pantony and Caplan (1991) characterized DSM-IV as "sex discrimination in one of its most damaging and dangerous forms" (p. 120).

The premenstrual dysphoric disorder diagnosis has been particularly controversial (Caplan, 1991; Ross et al., 1995). A majority of women may suffer from some form of premenstrual dysphoria. Only 3% to 5% of women would meet the DSM-IV diagnostic criteria for premenstrual dysphoric disorder, but the reliability of the distinction between normal premenstrual dysphoria and premenstrual dysphoric disorder in general clinical practice is questionable. DSM-IV requires daily ratings of mood for at least two months before the diagnosis is made, and it is unlikely that practicing clinicians or patients would actually adhere to this requirement. The pharmaceutical industry might also market treatments to women who are well below the threshold for the diagnosis, and attributions concerning the harm, pathology, and impairments of premenstrual dysphoria are often exaggerated and can be highly stigmatizing.

Histrionic personality disorder has been criticized for being too closely associated with stereotypic traits of femininity (Kaplan, 1983). Kaplan (1983) went so far as to argue that by virtue of being feminine "a healthy woman automatically earns the diagnosis of Histrionic Personality Disorder" (p. 789). There is no research to support the claim that normal, healthy women meet diagnostic criteria for histrionic personality disorder. Studies have indicated that the diagnostic criteria for this disorder include maladaptive variants of stereotypic feminine traits, but it is unclear whether this association is inappropriate for a personality disorder diagnosis. The inclusion of gender-related traits, however, does appear to contribute to the

occurrence of gender-biased applications of the diagnostic criteria and gender-biased assessment instruments (Widiger, 1998).

There may not be a disorder in DSM-IV for which gender differences have not been problematic and even controversial (Kaplan, 1983). Concerns about gender bias have been raised for almost every diagnosis, either with respect to the diagnostic criteria, the applications of these diagnostic criteria by clinicians, the assessment instruments used in research and clinical practice, or the populations that have been sampled (Hartung & Widiger, 1998). An issue for the authors of DSM-V is whether to revise diagnostic criteria to improve their gender neutrality or to develop different criterion sets for males and females. Currently, the same diagnostic criteria are used for males and females for all but a few of the disorders (the exceptions being gender-identity disorder and sexual dysfunctions), but the text of DSM-IV indicates how each respective disorder appears differently in males and females (Frances et al., 1995). Achieving gender-neutral diagnostic criteria for many of these disorders might be difficult (Sprock, Crosby, & Nielsen, 2001). On the other hand, separate diagnostic criteria could result in the creation of different disorders for each sex that might have even more problematic implications of gender bias (Wakefield, 1987; Zahn-Waxler, 1993). For example, Zoccolillo (1993) suggested that the diagnostic criteria for conduct disorder were gender biased because they described a masculine way in which the disorder is expressed. She suggested placing relatively more emphasis for girls on rule violations, substance abuse, prostitution, chronic lying, running away from home, and poor school performance and less emphasis on vandalism, fire setting, burglary, use of a weapon in fights, and rape. However, placing more emphasis on rule violations, rebelliousness, and deceitfulness for girls, and violent and aggressive behavior for boys, could have the effect of diagnosing (and stigmatizing) girls at a level of dysfunction that is much lower than is used to diagnose the disorder in boys (Zahn-Waxler, 1993). Zahn-Waxler suggested alternatively that the criterion set appropriately includes gender-related behaviors (e.g., rape) because the disorder is itself related to gender in its etiology and pathology. (See Winstead & Sanchez, this book, for a more detailed discuss of gender and psychopathology.)

### Laboratory Measures, Diagnostic Criteria, and Clinical Diagnosis

"Diagnoses in the rest of medicine are often heavily influenced by laboratory tests" (Frances et al., 1995, p. 22). Laboratory tests within medical practice go beyond the assessment of symptoms. They provide a more direct and objective assessment of an underlying physical pathology. A hope is that laboratory tests could do the same for psychiatry as they have done for other domains of medicine (Nemeroff, Kilts, & Berns, 1999; Rounsaville et al., 2002). "The increasing use of laboratory tests in psychiatric research raises the question of whether and when these tests should be included within the diagnostic criteria sets" (Frances et al., 1995, p. 22).

Substantial attention is being given to structural and functional brain imaging with the expectation that these instruments could be used eventually to diagnose neurophysiological pathology (Drevets, 2002; Epstein, Isenberg, Stern, & Silbersweig, 2002). However, clearly limiting these and other neurophysiological measures' potential for incorporation within diagnostic criterion sets is the virtual absence of research indicating their ability to provide independent, blind diagnoses. Despite the enthusiasm for their potential diagnostic value, there are currently no studies that have assessed the sensitivity and specificity of neuroimaging techniques for the diagnosis or differential diagnosis of specific mental disorders (Rounsaville et al., 2002; Steffens & Krishnan, 1998).



The inclusion of laboratory data in the diagnosis of a disorder has been particularly controversial for the sleep disorders. Most sleep disorder specialists use the International Classification of Sleep Disorders (ICSD) developed by the American Sleep Disorders Association (1990). The twelve DSM-IV sleep disorder diagnoses are coordinated with the ICSD, but differ significantly in failing to include polysomnographic diagnostic criteria (e.g., time of onset of rapid-eye-movement sleep). Detailed references are made to polysomnographic findings within the text of DSM-IV, and it was acknowledged by its authors that "for sleep disorders other than insomnia, such as narcolepsy and sleep apnea, the utility of sleep laboratory testing is widely accepted" (Buysse, Reynolds, & Kupfer, 1998, pp. 1104-1105). Nevertheless, polysomnography findings were not required because of the extensive cost of the technology and their lack of availability within many clinical settings (Buysse et al., 1998; Frances et al., 1995).

There is, however, a precedent in DSM-IV for the requirement of laboratory test findings obtained by a specialist. Laboratory tests are fundamental components of the diagnostic criteria for learning disorders and mental retardation. For example, "the essential feature of Mental Retardation is significantly subaverage general intellectual functioning... [and] general intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children, 3rd Edition; Stanford-Binet, 4th Edition; Kaufman Assessment Battery for Children)" (APA, 2000, p. 41). Psychological tests administered by a trained specialist using standardized equipment are essentially equivalent to the provision of laboratory testing. There are compelling concerns regarding the precise accuracy of IQ tests (Neisser et al., 1996), but routine diagnoses of mental retardation by practicing clinicians without the input of individually administered IQ tests would be substantially more problematic and controversial.

The precedent established by mental retardation and learning disorders should perhaps be extended to other disorders (Widiger & Clark, 2000). "Although diagnostic criteria are the framework for any clinical or epidemiological assessment, no assessment of clinical status is independent of the reliability and validity of the methods used to determine the presence of a diagnosis" (Regier et al., 1998, p. 114). The DSM-III innovation of providing relatively specific and explicit diagnostic criteria is not realized if clinicians do not in fact adhere to the criterion sets and assess them in a comprehensive, systematic, and consistent fashion (Rogers, 2001). Researchers would be hard pressed to get their findings published if they failed to document that their diagnoses were based on a systematic, replicable, and objective method, yet no such requirements are provided for clinical diagnoses, with the exception of mental retardation and learning disorders. Clinicians generally prefer to rely on their own experience, expertise, and subjective impressions obtained through unstructured interviews (Westen, 1997), but it is precisely this reliance on subjective and idiosyncratic clinical interviewing that often undermines the reliability and ultimately the validity of clinical diagnoses (Garb, 1998; Rogers, 2001).

One of the new additions to the text of DSM-IV was a section devoted to laboratory and physical exam findings. This material was intended to provide the initial step toward the eventual inclusion of laboratory tests within diagnostic criterion sets (Frances et al., 1995). A noteworthy exclusion from this text are references to psychological tests and instruments (Rounsaville et al., 2002; Widiger & Clark, 2000). It is ironic that psychological tests are included already within the criterion sets for mental retardation and learning disorders, yet virtually no reference is made to any psychological tests within the sections devoted to laboratory test findings.

The discussion of laboratory instruments is confined in DSM-IV to measures of neurophysiology (e.g., functional brain imaging and the dexamethasone suppression test). Semistructured interviews and self-report inventories that assess cognitive, behavioral, affective, or other components of psychological functioning that comprise explicitly the diagnostic criterion sets for these disorders, and for which substantial research already provides specificity and sensitivity



rates not obtained by the neurophysiological instruments, should at least be acknowledged along with the neurophysiological measures. The inclusion of additional psychological tests within diagnostic criterion sets might have professional implications for the necessary qualifications to render a clinical diagnosis. For example, it is unclear whether many psychiatrists and even some psychologists are sufficiently trained in the administration and interpretation of the most informative and valid psychological tests. In any case, the American Psychiatric Association has already developed an authoritative manual for the best "psychiatric" instruments for the assessment of each disorder included within DSM-IV (Rush et al., 2000).

## CONCLUSIONS

Nobody is fully satisfied with, or lacks valid criticisms of, DSM-IV and ICD-10. Zilboorg's (1941) suggestion that budding 19<sup>th</sup> century theorists and researchers cut their first teeth by providing a new classification of mental disorders still applies, although perhaps the right of passage today is to provide a critique of the ICD and/or DSM.

None, however, appear to be suggesting that all official diagnostic nomenclatures be abandoned. The benefits do appear to outweigh the costs (Salmon et al., 1917; Stengel, 1959; Regier et al., 1998). Everybody finds fault with this language, but there is at least the ability to communicate disagreement. Communication among researchers, theorists, and clinicians would be much worse in the absence of a common language.

Clinicians, theorists, and researchers will at times experience the frustration of being required to use the DSM or the ICD. It can be difficult to obtain a grant, publish a study, or receive insurance reimbursement without reference to a DSM-IV diagnosis. However, DSM-IV also provides a useful point of comparison that ultimately facilitates the development and understanding of a new way of conceptualizing psychopathology. Viable alternatives to particular sections of DSM-IV are being developed, some of which will eventually be incorporated within future revisions of the diagnostic manual. Their effective development will have been due in part to the existence of and empirical support for DSM-IV. DSM-IV and ICD-10 are the official diagnostic systems because of their substantial empirical support, theoretical cogency, and clinical utility. They provide a common language of communication and a well-validated foil for future contenders to overcome.

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