PART

I

THINKING ABOUT PSYCHOPATHOLOGY
CHAPTER 1

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
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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
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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 fetishisms, 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 evidence by American society’s changes over the past several decades in attitudes toward sex, race, and gender. For example, psychiatrists in the 1800s classified masturbation, especially in children and women, as a disease, and it was treated in some cases by clitoridectomy (removal of the clitoris), which
Western society today would consider barbaric (Reznek, 1987). Homosexuality was an official mental disorder in the DSM until 1973.

In addition, the conception of psychopathology as social norm violations is at times in conflict with the conception of psychopathology as maladaptive behavior. Sometimes violating social norms is healthy and adaptive for the individual and beneficial to society. In the 19th century, women and African-Americans in the 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 19th century, slaves who desired to escape from their owners were said to have “dрапетомания.” 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
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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 to not 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 con-
sidered 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 be-
tween 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 cat-
egorical 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 psy-
chological 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
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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
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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. p.##” 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 so basic a psychological construct as the self (Baumeister, 1987) and self-esteem (Hewitt, 2002) have changed over
time and the different ways they are conceived by different cultures (e.g., 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 profitaible. 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 of 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
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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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REFERENCES


