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CLASSIFICATORY CHALLENGES IN PSYCHOPATHOLOGY

Harold Kincaid

1. Introduction

Psychiatry, clinical psychology, and other professions that deal with psychopathology, abnormal behavior, and personal psychological problems naturally try to distinguish among the different kinds of phenomena and behavior they encounter. Basic research about the causes and courses of psychopathology and about appropriate treatment depends on sorting the various psychological problems that professionals see into distinct categories. However, there is considerable controversy about how to do that and how those categories are to be understood.

Psychiatrists, who have MD degrees, naturally approach psychopathology with a medical model and think in terms of different diseases or mental illnesses. However, medicine usually picks out diseases by identifying localizable lesions, malfunctions, or infectious agents that cause the symptoms of a disease; yet few if any psychiatric disorders are currently understood in terms of such physical causes.

In North America and much of the world, psychological disorders are classified according to the *Diagnostic and Statistical Manual of Mental Disorders*, produced by the American Psychiatric Association (2013), or other quite similar classification schemes such as the *International Classification of Diseases*, produced by the World Health Organization (2015). The purported disorders in these manuals vary greatly in nature. Some of them do not really look like diseases at all: In the DSM, homosexuality and non-standard gender identities were at one time classified as disorders. Individuals given these labels do not seem to have disorders or diseases in the way that someone who hears voices instructing him or her to murder seems to be mentally ill. Rather, these labels seem to be about behaviors that are socially disapproved.

Social science studies of the processes that produce classification manuals show a variety of interest groups and sociological factors at work in constructing classification schemes that do not seem to promote objectively identifying diseases. Moreover, the classification manuals for psychiatric disorders have very open-ended definitions of disorders, often allowing two individuals to be classified in the same way without having any symptoms in common. These facts have led some critics to doubt that the currently dominant classification systems of psychopathology are identifying diseases and to argue that they are instead a reflection of societal norms being used illegitimately to turn ordinary problems in living into medical problems. Some
critics think current systems can be reformed to identify disease; others think the problems are inevitable in any classification systems similar to those currently used.

Because current classification systems are widely used and influence how psychological problems are treated by professionals and how research on them is done, these disputes are of great practical import. The key issues thus revolve around the ability of current and future classification systems to group individuals objectively in ways that inform decisions about treatment and research. In what follows, I first provide some illustrative cases of psychological disorders to use as reference points in our discussion. Then a more detailed outline of the issues at stake follows after that. I look at three approaches to the classification of psychopathology: an approach based on the medical disease model, approaches that emphasize the role of social disapproval of abnormal behavior, and a third position that tries to bridge the first two approaches.

2. Some Illustrative Cases

Describing some cases of typical behavior that can be classified as psychopathology will be useful for the rest of our discussion. The cases that follow are fictional but nonetheless are representative of real-world situations.

Alex was a blue-collar worker in a small Midwestern U.S. city. Alex first started showing symptoms of depression in his early 20s. Aside from a very sad mood, Alex had major difficulties sleeping, very low energy, very low self-esteem, feelings of guilt, and difficulties being around people. Several individuals in his family—a grandfather and uncle—had had similar problems. Alex underwent electroshock treatment and eventually returned to normal. Yet his problems returned at regular intervals, and despite treatment with the latest antidepressant medication, Alex eventually committed suicide at age 44.

Jean, Alex’s wife, suffered similar symptoms to those of Alex after his death. She was left with two children to raise and no income; she also experienced very low mood, severe feelings of guilt, difficulty in sleeping, and so on. Yet after six to nine months, her difficulties became manageable and she went on to live a relatively happy and successful life. Her symptoms never returned, though of course like everyone she had her down days.

Shannon lived in the same small Midwestern U.S. city as Alex and Jean. Shannon was born male, but from early on just did not behave like most boys do. His mannerisms were described by those around him as effeminate. In Shannon’s early teens, he began to dress on occasion as a woman and had an online identity as a female. By his late teens, Shannon had adopted a female gender. She felt much more at ease with her new identity, yet her behavior met with a fair amount of ridicule and disapproval in the relatively conservative community where Shannon lived. This produced some distress for her and caused her at times to feel conflicted about her new gender identity.

Alex, Jean, and Shannon all saw psychiatrists. Alex and Jean were diagnosed with major depressive disorder and Shannon with gender identity disorder. (Shannon’s classification has recently been changed to “gender dysphoria” because the DSM manual changed the title and restricted the condition to individuals who are distressed by their gender identity [this includes Shannon]; however, it is still regarded as a disorder, as are all the entries in the DSM.)

3. The Issues Further Developed

The introduction above sketched some of the issues involved in debates over the status of and the proper methods for classifying psychological disorders. It will be useful to explain those issues further before looking at different positions in detail.
A first thing to note: you may have noticed that I have been switching my terminology when it comes to speaking of what we classify. Sometimes the target is labeled as psychopathology. Other times I have spoken of mental illness, psychological problems, abnormal behavior, or problems in living. I use these different terms because they reflect different viewpoints on how to think about classification systems. Medical approaches want to talk about psychopathology because they believe that disease in the form of dysfunctions in biological or psychological systems is fundamental. Those who reject the medical model will tend to reject the talk of pathology in favor of some less medical description such as “abnormal.” There is no completely neutral way to describe the behavior and phenomena we want to classify that does not favor one approach or the other. Thus, I will switch back and forth between these various terminologies.

Even if we approach psychopathology from a medical point of view, it will be useful to make a distinction between disease, illness, and sickness (used in the specific defined senses that are outlined in Chapter 2 and that do not necessarily line up with everyday usage of these terms). The clearest cases of diseases are usually conditions where an identifiable physical malfunction exists. AIDS is a paradigm example: a virus causes pathologies in immune system functioning. Illness refers to individual suffering (often caused by diminished functioning). For example, chronic fatigue syndrome may be an illness but not a disease at the current state of knowledge, for while there is suffering, there is no identified physical cause. Traditionally, such conditions would be labeled by the medical profession as syndromes until a true disease basis is found. It is also possible to have a disease without an illness. Asymptomatic cancer is an example, but obviously most disease does result in illness. Sickness then refers to a socially recognized role or situation that gets special handling from society. For example, individuals labeled as sick may be excused from work and other social obligations. Not every illness gets such treatment. Some societies identify sickness where there may be no obvious disease or illness at all. For example, Germans have the concept of a Gesundheitsurlaub—a health vacation. Individuals in these cases are sometimes entitled to absence from work for the sake of their health, even though they are not ill.

Given these distinctions, the basic paradigm in much of current psychiatry is based on a medical model that treats psychopathology as a disease. This approach asserts that the best-grounded classifications are those based on identifiable aberrations in the proper functioning of bodily systems. Different disease classifications should be based on differences in the kind of malfunctions present. These are objective facts about human bodies and are true independently of what we believe about human maladies, do not depend on human judgments about what is good, bad, or moral, and can be identified by verifiable means by different observers. The different diseases are a part of the world in the same sense that the atomic elements, for example, are. On this view, psychiatric classifications should ultimately be based on identifiable malfunctions.

To refer back to one of our examples, the disease-based view classifies Alex as having a real mental illness. Alex seems to have major depressive disorder that reflects fundamental dysfunction in psychological and probably biochemical systems in ways that neurobiology and cognitive psychology can help identify. Alex has profound depression that is persistent and apparently not simply the result of adverse life events, for example.

This disease-based view can allow for some complications. Current classifications may pick out what we called above syndromes—symptoms of suffering for which we currently have no identifiable disease. Yet, on the medical model approach, classifications of psychiatric syndromes should ultimately be halfway houses on the road to finding the diseases behind them.

To give us a clear map of the possible views on classifying psychopathology, it is useful to contrast the disease view just sketched with its polar opposite, what we can call the social
constructivist view. The starkest form of this view claims there is no such thing as mental illness or psychopathology. The view is called social constructivist because it claims that the classifications of behaviors as psychopathological (a term constructivists would reject) are made by society in various ways that are not based on real psychological or biological diseases. Rather, social norms, interest groups such as clinicians and pharmaceutical companies, and various social processes pick out some behaviors to label as mentally ill. In terms of our tripartite distinction above between disease, illness, and sickness, on the social constructivist view what gets called mental illness is not a disease. It may involve suffering and thus might be called an illness, and classified individuals may have different responsibilities than those labeled as normal and thus might fall into the sick category. But the suffering may result entirely due to social stigma, as in the case of homosexuality, and whether the sickness concept applies depends on societal value judgments with no grounding in objective disease processes. Thus, on the social constructivist view, there is no value-free classification of psychopathology; psychopathology does not exist in the world independently of our conceptions of it.

In terms of our examples, Shannon’s diagnosis as suffering from “gender dysphoria” is a good example of how the social constructivist thinks of our labeling of behavior as mentally ill. Failing to identify with one’s biological sex is a phenomenon that (some) societies choose to treat as a distinct kind of behavior, one that many individuals in such societies find troublesome and disapprove of. There is nothing here, the argument goes, approaching a physical disease like cancer. Society has chosen to relate to these individuals under the description of having a mental disorder. Individuals who do not identify with their biological sex may well suffer, but not from biologically based disease but from social disapproval. Labeling them as having a disorder is likely to contribute to that suffering.

4. The Disease Model of Classification in More Detail

We saw above that the disease model of classification wants to ground psychiatric classification on objective facts about bodily disorders causing psychopathology. Let’s look at this approach in more detail, as well as some of its problems. Two of the most developed defenses of this position are those of Murphy (2006) and Wakefield (2007), and I will focus on their accounts.

Wakefield bases his approach on the evolutionary function account of disease. Disease—whether physical or mental—on his view consists in the breakdown of the proper functioning of the systems of the body. The “proper function” of these systems consists in what they were designed to do by evolution. The systems of our body exist and have the functions they do because at some point in our evolutionary history those systems with their functions were selectively advantageous. Wakefield recognizes as noted above that some malfunctions in the systems of our body may not cause us problems, so he adds to his definition that the dysfunctions are harmful—they are conditions we dislike. So there is a value component in Wakefield’s definition, but its key component is still value free and supposedly based on objective biological science.

Murphy advances a similar view, except for him disease involves deficits in the normal functioning of the relevant systems of the body. Normal functioning is not understood in terms of functions selected by evolution but instead in terms of the activities of systems typical of our species. This is a notion of disease defended by Boorse (see Chapter 1), which defines disease in terms of deviations below the normal or average functioning of the component systems of human beings. This view does not depend on identifying the selective advantage of our biological or psychological subsystems; it instead focuses on identifying the causal role that various systems play in normal human functioning.

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For Murphy, classifications of psychopathology must be grounded in causal knowledge of biological and psychological systems; classifications should be based on the deficits in functioning that explain the symptoms used to classify disorders. Correct classifications are those that identify the causes of psychopathological symptoms in terms of deviations from normal functioning.

Wakefield and Murphy both talk of malfunctioning systems causing symptoms and providing the basis for psychopathological classification. However, psychopathology would seem to be a mental disorder. So an obvious question is whether the classification of psychopathology must be based on dysfunctional psychological systems. Both Wakefield and Murphy are, reasonably enough, flexible in this regard: the malfunctioning systems may be described in psychological terms or neurobiological terms, or, perhaps best, in terms of integrated psychological-neurobiological terms. So let’s return to Alex, who has major depressive disorder. He has clear psychological malfunctions: his memory recall is biased towards negative events—compared to normals he is much more likely to remember negative events in the past. On the neurobiological level, brain imaging shows, for example, that brain regions responsible for fear reactions are much more active in Alex than in individuals without psychopathology.

Given their approaches to classification, which require classifications to be based on identified malfunctions, both Wakefield and Murphy are critical of current mainstream classification systems such as the DSM. Wakefield, with coauthor Horwitz, a sociologist, has argued that the current DSM system significantly overdiagnoses depression, for example. To “overdiagnose” is to mistakenly label people with major depressive disorder who do not have it. In The Loss of Sadness (Horwitz and Wakefield, 2007), they argue that the DSM classification system treats individuals with an understandable and temporary depressed mood—for example, that following the death of a close relative or friend—as in the same category as Alex. So they would argue that, contrary to how she would be labeled under the DSM, Jean, who has understandable depressed feelings, should not be classified as psychopathological—there is not an underlying disease behind her problems, but rather the ordinary if regrettable difficulties of life. Alex’s problems are recurring symptoms that have no obvious cause in recent major life events; his condition is ongoing or chronic. But the DSM-5 treats the two cases the same. Important revisions in our classification of psychopathology are thus called for by Wakefield and Horwitz.

Murphy is equally or more critical of classification systems such as the DSM. Those systems generally do not have a strong grounding in our scientific understanding of mind-brain dysfunction; to the extent that they do not, they are questionable and cut themselves off from connections needed to make scientific progress.

It is interesting to note that while the current DSM classification system in its introduction advocates the disease view of psychopathology, it vacillates between the evolutionary function account that Wakefield defends and the malfunctioning systems account of Murphy. So the latest version (DSM-5) says that:

>a mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

(APA, 2013, 20)

But it also says that mental illness is a “psychopathological condition in which physical signs and symptoms exceed normal ranges” (APA, 2013, 19). The deviation from normal ranges is invoked often in the criteria for specific psychopathologies.
These are two different objective definitions of disease; the first is an evolutionary function view and the second focuses on deviations from species-typical functioning. However, this difference is in a way of minor importance, because in practice the DSM classification system openly rejects basing classifications on causes. The first objective of the system is to provide categories that can be consistently applied by clinicians and researchers. It explicitly claims to be “theory neutral”—to provide classifications that make no specific assumptions about the underlying causes of psychopathology. It takes this stance because its primary goal is to allow clinicians and researchers to communicate successfully despite their theoretical differences about the underlying causes of psychopathology. Yet, for Wakefield and Murphy, this stance means that the DSM classification system loses the underpinning it must have to be a scientific and successful medical practice.

There are some significant problems for the disease approaches to classifying psychopathology. As just seen, the disease account really does not do much work in actual psychopathology classification systems. That can, of course, be a basis of criticism of these classification systems, a conclusion that Murphy and Wakefield draw. However, in Wakefield's own work distinguishing real depression from situational depressed mood, he does not actually cite dysfunctions in evolutionary selected mental or biological modules (Kincaid forthcoming a). That is not surprising, since we have no developed way of saying what those are. Talk of capacities selected by evolutionary forces in our evolutionary past as hunter-gatherers when our basic psychology was set is largely speculative sociobiology and not something that can give us detailed guidance on how to classify abnormal behavior. Wakefield's own arguments for separating major depression from understandable grief do not use this evolutionary story but instead rely on much more commonsensical considerations such as that grief is a normal and understandable response to loss.

Psychiatry and psychology can usually provide classifications that allow us to predict with some accuracy the causes and course of behavior without identifying malfunctioning biological or psychological systems. These conditions are thus reasonably seen as illnesses or syndromes as we defined those terms earlier, but not diseases.

5. Psychopathology Classification as a Social Construction

The polar opposites of a disease-based account of psychopathology classification are social constructivist views. An early and influential statement of this view was made in 1961 by Thomas Szasz in *The Myth of Mental Illness* (anniversary edition, 2010). What gets classified as mental illness is, on his view, the result of medicalizing disturbing or unusual behaviors. These behaviors are symbolic actions in response to specific social situations; Szasz thinks of them as strategies and signs we use in “games” we play with each other all the time. For most behavior that gets classified as mental illness, individuals have their reasons for why they behave the way they do—they are agents with free will whose behavior is not determined in the way that the behavior of a body with a disease is. Our classifications of psychopathology are mostly just the ways society has chosen to deal with certain sorts of behaviors and very rarely reflect real disease classifications (exceptions are things such as neurological diseases). Thus, Szasz thinks mental illness classifications are largely social constructs. Whether we should continue to use our current classifications is a societal decision about how we deal with each other in certain situations and not a problem solvable by the advance of medical knowledge. Szasz doubts the utility of the mentally ill label because he thinks it leads to abuse of individual rights, among other things.

It is important to see how Szasz's view differs from the disease views of Wakefield and Murphy discussed earlier. Defenders of the disease view of classification were willing to grant that some
classifications are misapplied, as in the case of depression, and that others have such little scientific backing they probably should be jettisoned. Yet defenders of the disease approach are firmly committed to the idea that classifications of psychopathology can and should be based on identifiable malfunctioning of human systems. For the social constructivist, mental illnesses are just behaviors that society happens to group together and label as dysfunctions. Different societies or the same societies at different times can do this differently, and there is no right or best way to make such groupings; we impose these groupings on the behavior we dislike and label them as diseases.

Szasz has a general conceptual or philosophical argument for his view. His argument has a long history in debates over the scientific understanding of human behavior. The argument is this: we have to understand human behavior as based on reasons for action, as meaningful, and as rule or norm following (these are generally thought to be tightly interrelated). But reasons and meanings are not understandable scientifically; instead they call for the kind of interpretive understanding that we use constantly in our everyday social interactions.

Assessing this argument raises a large debate about what is often called the naturalistic approach to explaining human behavior and social organization. Naturalists claim that the broad methods of the sciences—e.g., observation and testing of hypotheses—are the best routes to explaining human behavior and that arguments like that given by Szasz make humans something special and outside the natural order. Naturalists point to advances in brain science, psychology, cognitive neuroscience, and related fields to support their case. Full consideration of this debate is beyond the scope of this chapter; however, the basic naturalist response to Szasz’s argument is that reasons for behavior are psychological states that are subject to scientific explanation.

Another route to constructivism comes from anti-realist positions in debates over what is called scientific realism. One version of scientific realism claims roughly that current science is true, approximately true, or truer than our past science (see Chapter 9). Some anti-realists in those debates argue that results in the natural sciences are best understood as resulting from social processes where what counts as evidence, what counts as sufficient evidence to draw conclusions, how evidence is interpreted, what questions need to be answered, and so on are the product of social negotiation by individuals pursuing their own agendas and not objective statements about the way the world is. There are multiple studies of specific psychopathological classifications or psychopathological systems in general that draw the same conclusions about them. Kirk and Kutchens (1992) argue this about the DSM in general. Kincaid (forthcoming b) argues for this claim about the diagnosis of bipolar disease in children aged two and under, a condition that is identified in a significant number of children in the United States but is nearly unknown outside of the United States.

A further aspect of social construction has been emphasized by Hacking (1995) in *Rewriting the Soul*. When medicine and other professions that deal with psychological problems settle on a classification for a given set of behaviors and that classification becomes widely circulated in society, it may actually come to influence the behavior itself. Individuals with problems naturally enough use what they take to be well-supported professional diagnoses to understand their situation. Individuals may then interpret their problems using the categories of psychopathology advanced by the professions that treat it; they may begin to describe their symptoms in terms of the criteria defining specific psychopathological classifications and then may act in terms of this altered understanding, producing a process Hacking terms “looping.” Hacking argues in detail that this is true of the category of multiple personality disorder, a condition that was basically unknown until the mid-1990s but was then quite rapidly claimed to be a problem affecting a number of individuals.
Social constructivism, as described here, like the disease view, has its problems. Is it really reasonable to think that the real difference between ordinary people and Alex, who can only sit in a dark room, is unable to work or function socially, and has identifiable and measurable psychological and biological abnormalities, does not reflect a difference in reality but is just the way we have chosen to label him as a society? It does not seem so. That all behavior classified as psychopathological is only a societal decision to label unwanted behaviors seems an overgeneralization.

6. A Third Pragmatic Route to Thinking about Classifying Psychopathology?

A compromise alternative to thinking of psychopathology as best understood as either disease or as social construction would be good, since both of those views have problems. A third approach is sketched in this section.

As we saw above, the notion of disease is not much help in actual classifications of psychopathology. However, at least for some behaviors that get labeled as mental illnesses, it seems pretty clear that they are not just behaviors that society decides to group together without there being an objective difference in reality. The intuition here is that people like Alex share something important in common that can ground our decision to see those individuals as falling into a specific category and to distinguish them from individuals like Jean, who is having transitory problems. We seemingly can make these distinctions even if we do not know how Alex’s behavior results from some evolutionarily selected malfunctioning system or that Jean’s behavior is the normal functioning of such systems.

A long philosophical and scientific tradition argues that our categorizations of the world pick out something real if (1) we have multiple independent measures for those categories and (2) they allow us to predict and explain a variety of phenomena. Put this way, the question is whether classifications of behavior into various types of psychopathology seem to be objective and allow the use of those classifications to make predictions, especially causal predictions. Having multiple independent measures—that do not rely on each other—is evidence that what we are classifying is not just something we are making up or subjective impositions. Scientists came to believe in electrons, for example, because they could detect them by many different means. Our evidence gets stronger if we can use classifications to make reliable predictions, especially about causes. So belief in electrons gets stronger if we can predict what will change their behavior (e.g., magnetic fields) and what influences changes in their behavior will have (chemical reactions resulting from “excited” electrons).

So the proposed third way treats psychopathological classifications as real if we have multiple indicators or measures picking out the individuals falling under the category and we can use the categorization to predict the causes and consequences of falling into that category (Kincaid, 2014). So back to Alex: there is good reason to think that the category of major depressive disorder is justified if we can identify various different characteristics that individuals classified like him share and if we can make confirmed predictions about individuals falling into the category.

There is in fact substantial evidence that we can do these things for people like Alex. People classified as having major depressive disorder for example generally:

- Score high on questionnaires about symptoms characterizing depression such as suicidal thoughts or feelings of worthlessness
- Have greater difficulty than those not categorized as suffering major depressive disorder in recalling positive memories
Have a higher level of stress hormones than those not categorized as suffering major depressive disorder
Have parents who have been classified as having major depressive disorder
Are more likely to attempt suicide

There are numerous other such characteristics that seem to separate those falling into the major depressive disorder category from those that do not. These characteristics are all ones that can be identified or verified by different observers without much need for subjective judgment; they are relatively objective measures, with only the assessment of parental depressive episodes calling sometimes for significant investigator interpretation of patient reports, since they have to rely on subject memories and interpretation of their parents' psychological states.

Contrast Alex with Shannon’s gender dysphoria. There are not multiple independent measures of her “condition.” We do not have physiological measures or tests of cognitive function that identify those with her condition. Significant value judgments about what is appropriate gender behavior may be a major factor in the distress that individuals who are given this classification report. The case for social construction—for the conclusion that classification represents behavior that is picked out by society for disapproval—seems pretty strong in Shannon’s case. It does not in Alex’s case.

However, Hacking’s insight mentioned above that classification systems imposed by society may nonetheless influence the behavior of those classified suggests that social constructivists need not be as skeptical as Szasz about the classification of psychopathology. Social values may be involved in our classification systems, yet those classification systems may nonetheless still have some ability to objectively pick out and predict behavior. If society classifies according to what it disapproves, it must nonetheless pick out some objective traits of persons to do so. Also, deep-seated social norms of disapproval can have consequences for how individuals come to behave that result in possibly identifiable patterns.

So the third pragmatic route I am suggesting asserts that:

- There are some classifications of psychological problems that seem reasonably grounded in measurable, objective traits of individuals and fit the ideas of illness and syndromes from the medical model of psychopathology, although we may still be some distance from giving a full medical-style account of malfunctioning systems of the body. Alex’s depression falls into this category. The extent to which specific individual psychiatric classifications are able to provide objective categorizations like those given for major depressive disorder is likely to be a matter of degree.
- Some behaviors that are really understandable, nonpathological problems in living may be misclassified as more serious illness-like conditions. Wakefield and Murphy make a compelling case for this claim. Jean’s temporary depression, if labeled major depressive disorder and treated accordingly, would be a case in point. That does not mean that some better classification—grief-related depression—might not still be a useful way to understand her condition.
- There are some classifications of behavior as psychopathological that reflect social values, that are not reasonably thought of as diseases or illnesses, and that do not have the kind of objective indicators of physiological and psychological abnormality that major depressive disorder does; it may nonetheless still be an open question whether these classifications track behaviors well enough to be of use in dealing with human problems. So, for example, in the case of Shannon and gender dysphoria, there is currently a lively controversy over the usefulness of the category.
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References


Further Reading