Defining Normality and Abnormality

Much of the practice and research conducted by clinical psychologists focuses on abnormality, also known as mental disorders, psychiatric diagnoses, or, more broadly, psychopathology. Through their training and their professional activities, clinical psychologists become very familiar with the definitions of various forms of abnormal behavior and the ways it differs from normal behavior. But before these diagnostic categories are put to use by clinicians and scholars, they must be defined.
What Defines Abnormality?

Over time, mental health professionals have put forth a variety of answers to the question of what makes behavior abnormal. These answers have included criteria such as personal distress to the individual (as in severe depression or panic disorder), deviance from cultural norms (as in many cases of schizophrenia), statistical infrequency (as in rarer disorders such as dissociative identity disorder), and impaired social functioning (as in social phobia and, in a more dangerous way, antisocial personality disorder).

In the 1990s, Jerome Wakefield, a renowned scholar in the field of abnormal psychology, offered a theory that put forth a more simplified (in comparison with the multifaceted criteria above) definition of mental disorders (Wakefield, 1992, 1999). His theory has generated enough support to become quite prominent in recent years. Wakefield (1992) explains his harmful dysfunction theory of mental disorders in the following way:

I argue that a 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. Thus, the concept of disorder combines value and scientific components. (p. 373)

The harmful dysfunction theory proposes that in our efforts to determine what is abnormal, we consider both scientific (e.g., evolutionary) data and the social values in the context of which the behavior takes place. As such, it can account for a wide range of behavior that clinical psychologists have traditionally labeled as psychopathological according to the multiple criteria listed above.

---

**BOX 7.1**

**Considering Culture**

**Typical but Abnormal?**

At one time or another, many of us have used the “everybody else is doing it” explanation to rationalize our aberrant behavior. Drivers who speed, kids who steal candy, partiers who drink too much, citizens who cheat on their taxes: Any of them might argue, “I’m not the only one,” and they’d be right. Should the commonality of a behavior affect the way we evaluate that behavior? If we tweak the question to consider abnormal (but not necessarily unlawful or unruly) behavior, does behavior become normal—and possibly, by extension, healthy or
acceptable—if lots of people engage in it? Or is it possible that abnormal is abnormal—and possibly, by extension, unhealthy or unacceptable—no matter how many people do it?

These questions are particularly relevant to the definition of mental illness, especially when we take cultural variables into account. Recently, Thomas A. Widiger and Stephanie Mullins-Sweatt (2008) considered the issue and came to this conclusion: “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” (p. 360). This statement suggests that it is possible for a behavior to be quite common, even conventional, within a culture yet pathological at the same time. They question whether numerous behavior patterns—extensive and meticulous rituals among some religious groups, patterns of interpersonal submission in some Asian cultures, and the practice of remaining house-bound among some Muslim women in certain parts of the world—might actually represent disordered behavior (obsessive-compulsive disorder, dependent personality disorder, and agoraphobia, respectively) despite their prevalence within the culture.

Do you agree with the idea that a behavior can be pathological within a particular culture even if it is common or typical within that culture? Why or why not? If so, can you think of examples in other cultures and in your own culture as well? And, importantly, who should determine the definitions of universal psychological wellness or disorder?

**Who Defines Abnormality?**

Wakefield's definition of abnormality, along with other definitions, continues to be debated by academics and researchers in the field (e.g., Lilienfeld & Marino, 1999; Wakefield, 2010). However, clinical psychologists have certainly not waited for a resolution of this scholarly debate before assigning, treating, and studying disorders. They use disorders—as defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the prevailing diagnostic guide for mental health professionals—every day as they perform assessments, conduct therapy, and design and execute research studies.

In the introductory pages of the latest versions of the *DSM* (DSM-5; American Psychiatric Association, 2013), its authors offer a broad definition of mental disorder. It is not entirely dissimilar to Wakefield's harmful dysfunction theory (Spitzer, 1999), yet it also incorporates aspects of the other criteria discussed above.

In *DSM-5*, mental disorder are defined as a “clinically significant disturbance” in “cognition, emotion regulation, or behavior” that indicate a “dysfunction” in “mental
functioning” that are “usually associated with significant distress or disability” in work, relationships, or other areas of functioning (American Psychiatric Association, 2013, p. 20). In addition, the definition states that expectable reactions to common stressors are not mental disorders.

Who created this definition, as well as the specific diagnostic categories that fill DSM? Many people played significant roles, but the most significant were those on the Task Force for each edition of DSM (American Psychiatric Association, 2013). This group consisted largely of leading researchers in various specialty areas within psychopathology who were selected for their scholarship and expertise in their respective fields. It is noteworthy that this task force consisted primarily of psychiatrists, and a relatively small number of psychologists and other mental health professionals were included. Moreover, the DSM-5 and all previous editions of the DSM have been published by the American Psychiatric Association (as opposed to the American Psychological Association). Thus, although the DSM has been used extensively by clinical psychologists and a wide range of other nonmedical mental health professionals (social workers, counselors, etc.), the authors who have had the most significant impact on its contents are medical doctors. So it should come as no surprise that the DSM reflects a medical model of psychopathology in which each disorder is an entity defined categorically and features a list of specific symptoms. (We discuss these aspects of DSM disorders in more detail later in this chapter.)

Besides their profession, what else do we know about the primary authors of the DSM? The first edition of the DSM, published in 1952, was created by the foremost mental health experts of the time, who were almost exclusively white, male, trained in psychiatry, at least middle age, and at least middle class. Especially with the most recent revisions of the DSM, deliberate efforts have been made to include more diversity among the contributors. In spite of this forward progress, some have remained critical: “The designers of the DSM-III and DSM-III-R (and to a lesser extent the fourth edition and the text revision) were still predominantly senior White male psychiatrists who embedded the document with their biases” (Malik & Beutler, 2002, pp. 5–6). As we will explore later in this chapter, the culture and values of those who define mental disorders can play an influential role in the definitions they produce.
Why is the Definition of Abnormality Important?

The process by which disorders are defined is much more than an academic exercise for scholars to debate. Instead, this process and the definitions it yields have very real consequences for professionals and nonprofessionals alike (Kinghorn, 2013; Widiger & Mullins-Sweatt, 2008).

As an example, consider **attenuated psychosis syndrome**. Currently, attenuated psychosis syndrome is not an official diagnostic category. Instead, it is listed as a **proposed criteria set** in the “Emerging Measures and Models” section of DSM-5 (American Psychiatric Association, 2013). This section describes conditions that DSM authors decided to leave out of the list of “official” disorders, at least for now, but to list as “unofficial” conditions for the purpose of inspiring clinicians and researchers to study them more. Attenuated psychosis syndrome (as described earlier in this chapter) is a bit like a “light” version of schizophrenia (“attenuated” means reduced or lessened). Its symptoms include delusions, hallucinations, and disorganized speech that are not severe or long-lasting. Its description also mentions that the person’s “reality testing”—their ability to stay in touch with the same reality that the rest of us experience—remains relatively intact. The symptoms must only be present once per week within the last month, but have been distressing or disabling.

**Importance for Professionals**

By listing attenuated psychosis syndrome as a proposed criteria set, the DSM authors have facilitated the study of attenuated psychosis syndrome by researchers and its consideration by clinicians. If attenuated psychosis syndrome becomes an official diagnosis, we will undoubtedly see an increase in both these activities. Additionally, if attenuated psychosis syndrome becomes official, people will be diagnosed with it and will be conceptualized (by professionals and themselves) as having this form of mental illness. On the other hand, if attenuated psychosis syndrome had never appeared in any form in any edition of DSM, it is less likely that researchers would study it or clinicians would add it to their professional vocabulary. And the same people who would have received the diagnosis, and the clinicians who might have assessed or treated them, would view these clients as slightly odd or eccentric, but not mentally ill. Thus, the presence or absence of a diagnostic label for a particular human experience has a powerful impact on the attention it receives from clinical psychologists.

**Importance for Clients**

For clients, future decisions by DSM authors about the status of attenuated psychosis syndrome may carry special significance. Some clients could experience beneficial consequences of being diagnosed with attenuated psychosis syndrome. Consider Lucinda, a woman whose experience over the past few months meets the criteria for attenuated...
psychosis syndrome. If this disorder was available as an official label, the label could help Lucinda identify and demystify an otherwise nameless experience; feel as though she shares a recognized problem with others (rather than feeling like the only one with the problem); acknowledge the significance of her experience with family, friends, and employers; and gain access to treatment that might have been unavailable without a diagnosis (especially if she uses health insurance to pay; Eriksen & Kress, 2005; Langenbucher & Nathan, 2006). On the other hand, Lucinda could also experience harmful consequences from being diagnosed with attenuated psychosis syndrome. The label could carry a stigma that damages her self-image; lead to stereotyping by individuals who know her or work with her; and even have an effect on the outcome of legal issues she may encounter, such as child custody cases, sentencing decisions, and fitness-to-stand-trial decisions (Butcher, Mineka, & Hooley, 2007; Eriksen & Kress, 2005).

Thus, the decisions DSM authors make when defining abnormality, both as a broad concept and as specific diagnostic categories, profoundly influence many aspects of clients’ lives.

**Diagnosis and Classification of Mental Disorders: A Brief History**

**Before the DSM**

Abnormal behavior garnered attention long, long before the first version of the DSM appeared. Discussion of abnormal behavior appears in the writings of ancient Chinese, Hebrew, Egyptian, Greek, and Roman societies (Butcher et al., 2007; Millon & Simonsen, 2010). Hippocrates (460–377 BCE) wrote extensively about abnormality, but unlike most of his predecessors, he did not offer supernatural explanations such as possession by demons or gods. Instead, his theories of abnormality emphasized natural causes. Specifically, he pointed to an imbalance of bodily fluids (blood, phlegm, black bile, and yellow bile) as the underlying reason for various forms of mental illness (Blashfield, 1991; Butcher et al., 2007). Although his specific theory is viewed by contemporary mental health experts as outdated, Hippocrates’ accent on natural causes of psychopathology was a significant early step toward more current definitions.

If we fast-forward from Hippocrates to the 19th century, we find an era when many cities in Europe and the United States were establishing asylums for the treatment of the mentally ill (as opposed to the imprisonment or abuse they might have suffered previously). In these inpatient treatment settings, mental health professionals had the opportunity to observe individuals with mental disorders for extended periods of time. In many such settings, a byproduct of this extended care was a list of categories into which clients could be
organized. One example occurred in France, where Philippe Pinel (discussed in more detail in Chapter 2) proposed specific categories such as melancholia, mania, and dementia, among others. Eventually, the staff of some of these institutions shared their idiosyncratic diagnostic systems with one another, and more common terminology evolved (Langenbucher & Nathan, 2006).

Around 1900, more important steps were taken toward the eventual DSM system that we currently use (Widiger & Mullins-Sweatt, 2008). Emil Kraepelin (also discussed in Chapter 2) labeled specific categories such as manic-depressive psychosis and dementia praecox (roughly equivalent to bipolar disorder and schizophrenia, respectively) (Millon & Simonsen, 2010). These and other contributions by Kraepelin have resulted in his reputation as a founding father of the current diagnostic system (Langenbucher & Nathan, 2006).

During the late 1800s and early 1900s, the primary purpose of diagnostic categories was the collection of statistical and census data. Later, in the mid-1900s, the U.S. Army and Veterans Administration (now Veterans Affairs) developed their own early categorization system in an effort to facilitate the diagnosis and treatment of soldiers returning from World War II (American Psychiatric Association, 2000; Office of the Surgeon General, Army Service Forces, 1946). This military categorization system was quite different from the most recent editions of the DSM, but it actually had significant influence on the creation of the first edition of the DSM, which appeared less than a decade later (Langenbucher & Nathan, 2006).

**DSM—Earlier Editions (I and II)**

*DSM-I* was published by the American Psychiatric Association in 1952. *DSM-II* followed as a revision in 1968. These two editions of the DSM were actually quite similar to each other, but as a pair, they were quite different from all the DSM editions subsequently published (Lilienfeld & Landfield, 2008). *DSM-I* and *DSM-II* contained only three broad categories of disorders: psychoses (which would contain today’s schizophrenia), neuroses (which would contain today’s major depression, bipolar disorder, and anxiety disorders), and character disorders (which would contain today’s personality disorders) (Blashfield, Flanagan, & Raley, 2010).

It is particularly noteworthy that the definitions of disorders in *DSM-I* and *DSM-II* were not scientifically or empirically based. Instead, they represented “the accumulated clinical wisdom of the small number of senior academic psychiatrists who staffed the DSM task forces” (Langenbucher & Nathan, 2006, p. 5). Most of these psychiatrists were psychoanalytic in orientation, and the language of the first two DSM editions reflected the psychoanalytic approach to understanding people and their problems. Additionally, the descriptions of individual disorders in *DSM-I* and *DSM-II* were not lists of specific symptoms or criteria; instead, they were simply prose, typically one paragraph per disorder, offering relatively vague descriptions of clinical conditions. As a result, the diagnostic categories in
DSM-I and DSM-II had very limited generalizability or utility for clinicians in practice at the time (Woo & Keatinge, 2008).

**DSM—More Recent Editions (III, III-R, IV, and IV-TR)**

**DSM-III**, published in 1980, was very dissimilar from DSM-I and DSM-II (Widiger & Mullins-Sweatt, 2008; Widiger & Trull, 2007). In comparison to DSM-I and DSM-II, it reflected an approach to defining mental disorders that differed substantially in some important ways (Decker, 2013; Whooley & Horwitz, 2013; Blashfield et al., 2010):

- It relied to a much greater extent on empirical data to determine which disorders to include and how to define them.
- It used specific diagnostic criteria to define disorders. Whereas the DSM-III retained some descriptive paragraphs (and in fact augmented them for most disorders), these paragraphs were followed by specific criteria—checklists, basically—that delineated in much greater detail the symptoms that must be present for an individual to qualify for a diagnosis.
- It dropped any allegiance to a particular theory of therapy or psychopathology. As a result, the psychoanalytic language of previous editions was replaced by terminology that reflected no single school of thought.
- It introduced the **multiaxial assessment** system that remained in DSM through the next several editions but was dropped in DSM-5. When multiaxial assessment was in place, the psychiatric problems were described on each of five distinct axes. Axis I included disorders thought to be more episodic (likely to have beginning and ending points), and Axis II included disorders thought to be more stable or long-lasting. Axes III and IV offered clinicians a place to list medical conditions and psychosocial/environmental problems, respectively, relevant to the mental health issues at hand. And Axis V, known as the Global Assessment of Functioning (GAF) Scale, provided clinicians an opportunity to place the client on a 100-point continuum describing the overall level of functioning.

The most immediately noticeable feature of DSM-III was its size: it was a significantly longer, more expansive diagnostic manual than its predecessors. For the disorders that had appeared in earlier editions, DSM-III offered extended descriptions and added lists of specific criteria. In addition, it included many new disorders—265 disorders in total, as compared with 182 in DSM-II and 106 in DSM-I. As a result of all these factors, DSM-III contained more than three times as many pages as DSM-II (Houts, 2002). Subsequent revisions to the DSM—DSM-III-R (American Psychiatric Association, 1987), DSM-IV (American Psychiatric Association, 1994), and DSM-IV-TR (American Psychiatric Association, 2000)—retained the major quantitative and qualitative changes instituted by DSM-III in 1980. DSM-5 retained many of these changes as well, although it also features some significant changes of its own (to be discussed in detail later in this chapter).
Table 7.1 offers an example of a specific disorder—generalized anxiety disorder, or “anxiety neurosis,” as it was previously described—defined at an early stage of DSM history (DSM-II; American Psychiatric Association, 1968) and at the most recent stage (DSM-5; American Psychiatric Association, 2013). In contrast to the current definition, several features of the DSM-II definition are noteworthy, including the psychoanalytically derived term neurosis in the title of the disorder and the use of a brief descriptive paragraph rather than the more detailed checklist of specific criteria.

### Table 7.1  Anxiety Neurosis/Generalized Anxiety Disorder as Defined in DSM-II and DSM-5

|---|---|
| This neurosis is characterized by anxious over-concern extending to panic and frequently association with somatic symptoms. Unlike Phobic neurosis, anxiety may occur under any circumstances and is not restricted to specific situations or objects. This disorder must be distinguished from normal apprehension or fear, which occurs in realistically dangerous situations | A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)  
B. The person finds it difficult to control the worry  
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children  
1. restlessness or feeling keyed up or on edge  
2. being easily fatigued  
3. difficulty concentrating or mind going blank  
4. irritability  
5. muscle tension  
6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)  
D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. |

(Continued)
Table 7.1 (Continued)

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).</td>
<td></td>
</tr>
<tr>
<td>F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).</td>
<td></td>
</tr>
</tbody>
</table>


**DSM-5—The Current Edition**

In May 2013, DSM-5 was published. It was the first substantial revision of the manual in about 20 years, and it was a massive effort. Led by two prominent mental health researchers, David Kupfer and Darrel Regier, it involved hundreds of experts from over a dozen countries contributing their time and expertise over a 12-year period that was particularly intensive in the last half-dozen years before its release (American Psychiatric Association, 2013; Kupfer et al., 2013; Regier, Kuhl, et al., 2013; Paris, 2013b, 2013c).

Many steps were involved in this huge undertaking. Early on, a Task Force—essentially, a committee of prominent researchers in various areas of mental disorders—was created. The members of this Task Force then led Work Groups, each of which focused on a particular area of mental disorders (e.g., the Eating Disorders Work Group, the
Psychotic Disorders Work Group). These Work Groups reviewed the disorders listed in the previous DSM and considered proposals for revision, including ideas for adding, eliminating, combining, splitting, or revising the definitions of disorders. The leaders also created a Scientific Review Committee of experts separate from the Work Groups whose job was to make sure that there was sufficient scientific evidence to support the changes proposed by the Work Groups (Kendler, in press). Later in the process, they conducted field trials for their proposed changes—in other words, they asked practicing clinicians to try using them with clients, with the intention of determining how reliable and clinically useful they were (Clarke et al., 2013; Regier, Narrow, et al., 2013; American Psychiatric Association, 2013).

Beginning in 2010, the DSM-5 authors maintained a website (dsm5.org) on which they communicated to the public about their progress, including posts of the drafts of proposed changes. The website also solicited comments from interested parties, whether professionals, clients, mental health advocacy groups, or any member of the public. And they received plenty—over 13,000 comments through the website, plus another 12,000 in other forms such as email and letters (Jeste et al., 2012; Porter, 2013; American Psychiatric Association, 2013).

Throughout the process, the DSM-5 authors tried to coordinate their efforts with those of the World Health Organization (WHO), which publishes the International Classification of Diseases (ICD). ICD, currently on its 10th edition with an 11th expected soon, is the primary way that diseases—both mental disorders and all other health-related problems—are coded and categorized in many countries outside the US. Greater consistency between DSM and ICD will allow better communication between countries and improved research design (Frances, 2013a, Regier, Kuhl, et al., 2013, Paris, 2013c; Frances & Nardo, 2013; American Psychiatric Association, 2013). (China also has its own system of classifying mental disorders, the Chinese Classification of Mental Disorders).

**Changes DSM-5 Didn’t Make**

The authors of DSM-5 made plenty of changes, but before we review them, let’s review the changes they considered but ultimately did not make. These are important because they illustrate decision-making processes used by the DSM-5 authors, the fact that not every proposal is adopted, and changes that may be reconsidered for future editions of the manual.

- Initially, the authors of DSM-5 considered significantly overhauling the manual to emphasize neuropsychology, or the biological roots of mental disorders. This would have been a significant paradigm shift in which the fundamental way we define mental disorders changes from descriptions of behavioral symptoms to biological evidence—in much the same way that many areas of medicine use blood tests, biopsies, x-rays, PET
scans, gene analyses, or other lab results to determine whether a person has a disease. However, it became evident to the DSM authors that mental health lags behind many other specialties in this regard. In other words, although there are many mental disorders that involve biological factors, those disorders lack definitive, reliable “biological markers”—the kinds of things that indicate that a person “tests positive” or “tests negative” in a conclusive way. Such biological markers may become known in time as neuroscience advances, but for now, research has simply not yet uncovered them clearly enough to use them as diagnostic tools (Paris, 2013b, 2013c; Pierre, 2013; Stringaris, 2013). As one author put it, “DSM-5 has been written for 2013, not for 2063 or 2113,” at which time the connections between mental disorders and their neurological or biological underpinnings will be sufficiently strong (Paris, 2013a, p. 41).

• Another across-the-board change that the DSM-5 authors considered was a shift toward a dimensional definition of mental disorders. This issue is discussed in more detail later in the chapter, but essentially, it involves viewing disorders not strictly in a categorical or “yes or no” way, but along a continuum. In other words, rather than describing a client only as either “having” or “not having” major depressive disorder, the clinician could rate the client’s depression symptoms (or another underlying characteristic) on a scale (e.g., a range of 1-10) (Whooley & Horwitz, 2013). Ultimately, this idea was rejected as too premature and overly complicated to justify such a comprehensive renovation of the manual, but the DSM-5 authors suggest that it may be seriously considered for future editions (DeFruyt et al., 2013; Phillips, 2013; Gore & Widiger, 2013; American Psychiatric Association, 2013).

• A dimensional approach was also seriously considered for a particular subset of mental disorders: personality disorders. As described later in this chapter, a significant body of research has accumulated to suggest that personality disorders fit best with the idea of dimensional, as opposed to strictly categorical, conceptualization. The DSM-5 authors proposed a specific way of understanding personality disorders dimensionally, but the proposal was rejected as being too complex and not clinically useful enough. Although it is not in effect, that proposal is included in a later section of DSM-5 called “Emerging Measures and Models” with the hope that researchers will study and possibly revise it for future consideration (Hopwood et al., 2013; Skodol et al., 2013; Black, 2013; American Psychiatric Association, 2013).

• Speaking of personality disorders, the DSM-5 authors considered removing 5 of the 10 personality disorders previously included in that section, a change that would have significantly reshaped that category. The five that were on the chopping block at one point were paranoid, schizoid, histrionic, dependent, and narcissistic personality disorders. The DSM-5 authors ultimately decided to retain all of them (Pull, 2013).

• There were numerous proposals for specific new disorders that were considered but rejected. Many of these appear in the “Emerging Measures and Models” section as
“proposed criteria sets” to enable researchers to conduct studies that will help determine whether they “make the cut” for future editions of DSM. Among them:

- *Attenuated psychosis syndrome*, which features the hallucinations, delusions, and disorganized speech characteristic of schizophrenia but in much less intense and more fleeting forms, and in which the person doesn’t touch with reality in a pervasive way (American Psychiatric Association, 2013; Frances, 2013a, Wakefield, 2013a; Tsuang et al., in press)

- *Mixed anxiety-depressive disorder*, which features some symptoms of anxiety, some symptoms of depression, but not enough of either to qualify for any existing disorder (such as generalized anxiety disorder or major depressive disorder) (American Psychiatric Association, 2013; Frances, 2012a)

- *Internet gaming disorder*, which features excessive and disruptive Internet game-playing behavior, and to a lesser extent, other disorders based on various non-substance addictive-related behaviors such as shopping, exercise, work, and sex (American Psychiatric Association, 2013; Wakefield, 2013a; Frances, 2013a; Greenberg, 2013; Kafka, 2013; King & Delfabbro, 2013; Petry & O’Brien, 2013)

**New Features in DSM-5**

Some of the most significant changes in DSM-5 do not focus on specific disorders, but on the way the entire manual is organized or presented. Among them:

- The title of the manual is not *DSM-V*, but *DSM-5*. That is, the authors deliberately shifted away from the traditional Roman numerals used in previous editions (e.g., *DSM-II*, *DSM-III*, *DSM-IV*) and toward Arabic numerals instead. The reason for this shift is to enable *DSM* more frequent minor updates that will be named just as changes to computer operating systems and applications are often named: *DSM-5.1*, *DSM-5.2*, etc. Thus, this naming change is not merely superficial. It suggests that *DSM* is a “living document” that, in the future, will be more quick to respond to new research that improves our understanding of mental disorders. No longer will we have to stick with a single, static version of *DSM* for a decade or two until the time arrives for a major revamp; instead, smaller-scale changes can be made more continuously. The “Emerging Measures and Models” section of the manual (mentioned above) goes hand-in-hand with this notion of a living document, as it prompts researchers and clinicians to consider conditions that have not yet been officially included in *DSM* but may, after more attention, be included in future editions (Whooley & Horwitz, 2013; Kraemer, 2013; Moran, 2013a; Paris, 2013b, 2013c; Wakefield, 2013a; Stringaris, 2013).

- The multiaxial assessment system—a central feature of *DSM* since its introduction in *DSM-III* in 1980—was dropped altogether from *DSM-5*. This change brings a number of important changes to the way clinicians diagnose clients. For example, the tradition of separate axes for disorders that tend to persist long-term (such as developmental disorders...
and personality disorders, formerly on Axis II) from disorders that tend to be more short-term or episodic (such as major depression, formerly on Axis I) is now gone. This could result in different conceptualizations of these disorders by researchers, clinicians, clients, or third-party-payers in the future. Also, Axis V, the Global Assessment of Functioning (GAF) scale, is now eliminated, so there is no longer a single numeric scale on which clinicians can describe their clients’ level of functioning across all disorders (although a questionnaire that clients complete themselves that the World Health Organization has created is included for future consideration in the “Emerging Measures and Models” section) (American Psychiatric Association, 2013; Kupfer et al., 2013; Paris 2013c, Wakefield, 2013a).

New Disorders in DSM-5

DSM-5 introduced a number of new disorders—not merely revisions or regroupings of existing disorders (as we’ll see in the next section), but disorders that at least to some extent cover problems that were not covered by any disorders in the previous edition of the manual. Among them:

- **Premenstrual dysphoric disorder** (PMDD; discussed in more detail in a box later in this chapter), which is essentially a severe version of premenstrual syndrome (PMS) including a combination of at least 5 emotional and physical symptoms occurring in most menstrual cycles during the last year that cause clinically significant distress or interfere with work, school, social life, or relationships with others (American Psychiatric Association, 2013; Paris, 2013b, Wakefield, 2013a; Regier, Kuhl, et al., 2013).

- **Disruptive mood dysregulation disorder** (DMDD), which is essentially frequent temper tantrums in children 6-18 years old (at least 3 tantrums per week over the course of a year) that are clearly below the expected level of maturity and occur in at least two settings (e.g., home, school, or with friends) along with irritable or angry mood between the temper tantrums. The creation of this new diagnosis was prompted by the drastic increase in the diagnosis (and possible overdiagnosis and overmedication) of bipolar disorder in children in recent decades (American Psychiatric Association, 2013; Pierre, 2013; Copeland et al., 2013, Frances & Bastra, 2013).

- **Binge eating disorder** (BED), which resembles the part of bulimia nervosa in which the person overindulges on food but lacks the part in which the person tries to subtract the calories through compensatory behaviors like excessive exercise. Binges must take place at least once per week for three months and be accompanied by a lack of control over the eating as well as other symptoms like rapid eating, eating until overly full, eating alone to avoid embarrassment, and feelings of guilt or depression afterward (American Psychiatric Association, 2013; Ornstein et al., 2013; Moran, 2013b, Stice et al., 2013).

- **Mild Neurocognitive Disorder** (mild NCD), which is essentially a less intense version of major neurocognitive problems like dementia and amnesia. It requires modest decline in
such cognitive functions as memory, language use, attention, or executive function, but nothing serious enough that it interferes with the ability to live independently (American Psychiatric Association, 2013; Blazer, 2013; Frances, 2013a).

- **Somatic symptom disorder** (SSD), which involves a combination of at least one significantly disruptive bodily (somatic) symptom with excessive focus on that symptom (or symptoms) that involves perceiving it as more serious than it really is, experiencing high anxiety about it, or devoting excessive time and energy to it (American Psychiatric Association, 2013; Frances & Chapman, 2013; Frances, 2012; 2013d).

- **Hoarding disorder**, in which the person has continuing difficulty discarding possessions no matter how objectively worthless they are, and as a result lives in a congested or cluttered home and experiences impairment in important areas such as work, socialization, or safety. In past DSMs, the diagnosis of obsessive-compulsive disorder may have been considered for hoarders, but their behavior often matched OCD criteria imperfectly, and with DSM-5, the criteria for hoarding are now distinct (American Psychiatric Association, 2013; Regier, Kuhl, et al., 2013; Greenberg, 2013).

**Revised Disorders in DSM-5**

In some cases, changes in DSM-5 involved established disorders being revised in some way—diagnostic criteria were modified, disorders were combined, or age limits were adjusted. Among the revisions:

- The so-called “bereavement exclusion” formerly included in the diagnostic criteria for major depressive episode was dropped. To explain, previous editions of DSM featured a statement that major depression could not be diagnosed in a person who was mourning (or bereaving) the death of a loved during the first two months following the death. The rationale for the exclusion was that the sadness that commonly comes with such loss should not be confused with the mental disorder of major depression. The decision to drop this statement in DSM-5 means that now the diagnosis can be given to people who lost a loved one within the last two months, but only if the clinician determines that the symptoms (sadness, changes in sleeping and eating, etc.) exceed expectations based on the person’s own history and culture. The rationale for dropping the exclusion was to make sure that people in mourning who are indeed experiencing abnormal levels of depressive symptoms will be recognized, diagnosed, and promptly treated before things get even more dire (American Psychiatric Association, 2013; Fox & Jones, 2013; Parker, 2013; Porter et al., 2013; Wakefield, 2013; in press).

- The DSM-IV diagnoses of autistic disorder, Asperger's disorder, and related developmental disorders were combined into a single DSM-5 diagnosis: autism spectrum disorder. The reason for consolidating these disorders is that, according to DSM-5 authors, they represent various points on the same spectrum of impairment, defined by social
communication problems and restrictive or repetitive behaviors and interests (American Psychiatric Association, 2013; Kupfer, Kuhl, et al., 2013; Regier et al., 2013; Mayes et al., 2013; Kent et al., 2013; Pina-Camacho et al., 2013). In other words, they now seen as mild, moderate, or severe versions of the same problem.

- In the criteria for attention-deficit/hyperactivity disorder (ADHD), the age at which symptoms must first appear was changed from 7 to 12 years old, and the number of symptoms required for the diagnosis to apply to adults was specified as 5 (as opposed to 6 for kids) (American Psychiatric Association, 2013; Paris, 2013a; Wakefield, 2013a; Frances, 2013a).

- In the criteria for bulimia nervosa, the frequency of binge eating required for the disorder was dropped from twice per week to once per week. In the diagnosis of anorexia nervosa, the requirement that menstrual periods stop has been omitted, and the definition of low body weight has been changed from a numeric definition (less than 85% of expected body weight) to a less specific description that takes into account age, sex, development, and physical health (American Psychiatric Association, 2013; Ornstein et al., 2013; Moran, 2013b).

- The two separate DSM-IV diagnoses of substance abuse and substance dependence have been combined into a single diagnosis: substance use disorder. Tolerance and withdrawal, which had been solely linked to substance dependence in DSM-IV (and confused with addiction), were not in fact solely experienced by those with substance dependence but also by people who use substances in various capacities (American Psychiatric Association, 2013; Hasin et al., 2013; Compton et al., in press).

- Mental retardation was renamed intellectual disability (intellectual development disorder), and learning disabilities in reading, math, and writing were combined into a single diagnosis with a new name: specific learning disorder (American Psychiatric Association, 2013).

**Controversy Surrounding DSM-5**

DSM-5 arrived in May 2013 amidst controversy that had already been swirling for many months (Cooper, 2013). The controversy extended well beyond academic journals and professional conferences into popular media such as magazines, newspapers, books, television, and websites geared toward the general public. Coverage of controversy extended well past the US into Europe, Australia, Asia, and South America (Frances, 2013e). Members of multiple Work Groups quit in the middle of the revision, publicly casting doubt on the process used to create the DSM-5 (Frances, 2012c; Greenberg, 2013). Letters of protest came from leaders of multiple mental health organizations, including Division 32 (Society of Humanistic Psychology) of the American Psychological Association, the American Counseling Association, and the British Psychological Society (Whooley & Horwitz, 2013; Greenberg, 2013). Numerous mental health professionals called for a boycott of DSM-5 (Caccavale, 2013; Frances, 2013g).

Almost all of the commentary surrounding DSM-5 was critical, and the most vocal critic was Allen Frances (Frances 2012a, 2012b, 2013a, 2013b, 2013c, 2013d, 2013e, 2013f, 2013g). It
is important to recognize that Frances was the Chair of the Task Force for DSM-IV—in other words, he led the previous revision of the manual that published in 1994, and as such he has direct experience with the enormous challenge and consequences of producing a new DSM. Frances had actually been retired for almost a decade, with no intention of being involved in DSM-5 at all, until he found himself at a cocktail party at the annual meeting of the American Psychiatric Association in 2009 and was pulled into the debate about DSM-5 by colleagues who informed him about the revision process (Frances, 2013a). Since that time, Frances has put forth a steady stream of articles, blog posts, radio and TV appearances, and even a full book on the flaws and failings of DSM-5. His tone has been consistently critical and condemning, and in many cases, he has been remarkably outspoken. For example:

- “This is the saddest moment in my 45-year career of studying, practicing, and teaching psychiatry. The Board of Trustees of the American Psychiatric Association has given its final approval to a deeply flawed DSM-5 containing many changes that seem clearly unsafe and scientifically unsound...Our patients deserve better, society deserves better, and the mental health professions deserve better.” (Frances, 2012b).

- “With the DSM-5, patients worried about having a medical illness will often be diagnosed with somatic symptom disorder, normal grief will be misidentified as major depressive disorder, the forgetfulness of old age will be confused with mild neurocognitive disorder, temper tantrums will be labeled disruptive mood dysregulation disorder, overeating will become binge eating disorder, and the already overused diagnosis of attention-deficit disorder will be even easier to apply” (Frances, 2013i).

- “[I have offered many] warnings about the risks that DSM-5 will mislabel normal people, promote diagnostic inflation, and encourage inappropriate medication use...Many other individuals, mental health organizations, professional journals, and the press have loudly sounded the very same alarm. We have had some positive impact...but overall we failed. DSM-5 pushes psychiatric diagnosis in the wrong direction...” (Frances, 2013a, p. x,iii).

- “My advice...is to ignore DSM-5...It is not well done. It is not safe. Don't buy it. Don't use it. Don't teach it.” (Frances, 2013f)

Frances is certainly not alone. Although few were quite so blunt, many others offered harsh criticism of many aspects of DSM-5 (e.g., Greenberg, 2013; Paris, 2013a, 2013c). What, specifically, did they criticize?

- **Diagnostic overexpansion.** The primary criticism of DSM-5, which is a continuation of a complaint of recent DSMs, is that its diagnoses cover too much of normal life —in other words, too often it takes difficult or inopportune life experiences and labels them as mental illnesses (Wakefield, 2013a). (The history of this criticism is covered later in this chapter, and the current version of the controversy is covered in more detail in Chapter 3.) These critics argue that prior to DSM-5, a woman with severe PMS, an aging adult whose memory isn't quite what it used to be, an adult who binges on food once a week and feels guilty
about it, and a child who throws temper tantrums were experiencing normal life struggles, but with the publication of *DSM-5*, they run the risk of being labeled mentally ill, with premenstrual dysphoric disorder, mild neurocognitive disorder, binge eating disorder and disruptive mood regulation disorder, respectively. These critics also point out that the addition of these disorders in *DSM-5* was often done in spite of questionable research evidence (Wakefield, 2013a, Frances, 2013a). They further emphasize the likelihood that the revisions in diagnostic criteria to existing disorders—the removal of the bereavement exception for major depressive episode, the older age by which ADHD symptoms may now start, the lower frequency requirement for binge eating for bulimia—will result in higher rates of these disorders (Wakefield, 2013b, in press; Fox & Jones, 2013; Parker, 2013). The only change likely to go against this trend is the consolidation of autistic disorder, Asperger's disorder, and similar developmental disorders into the single autism spectrum disorder (Frances, 2012b; Mayes et al., 2013; Dobbs, 2013). A possible explanation for this overexpansion—the pharmaceutical industry—is discussed in more detail in Chapter 3.

- **Transparency of the revision process.** Although the *DSM-5* authors maintained a website on which they shared information throughout the revision process, including proposals for changes to the manual, some critics argued that they were vague and selective about what they shared, that too many of their ideas and decisions were eventually made behind closed doors, and that the members of the Work Groups were required to sign confidentiality agreements to keep their processes out of public awareness (Frances, 2012c; Paris, 2013a; Cosgrove & Wheeler, 2013).

- **Membership of the Work Groups.** The decisions made by *DSM* authors depends, at least to some extent, on who those authors are. Those who were invited into the *DSM-5* revision process were, predominantly, researchers. Undoubtedly, they understand the disorders in their area of expertise in terms of designing and conducting empirical studies, but some of them do not practice at all, and those who do may only do so minimally, so their ability to assess the impact of *DSM* changes on full-time clinicians practicing in real-world clinics, hospitals, and private practices may have been lacking (Paris, 2013a, 2013c; Whooley & Horwitz, 2013). That is, the clinical utility of *DSM-5* may suffer from a lack of clinical practice experience among its authors. On the other hand, *DSM-5* also received criticism from the director of the National Institute of Mental Health (NIMH), a leading funding agency for mental health research, in which he announced that NIMH will be developing its own “Research Domain Criteria” (RDoC) by which to define mental health problems for research purposes. In the meantime, NIMH will show preference to research proposals that consider mental health issues across *DSM-5* categories, rather than within them (Insel, 2013). Also related to the membership of the Work Groups is the fact that some of these members have “pet” diagnostic proposals of their own, and that in the spirit of “the squeaky wheel gets the grease,” a Work Group member who promotes his or her pet proposal consistently and effectively had a better chance of a successful negotiation, resulting in *DSM-5* change, than someone who wasn’t invited into the Work Group in the first place (Shorter, 2013; Frances, 2013a).
• **Field Trial problems.** As mentioned earlier, the authors of DSM-5 ran field trials in which they tested the reliability of their new diagnoses with clinicians in real-world clinical settings. The problem, according to critics, is that some of the reliability ratings that these field tests produced were too low. In other words, these changes didn't yield sufficiently consistent diagnoses across clinicians. A second stage of field trials, in which some of these issues could have been corrected, was cancelled (Frances, 2012d, 2013a).

• **Price.** The list price for DSM-5 is $199 hardback, $149 paperback, and $149 ebook. By comparison, when DSM-IV was released in 1994, it cost $65 (Frances, 2013h). Some critics view this as a steep price for a book considered an essential reference for all mental health professionals, all students of clinical psychology, psychiatry, and related fields, and many health professionals more broadly. (It is worth noting that ICD, the manual of mental disorders used in other parts of the world outside the US, is available for free on the internet.) In fact, since the success of DSM-III in the 1980s, DSM proceeds have provided significant funding to its publisher, the American Psychiatric Association. Sadler (2013) reports that according to American Psychiatric Association treasurer reports, DSM-IV brought in between 5 and 6 million dollars per year between 2005 and 2011—years well after its initial publication, when sales might be even higher. These critics and others have questioned the extent to which profits might influence the price point of the book as well as the decisions made in the process of creating it.

---

**BOX 7.2**

**Considering Culture**

**Are Eating Disorders Culturally Specific?**

*DSM-5* (American Psychiatric Association, 2013) includes a Glossary of Cultural Concepts of Distress, which lists syndromes and experiences that are relatively unique to particular cultures. Do anorexia and bulimia belong on this list?

(Continued)
Currently, of course, anorexia and bulimia are included among the official *DSM* disorders rather than among the cultural concepts of distress, most of which originate outside the United States. But there is reason to question whether these disorders are culturally specific—after all, they are far more prevalent among females in industrialized, Western societies, especially the United States, than in other cultures and locations. Pamela K. Keel and Kelly L. Klump (2003) conducted an extensive study of this question, examining the incidence rates of anorexia and bulimia in Western and non-Western parts of the world, as well as the history of these two disorders before they were officially defined and labeled. In their review of previous studies on the subject, Keel and Klump stated that some researchers had put forth the argument that these eating disorders were limited to Western culture and were therefore culture-bound. Other researchers emphasized that factors besides culture, including genetics, were the primary causes of these disorders. Ultimately, Keel and Klump concluded that although anorexia did not meet their definition of a culture-bound condition, bulimia did. Among the evidence they cited was a study of eating disorders in Fiji where bulimic behaviors (especially self-induced vomiting and other compensatory behaviors) were virtually nonexistent until immediately following the introduction of television—which glamorizes Hollywood’s thinness-based definitions of female ideal body image — at which point these behaviors increased suddenly and dramatically (Becker, Burwell, Gilman, Herzog, & Hamburg, 2002).

The questions raised by Keel and Klump’s (2003) study are certainly important to clinical psychology. What separates a local, indigenous, “folk” syndrome from a bona fide, official disorder? Culture can certainly shape psychological problems, but can each culture create entirely unique disorders that are unrelated to disorders elsewhere? And, ultimately, to what extent should a clinical psychologist’s treatment of a client depend on whether the client’s problem is defined as culturally bound or more universal?

**Criticisms of the *DSM***

The most recent editions of *DSM* have been widely used by all mental health professions, and they undeniably represent improvements over their predecessors in some important ways. Strengths of recent editions include their emphasis on empirical research, the use of explicit diagnostic criteria, interclinician reliability, and atheoretical language (e.g., Klerman, 1984; Malik & Beutler, 2002; Matarazzo, 1983). Additionally, the *DSM* has facilitated communication between researchers and clinicians by providing a common professional language that has become very widely accepted (Lilienfeld & Landfield, 2008; Wilson, 1993). However, the recent *DSMs* have received significant criticism as well. We touched
on some of this criticism in our discussion of DSM-5 above; here, we consider those topics in more detail and other topics as well.

Breadth of Coverage

Recent editions of the DSM include many more disorders than editions published a relatively short time earlier. Some have argued that this expansion has been too rapid and that the result is a list of mental disorders including some experiences that should not be categorized as forms of mental illness (e.g., Burr & Butt, 2000; Langenbucher & Nathan, 2006; Pilgrim & Bentall, 1999). Houts (2002) points out that many of the newer disorders are not entirely “mental” disorders, including some disorders with physical factors such as the sexual disorders, substance-related disorders, and sleep disorders. Kutchins and Kirk (1997) and Caplan (1995) make the case that the DSM includes an increasing number of disorders that are better understood as problems in day-to-day life than as diagnosable mental illnesses—an argument not dissimilar to the one made decades ago by Thomas Szasz (1961, 1970), when the diagnostic manual was nowhere near as wide ranging. A potential risk of expanding the range of pathology this way is that greater numbers of people may face stigma associated with a diagnostic label, either from others or as self-stigma. Or the concept of mental illness may be spread too thin, which would solve the stigmatization problem but could result in the trivialization of any form of mental illness, such that they are not taken as seriously as they should be (Hinshaw & Stier, 2008). In addition, as psychological diagnoses multiply, the chances that they will overlap with one another increase, leading to a likelihood of comorbidity (diagnosis of more than one disorder) that some argue is excessively high (e.g., Kendall & Drabick, 2010).

Controversial Cutoffs

One of the essential differences between earlier and later editions of DSM is the presence of lists of specific symptoms and, moreover, specific cutoffs regarding those lists of symptoms. For example, the current diagnostic criteria for major depressive disorder include nine specific symptoms, at least five of which must be present for at least a 2-week period. Why a minimum of five symptoms rather than three, seven, or some other number? And why 2 weeks rather than 1 week, 1 month, or some other duration? Some have argued that these cutoffs have been arbitrarily or subjectively chosen by DSM authors and that, historically, the consensus of the DSM authors (as opposed to empirical data) has played a significant role in these cutoff decisions (Barlow & Durand, 2005; Widiger & Mullins-Sweatt, 2008). Similarly, many DSM diagnoses include criteria intended to establish a level of severity that must be met in order for the diagnosis to be assigned—statements that the symptoms must cause significant distress or impairment in various areas of the client's life, including interpersonal relationships or functioning at work/school. What, exactly, constitutes significant distress or impairment? And how are mental health professionals trained to make such a judgment? Such questions remain problematic in the
controversy over cutoffs that separate normal from abnormal functioning (Narrow & Kuhl, 2011; Spitzer & Wakefield, 1999).

**Cultural Issues**

When *DSM-IV* arrived in 1994, it signaled important advances in the consideration of cultural issues regarding mental disorders. *DSM-5* continues many of those advances. As described in Chapter 4, *DSM-5* includes an Outline for Cultural Formulation and the accompanying Cultural Formulation Interview designed to help clinicians assess in a culturally competent way. It also includes a glossary of cultural concepts of distress, or terms used by various cultural groups to describe specific psychological conditions. In addition, for many disorders, the text describing the disorder now includes comments on cultural variations, such as the way a disorder may be expressed differently in different cultures. For example, in the paragraphs describing schizophrenia, *DSM-5* contains several paragraphs on cultural issues, including such statements as “Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another” (American Psychiatric Association, 2013, p. 103).

Despite this considerable progress toward improving cultural sensitivity, the recent editions of *DSM* have received pointed criticism for shortcomings related to culture (e.g., Mezzich, Kleinman, Fabrega, & Parron, 1996). For example, although more ethnic minorities and women were included among the authors of recent *DSMs* than earlier editions, these authors weren’t creating a new *DSM* from scratch. Instead, they were revising an established manual that was originally created by a group of authors that was overwhelmingly white and male. So although their input was valued and incorporated, its impact was limited to revisions of previously confirmed *DSM* decisions rather than a more substantive renovation (Velasquez, Johnson, & Brown-Cheatham, 1993).

Also, although the recent revisions of the *DSM* have been praised for basing decisions on empirical data, critics have questioned the extent to which culturally diverse populations are included among the participants in those empirical studies. In fact, some detractors of the *DSM* have stated that very few of the empirical studies considered by the authors of the current *DSM* have focused sufficiently on ethnic minorities, which suggests that the *DSM* still may not reflect minority experiences (e.g., Markus & Kitayama, 1991; Mezzich et al., 1996). The implicit values of Western culture have been the focus of some *DSM* critics as well. They argue that these values are embedded in the *DSM* and that they don’t encompass the values of many people from non-Western societies. Specifically, Eriksen and Kress (2005) explain that in comparison with the traditional Western view, the majority of the world’s population believes that the boundaries between an individual and the people or environment surrounding him or her are more permeable and that interdependence between individuals, rather than striving for independence and self-sufficiency, is highly valued.
The DSM conceptualizations of some disorders (such as some psychotic disorders, some personality disorders, and a number of others) may presume a Western worldview (Lewis-Fernandez & Kleinman, 1994).

**Gender Bias**

Some disorders are diagnosed far more often in males: alcohol use disorder, conduct disorder, ADHD, and antisocial personality disorder, to name a few. Other disorders are diagnosed far more often in females: major depression, many anxiety disorders, eating disorders, borderline personality disorder, histrionic personality disorder, and others (American Psychiatric Association, 2013; Cosgrove & Riddle, 2004). Critics of the current DSM have argued that some diagnostic categories are biased toward pathologizing one gender more than the other. Specifically, these diagnoses may represent exaggerations of socially encouraged gender roles, suggesting that society, rather than or in addition to the individual, plays a prominent role in their emergence (e.g., Caplan & Cosgrove, 2004; Kutchins & Kirk, 1997; Yonkers & Clarke, 2011). Some empirical studies have found that clinicians define mental health differently for males and females (e.g., Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Ritchie, 1994; Sherman, 1980) and that clients of different genders with identical symptoms often receive different diagnoses from clinicians (Becker & Lamb, 1994). The controversy over premenstrual dysphoric disorder (PMDD), which had been rejected from previous editions of DSM but is now included as a disorder in DSM-5, has renewed this criticism of DSM authors. See Box 7.3 for more on PMDD.

---

**Box 7.3**

**Premenstrual Dysphoric Disorder**

One of the most notable new disorders listed in DSM-5 is premenstrual dysphoric disorder (PMDD) to the DSM-5. It falls within the “Depressive Disorders” category, along with major depressive disorder and other disorders that center around sad or irritable mood. According to its description, PMDD should not be equated with premenstrual syndrome, or PMS, which is more common and less severe than PMDD. Instead, PMDD requires either “clinically significant distress” or “interference with work, school, usual social activities, or relationships with others” (p. American Psychiatric Association, 2013, p. 172) The diagnosis of PMDD requires at least 5 symptoms from a list of 11 occurring in most menstrual cycles of the past year during the week before the menstrual period, at least one of which is mood-related (e.g., mood swings, irritability, sadness) and at least one of which is behavioral or physical

(Continued)
(Continued)

(e.g., trouble concentrating, lack of energy, changes in eating or sleeping, breast tenderness or swelling, or pain in joints or muscles).

There is no question that some women experience severe premenstrual symptoms that meaningfully influence their lives. There is a question, however, as to whether that experience should be labeled a mental illness. Some benefits could certainly accompany the diagnosis of PMDD: It could legitimize the severity of the experience for women who receive the diagnosis, provide an explanation for their symptoms, elicit compassion from others, prevent misdiagnosis under another category, and enable treatment (Gallant & Hamilton, 1988). However, there may also be some drawbacks to the diagnosis of PMDD. Specifically, for a woman who has received the diagnostic label of PMDD and shared it with others, it may pose a significant challenge to convince other people (e.g., employers, friends, family) that she is not psychologically abnormal (Caplan, 1992). Moreover, the presence of a PMDD diagnosis in a woman’s medical record could have an effect on legal cases in which she is involved. For example, in a custody dispute, a woman with a PMDD diagnosis may be at a distinct disadvantage compared with a woman with identical symptoms for which no diagnostic category exists (Caplan, 1992; Eriksen & Kress, 2005).

The idea of a PMDD diagnosis has generated controversy since it was first proposed in the 1980s (under the name “Late Luteal Phase Dysphoric Disorder” at the time). It was considered for inclusion in previous editions of DSM, and listed in an appendix of conditions to be considered for the future in DSM-IV in 1994, but it became a full-fledged disorder in 2013 with the publication of DSM-5. Feminist groups in particular have opposed its inclusion as an official disorder in the DSM. They have emphasized that it represents a form of gender bias likely to overpathologize women, especially since there is no parallel diagnosis for men despite the fact that men also experience some degree of hormonal fluctuations. Additionally, they have pointed out that although premenstrual symptoms can be problematic, they are better understood as physical or gynecological problems rather than a form of mental illness, especially since they last a short time and subside on their own without treatment. Opponents of the proposed PMDD diagnosis have also criticized the quality and quantity of the research on PMDD, concluding that it does not substantiate PMDD as a distinct form of mental illness (Caplan, 1992, 1995; Caplan & Cosgrove, 2004; Eriksen & Kress, 2005).

Many questions relevant to contemporary clinical psychologists arise from the PMDD debate. Where should we draw the line between acknowledging diagnosable mental illness and the unpleasant or problematic aspects of normal life? What quantity and quality of empirical research should be necessary to support the inclusion of a new disorder in the DSM?
Looking ahead, these questions also apply not only the new disorders included in *DSM-5*, but to its “proposed criteria sets” as well—in other words, the non-official conditions that are being considered for official status in a future edition of DSM. These conditions include Internet Gaming Disorder (based on excessive use of Internet games leading to distress or impairment), Nonsuicidal Self-Injury (based on “cutting” or otherwise harming the surface of one’s own body), Persistent Complex Bereavement Disorder (based on prolonged severe grief after the loss of a loved one), and Attenuated Psychosis Syndrome (based on relatively mild and infrequent experiences of hallucinations, delusions, and disorganized speech).

**Nonempirical Influences**

Authors of recent editions of the *DSM* have increasingly used empirical evidence to determine the diagnostic categories, and the manual is certainly more reliable as a result. However, nonempirical influences have intruded on the process to some extent, according to various commentators on the *DSM* process (e.g., Blashfield, 1991; Caplan, 1995; Kutchins & Kirk, 1997). At times, political wrangling and public opinion may have pressured *DSM* authors to make certain decisions. For example, once-proposed disorders such as masochistic personality disorder have been strongly and publicly opposed by political organizations, and decisions not to include them officially in the *DSM* may stem in part from this opposition. The changing status of homosexuality—which was an official disorder in *DSM-I* and *DSM-II*, was a disorder only if “ego-dystonic” (in other words, if it caused distress) in *DSM-III*, and has been absent from the manual since *DSM-III-R*—also may reflect efforts during the 1970s and 1980s by organized groups to influence the mental health establishment as well as changing values in *DSM* authors and society more generally.

In addition to politics and public opinion, financial concerns may have played a role in some *DSM* decisions, according to some (e.g., Blashfield, 1991; Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006; Kirmayer & Minas, 2000). As increasing numbers of therapy clients paid via health insurance in the last several decades of the 1900s, clinicians found that, typically, the health insurance companies required a diagnosis for payment. As it happens, the number of *DSM* diagnoses expanded substantially around that time. Also, pharmaceutical companies sponsor a substantial number of research projects on various forms of psychopathology, including those that are proposed and under consideration for future inclusion in the *DSM*. As mentioned earlier in this chapter, quite a few *DSM* authors have financial ties to these companies (Cosgrove et al., 2006; Cosgrove & Krimsky, 2012). Of course, drug companies stand to boost profits when new diagnostic categories, and the new client “markets” that come along with them, are created.
Limitations on Objectivity

No matter how much the DSM authors emphasize empiricism in the process of defining mental disorders, there is a limit to their objectivity. In fact, the leading authors of the DSM-IV and DSM-IV-TR stated themselves that “although based on empirical data, DSM-IV decisions were the results of expert consensus on how best to interpret the data” (Frances, First, & Pincus, 1995, p. 34). To some extent, the opinions of these experts can be influenced by changes in our society: “Throughout the manufacture of the DSM, people are making decisions and judgments in a social context. Whether or not a new set of behaviors warrants a diagnostic label depends on culturally varying judgments about what is clinically significant” (Houts, 2002, p. 53).

Alternative Directions in Diagnosis and Classification

DSM has always offered a categorical approach to diagnosis. The word categorical refers to the basic view that an individual “has” or “does not have” the disorder—that is, they can be placed definitively in the “yes” or “no” category regarding a particular form of psychopathology. Popular and professional language reflects this categorical approach: “Does my child have ADHD?”; “Some of my clients have bipolar disorder”; “Michael has obsessive-compulsive disorder.”

In recent years, and especially regarding some disorders (e.g., personality disorders), noncategorical approaches to psychopathology have received significant attention and empirical support. Specifically, the dimensional approach has been proposed by a number of researchers and clinicians (e.g., Blashfield, 1991; Costa & Widiger, 2001; Trull & Durrett, 2005; Widiger & Trull, 2007). According to a dimensional approach, the issue isn’t the presence or absence of a disorder; instead, the issue is where on a continuum (or “dimension”) a client’s symptoms fall. As an example, consider Robert, a client with a strong tendency to avoid social situations because he fears criticism and rejection from others. A categorical system would require Robert’s psychologist to determine whether Robert has a particular disorder—perhaps social phobia or avoidant personality disorder. A dimensional system wouldn’t require a yes or no answer to the question. In place of this dichotomous decision, Robert’s psychologist would be asked to rate Robert on a continuum of anxious avoidance of social situations. In other words, rather than a “black-or-white” type of decision, Robert’s psychologist would determine which “shade of gray” best describes Robert’s symptoms.
The dimensions of psychological disorders may not be defined by traditional DSM categories. Instead, proponents of the dimensional approach to abnormality suggest that all of us—the normal and the abnormal—share the same fundamental characteristics but that we differ in the amounts of these characteristics that we each possess. What makes some of us abnormal is an unusually high or low level of one or more of these characteristics.

But what are these fundamental shared characteristics? The five-factor model of personality (also known as the “Big Five” model) is the leading candidate, at least for the personality disorders, and perhaps more broadly (Costa & Widiger, 2001; Widiger & Mullins-Sweatt, 2009; Widiger & Trull, 2007). In other words, according to the dimensional approach to abnormality, each of our personalities contains the same five basic factors—neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness. These five factors, rather than the disorders listed in the DSM, could constitute the dimensions on which clinical psychologists could describe clients with personality problems. Thus, in the case of Robert described above, instead of giving him a high rating on a dimension called “avoidant personality disorder” or “social phobia,” the clinician would give the client a low rating on the dimension of extraversion.

(As mentioned earlier in this chapter, the authors of DSM-5 seriously considered a dimensional make-over of the personality disorders, but ultimately decided against it, at least for now.)

Conceptualizing people's psychological problems the way DSM always has—categorically—certainly has many advantages. In fact, some have argued that categorical thinking is unavoidable and essential to our understanding and communication about mental disorders: “Just as water is basic to human existence, classification is fundamental to human cognition. As human beings, we are hardwired to think in categorical terms. Human cognition without categorization is unimaginable” (Blashfield & Burgess, 2007, p. 113). Perhaps most important, categories of mental illness facilitate efficient communication between professionals as well as nonprofessionals. If we instead conceptualized people's psychological problems dimensionally, communication would necessarily become more cumbersome. Moreover, generations of mental health professionals have been trained to understand psychopathology categorically, so it has become firmly established as the preferred model (Lilienfeld & Landfield, 2008), and accumulating evidence suggests that some specific disorders, such as the psychotic disorders, may indeed exist categorically rather than dimensionally (Linscott & van Os, 2010). However, the dimensional model offers some interesting advantages as well. It allows for a more thorough description of clients. Also, rather than arbitrarily dividing a dimension into two categories, it allows for more detailed placement on that dimension. Although clinical psychologists currently work within the categorical DSM system, a growing body of research supports the possible incorporation of a dimensional model.
of psychopathology, perhaps in some kind of combination with categorical approaches and at least with the personality disorders (Achenbach, 2009; Costa & Widiger, 2001; Maser et al., 2009; Simonsen, 2010; Skodol, 2010; Widiger & Trull, 2007). Although this dimensional model was not used to revamp the personality disorders section of DSM-5, it may appear in some form in a future edition of the manual.

---

**BOX 7.4**

**Metaphorically Speaking**

**If You’ve Eaten Chocolate Chip Cookies, You Understand the Dimensional Model of Psychopathology**

Chocolate chip cookies are usually made from the same short list of ingredients: flour, sugar, chocolate chips, butter, eggs, baking soda, vanilla. If you bite into a chocolate chip cookie and it tastes unusual, atypical, or even “abnormal,” what’s the reason? Perhaps it contains the same ingredients as other chocolate chip cookies but simply in different amounts—more sugar, less butter, fewer chocolate chips—than “normal” cookies. In other words, the difference between “abnormal” and “normal” cookies could be quantitative. Or maybe the “abnormal” cookie contains some entirely different ingredients that “normal” cookies simply don’t contain—nutmeg, cinnamon, pepper, garlic, or something else. In this case, the difference is qualitative.

The proponents of the dimensional model of psychopathology believe that the same question of qualitative versus quantitative differences between normality and abnormality applies to people as well as to chocolate chip cookies. They believe that all our personalities are made of the same short list of “ingredients,” or traits. In the past few decades, they have increasingly pointed to the Big Five—neuroticism, extraversion, openness, conscientiousness, and agreeableness—as characteristics that are common to all of us, including normal and abnormal individuals. According to the dimensional model, what is abnormal about abnormal people is the amount of one of these basic ingredients—extremely high neuroticism, extremely low extraversion, or extremely high openness, for example. In other words, abnormal people have the same “ingredients” as normal people but in significantly different amounts—a quantitative difference. In contrast, supporters of
the categorical approach to psychopathology tend to believe that the difference between abnormal and normal people is more qualitative, suggesting that abnormal people have an “ingredient” that normal people simply don’t have.

Certain forms of psychopathology tend to lend themselves to the dimensional model more than do others. Specifically, a growing body of research suggests that the personality disorders can be conceptualized quite well using the dimensional approach based on the Big Five personality factors (e.g., Widiger & Mullins-Sweatt, 2009; Widiger & Trull, 2007). This makes some intuitive sense: If human personality essentially consists of these five factors and we have a category of disorders called “personality disorders,” it stands to reason that the personality disorders we have identified should map onto the five factors of personality we have recognized. Empirical support for this theory has suggested several specific links: Paranoid personality disorder is characterized by very low agreeableness; histrionic personality disorder is characterized by very high extraversion; obsessive-compulsive personality disorder is characterized by very high conscientiousness; borderline personality disorder is characterized by very high neuroticism. Evidence linking the Big Five to other disorders, however, is less impressive (Costa & Widiger, 2001).

The debate regarding the dimensional and categorical models of psychopathology evokes important questions for clinical psychologists. Are people, in fact, all made of the same psychological “ingredients”? If so, should we understand the differences between abnormal and normal people as quantitative? Or are we made of entirely different “ingredients,” and would it be more advantageous to understand our differences as qualitative? How might the answers to these questions influence the assessment and treatment that clinical psychologists conduct?

CHAPTER SUMMARY

Diagnosis is a primary task of clinical psychologists, but the process of defining mental disorders, and abnormality more generally, has been the subject of some debate. The DSM is generally considered the authoritative source of definitions for mental disorders, and it is widely accepted and used among mental health professionals. The DSM has been revised several times since its original publication by the American Psychiatric Association in 1952. The most recent edition, DSM-5, was published in 2013 and offers numerous new features, new disorders, and revised definitions of previously included disorders, many of which have
elicited controversy and criticism. The DSM has always employed a medical model of psychopathology characterized by a categorical approach that describes disorders as either present or absent. An alternative, dimensional approach has been promoted in recent years, especially for the personality disorders, which would describe the extent to which clients have particular universal characteristics rather than whether or not they have a disorder. The DSM has become increasingly empirical and reliable as it has been revised, but it has also received criticism for pathologizing aspects of normal life, using arbitrary cutoffs regarding some diagnostic criteria, paying insufficient attention to issues of culture and gender, and allowing nonempirical factors too much influence.

**KEY TERMS AND NAMES**

<table>
<thead>
<tr>
<th>Term</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>abnormality</td>
<td>151</td>
</tr>
<tr>
<td>categorical approach</td>
<td>176</td>
</tr>
<tr>
<td>Diagnostic and Statistical Manual of Mental Disorders (DSM)</td>
<td>153</td>
</tr>
<tr>
<td>dimensional approach</td>
<td>176</td>
</tr>
<tr>
<td>DSM-I</td>
<td>157</td>
</tr>
<tr>
<td>DSM-II</td>
<td>157</td>
</tr>
<tr>
<td>DSM-III</td>
<td>158</td>
</tr>
<tr>
<td>DSM-III-R</td>
<td>158</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>158</td>
</tr>
<tr>
<td>DSM-IV-TR</td>
<td>158</td>
</tr>
<tr>
<td>DSM-5</td>
<td>160</td>
</tr>
<tr>
<td>Emil Kraepelin</td>
<td>157</td>
</tr>
<tr>
<td>harmful dysfunction theory</td>
<td>152</td>
</tr>
<tr>
<td>Jerome Wakefield</td>
<td>152</td>
</tr>
<tr>
<td>medical model of psychopathology</td>
<td>154</td>
</tr>
<tr>
<td>multiaxial assessment</td>
<td>158</td>
</tr>
<tr>
<td>premenstrual dysphoric disorder (PMDD)</td>
<td>173</td>
</tr>
<tr>
<td>proposed criteria set</td>
<td>155</td>
</tr>
<tr>
<td>five-factor model of personality</td>
<td>177</td>
</tr>
</tbody>
</table>

**CRITICAL THINKING QUESTIONS**

1. In your opinion, what factors are most important in distinguishing abnormal from normal behavior?

2. In your opinion, who should define normal versus abnormal behavior?

3. How might the changes in the DSM-5 influence both clinical psychologists and the clients they treat?

4. Of the criticisms of the current DSM described in this chapter, which seem most and least legitimate?

5. In your opinion, what are the strengths and weaknesses of the categorical and dimensional approaches to diagnosis?
STUDENT STUDY SITE RESOURCES

Visit the study site at www.sagepub.com/pomerantz3e for these additional learning tools:

- Self-quizzes
- E-flashcards
- Culture Expert Interviews
- Full-text SAGE journal articles
- Additional web resources
- Mock Assessment Data

QR codes at the end of each chapter link to chapter background videos by the author. Visit http://gettag.mobi using your smartphone browser to download the free Microsoft Tag app. Once installed, scan the tags to go directly to these brief videos.