Transforming Normality into Pathology: The *DSM* and the Outcomes of Stressful Social Arrangements

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The sociology of stress shows how nondisordered people often become distressed in contexts such as chronic subordination; the losses of status, resources, and attachments; or the inability to achieve valued goals. Evolutionary psychology indicates that distress arising in these contexts stems from psychological mechanisms that are responding appropriately to stressful circumstances. A diagnosis of mental disorder, in contrast, indicates that these mechanisms are not functioning as they are designed to function. The American Psychiatric Association's Diagnostic and Statistical Manual, *however, has come to treat both the natural results of the stress process and individual pathology as mental disorders. A number of social groups benefit from and promote the conflation of normal emotions with dysfunctions. The result has been to overestimate the number of people who are considered to be disordered, to focus social policy on the supposedly unmet need for treatment, and to enlarge the social space of pathology in the general culture.*

The stress process model has dominated research in the sociology of mental health for the past 30 years (Pearlin 1989; Aneshensel 2005). This model views stressful social arrangements and the coping resources that people use to respond to these arrangements as the major determinants of generalized states of psychological distress. Its central achievement has been to show how social factors often lead to distressed emotional states in normal, nondisordered people. In particular, research that follows the stress paradigm shows that people often become distressed in three general contexts, which we might call "fundamental causes" of distress (Link and Phelan 1995). Each posited fundamental cause corresponds to core traditions in classical sociological theory represented by the works of Marx, Durkheim, and Weber, as well as to three major themes of evolutionary psychology (Horwitz 2007).

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DISTRESS AS A NORMAL RESPONSE TO STRESSFUL SOCIAL ARRANGEMENTS

Sociological Perspectives

As Marx (1844) emphasized, inequalities in income, power, and prestige strongly affect mental health. People who have inadequate resources and those who occupy subordinate positions, especially when they see no prospects for upward movement or do not have beliefs that justify their positions, consistently display poor mental health. For example, considerable research indicates that low socioeconomic status increases distress (Eaton and Muntaner

1999; Turner and Lloyd 1999; Dohrenwend 2000). Sociological research shows the distressing mental health consequences not only of socioeconomic stratification but also of subordinate familial and interpersonal positions (Mirowsky and Ross 2003). For example, women are much more likely than men to be in such subordinate positions, which partially explains their higher rates of distress (Gove and Tudor 1973; Lennon and Rosenfield 1994).

A second core finding in the sociology of mental health is that the loss, weakness, or absence of valued attachments is associated with distress. As Durkheim (1897) showed, weak social ties are associated with high rates of suicide and, by inference, with much psychological distress. For example, the three most stressful life events in the Holmes and Rahe (1967) index—divorce, marital separation, and the death of an intimate—all entail the loss of close attachments. Another large body of research indicates that people who are unmarried and socially uninvolved have higher rates of distress than married and socially integrated people (e.g., Umberson and Williams 1999; Lin, Ye, and Ensel 1999). Likewise, community-level indicators show that inhabitants of neighborhoods with low levels of cohesiveness and connectedness have high levels of distress (Aneshensel and Sucoff 1996; Ross 2000).

Finally, following the Weberian tradition (Weber 1925), sociologists of stress have shown how the inability to achieve important goals that provide coherence and purpose to life are related to poor mental health (Idler 1987; Simon 1997). Social systems that do not provide their members the means to attain valued ends produce high rates of distress (Merton 1968; Aneshensel 1992). Among individuals, adults who do not attain goals they set for themselves in earlier stages of life report more distress than those whose attainments match their original aspirations (Carr 1997). Similarly, women who intensely desire to bear children but who are infertile also exhibit very high rates of distress (McEwan, Costello, and Taylor 1987).

Evolutionary Perspectives

Evidence from evolutionary psychology and biology is remarkably consistent with the sociological findings that humans become distressed in contexts of subordination, attachment loss, and the inability to achieve valued goals. Neurobiological and psychological research suggests that the mind is made up of many specific modules or mechanisms that are designed to respond to particular environmental challenges so that, when they are working appropriately, psychological mechanisms activate in particular contexts but not in others (Fodor 1983; Buss 1995; Pinker 2002). Evolutionary psychologists have emphasized three particular environmental contexts where states of distress might have been adaptive, and these three contexts map almost perfectly onto the major themes of classical sociology (Horwitz 2007).

One school of evolutionary thought emphasizes how distressful emotional states could have been naturally selected to develop among subordinates in hierarchical relationships (Price et al. 1994; Sloman, Gilbert, and Hasey 2003). Evidence from ethological studies shows that animals in chronic positions of subordination and those that move downward in social hierarchies show far more distress-like behaviors than those in dominant positions, as indicated by higher levels of stress hormones and lower levels of blood serotonin (Sapolsky 1989; Shively 1998). These advantages are only found in stable dominance hierarchies; when positions of dominants are precarious, high rank is not associated with fewer stress hormones (Sapolsky 2005). Moreover, studies of nonhuman primates indicate that occupying subordinate positions itself results in distress: Previously dominant monkeys who become subordinates show falling levels of serotonin, appetite, and activity, while serotonin levels of previously subordinate monkeys who gain high status change to values that characterize dominants (McGuire and Triosi 1998). The submissive qualities of distress responses that weaker parties typically display seem to be a naturally selected tendency that allowed dependents who made such responses to be more likely to survive and reproduce than those who made more aggressive responses toward dominants.

A second school of evolutionary thought emphasizes how distress after the loss of valued attachments involving intimacy, love, and friendship results from a common genetic inheritance (Bowlby 1973, 1980). As humans do, nonhuman primates respond to temporary separations from parental caregivers with a variety of distress reactions that dissipate when the connection is restored (Harlow and Suomi 1974; Suomi 1991). Findings from attachment theory also show that presocialized infants who

are briefly separated from their primary caregivers develop intense sadness responses that do not persist when the parental attachment is regained (Bowlby 1973; Rutter 1981). Distress that follows the loss of attachments might have had a number of consequences that led to its natural selection, including the generation of social support and enhanced motivation to maintain the lost tie (Bowlby 1980; Archer 1999; Hagen 2002).

Finally, a third evolutionary perspective indicates that organisms become distressed when they are blocked in their pursuit of incentives (Klinger 1975). Because values provide key incentives for human behavior, distress results when people can neither achieve nor disengage from goals to which they are committed (Nesse 2000). Distress arising from the inability to achieve valued goals might serve to facilitate the difficult shift of energy from unproductive efforts and unreachable goals to different and more productive activities.

Both classical sociological theory and evolutionary theory thus emphasize how factors external to individuals—factors that are aspects of their social circumstances—can activate distressing psychological states. Both theories are compatible with the assumption that distress that is a function of the external environment is a naturally selected response to stressful situations and not a genetic defect, a brain or personality dysfunction, or a mental disorder. Even highly distressing emotional states need not be viewed as indicative of mental disorders if they occur in situations that would naturally lead ordinary people to be seriously distressed, such as the sudden discovery of a betrayal by a romantic partner, the unexpected loss of a valued job, or the diagnosis of a life-threatening illness in oneself or a loved one. Likewise, the duration of nondisordered distress conditions is linked to the persistence of both primary and secondary stressors in the social environment (Pearlin 1989). In the stress process model, the emergence, severity, and duration of emotional distress are all functions of social arrangements acting in tandem with a common genetic inheritance, not of individual pathology.

Distress and Mental Disorder

Distress that arises from and is maintained by acute or chronic stressful situations is a fundamentally different outcome from mental disorder. Throughout history, mental illness has been viewed as thoughts, emotions, and behaviors indicating that the affected individual suffers from some sort of defect or disability (Horwitz 1982). In this view, some psychological mechanism is *not* acting in appropriate ways in given contexts. In all times and places, people who see or hear things that are not actually present, or those who are excessively exuberant, constantly sad, or continuously anxious regardless of their social circumstances have been regarded as mentally disturbed. Sometimes, emotions and behaviors occur "without cause" or stem from inappropriate causes that are not linked to real losses or to chronically stressful circumstances (Jackson 1986). In other cases, social stressors might initially trigger a distressing state that then becomes disengaged from its context and persists with a duration or severity disproportionate to its provoking cause. For example, while bereavement is a normal response to the death of a loved one, grief that involves symptoms of excessive intensity or persists for a very long period of time can indicate a disordered state (American Psychiatric Association 2000). Finally, some extreme symptoms, such as psychotic hallucinations and delusions or persistent vegetative states, usually indicate the presence of a mental disorder.

The boundaries between nondisordered states of distress and mental disorders are commonly fuzzy, vague, and ambiguous, making it difficult to distinguish between cases of distress and disorder. In addition, stressors can be more likely to trigger symptoms among people who suffer from preexisting mental disorders. For example, persons with previous psychiatric diagnoses were far more likely than those with no history of disorder to develop distressing symptoms after the terrorist attacks of September 11, 2001 (Clymer 2002). Moreover, distressing psychological conditions in some cases lead to, rather than result from, stressors; generally, however, stressors are causally prior to the kinds of outcome variables that sociologists of stress usually study (Ritsher et al. 2001; Johnson et al. 1999; Lorant et al. 2003). Despite these caveats, clear cases of distress and mental disorder are distinct: Distress states are proportionate responses that people make to stressful social arrangements, while mental disorders are dysfunctions that indicate some psychological mechanism is not functioning in accordance with the dictates of natural selection (Wakefield 1992). This distinction has im-

plications for clarifying the appropriate goals and outcome measures of sociology and psychiatry, as well as for providing grounds to critique overexpansive conceptions of mental disorder.

THE *DSM*'S CONFLATION OF NORMALITY AND PATHOLOGY

The *Diagnostic and Statistical Manual* (*DSM)*, currently in its fourth edition, is the psychiatric profession's official classification manual of mental disorders. Its general definition of mental disorder explicitly makes the appropriate distinction between mental disorders and nondisordered conditions that result from and are maintained by social stressors. Mental disorders, according to the *DSM-IV,* "must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (American Psychiatric Association 2000:xxxi). This definition limits mental disorders to conditions that are dysfunctions in the person and excludes conditions that are proportionate responses to social stressors. In this regard, the *DSM* conforms to common conceptions of mental disorder that have persisted for millennia (Horwitz 1982; Jackson 1986; Horwitz and Wakefield 2007). It uses "the death of a loved one" as an example of a stressor that expectably leads people to display symptoms that could otherwise indicate a disorder if they emerged in the absence of the stressor. The definition's use of "for example" implies that symptoms caused and sustained by stressors other than bereavement, such as a humiliating decline of status or the loss of all one's possessions after a natural disaster, should also not be considered disordered because they do not result from an internal dysfunction but instead are contextually appropriate responses.

The problem with the *DSM*'s definition of mental disorder is that many of the *DSM*'s criteria sets for particular disorders contradict its own definition. Instead, the *DSM* often uses the presence of certain symptoms—exclusive of the context in which they arise and are maintained—to diagnose disorders. The result is that psychiatric diagnoses often consider symptoms that are expectable responses to stressful circumstances to be signs of disorders, along with symptoms that are individual dysfunctions.

This conflation of normality and pathology began in 1980 when the American Psychiatric Association published the third edition of the *DSM,* the *DSM-III* (Horwitz 2002; Mayes and Horwitz 2005). The first two editions of this manual used vague definitions of disorders that typically implied particular psychodynamic etiologies, which assumed underlying unconscious causes of symptoms. Neither clinicians nor researchers could make reliable use of these definitions, causing their classifications of mental illness to be idiosyncratic and to vary widely across individual psychiatrists (Kirk and Kutchins 1992). The *DSM* definitions were applied in such eccentric ways that psychiatry became the object of not just criticism but open ridicule. For example, during the 1960s and 1970s, some prominent critics of psychiatry, such as psychiatrist Thomas Szasz (1961), claimed that mental illness didn't exist, while others, such as psychologist David Rosenhan (1973), argued that psychiatry could not even distinguish between those who were normal and those who were insane.

To deal with this dire situation, a group of researchers, led by psychiatrist Robert Spitzer, understandably concluded that if psychiatry was ever to attain scientific status, it would first need to develop clear, precise, and reproducible definitions of the entities it studies, which would then serve as the foundation for a new, scientific discipline. Therefore, they developed the *DSM-III,* which replaced the amorphous conditions of psychodynamic psychiatry with the specific entities of what I called, in *Creating Mental Illness,* "diagnostic psychiatry" (Horwitz 2002). At the heart of diagnostic psychiatry were several hundred specific definitions of various types of mental illnesses that relied on the characteristic symptoms of each entity. Because of the desire to purge psychodynamic assumptions from the new manual, a core principle of the *DSM-III* was that these definitions could not assume any particular etiology of symptoms.

The *DSM-III* diagnosis of "major depressive disorder" (MDD) illustrates how many psychiatric diagnoses conflate normality and pathology (Horwitz and Wakefield 2007). Major depressive disorder is the most common diagnosis in mental health treatment (Olfson et al. 2002), and it is the psychiatric condition of most relevance to the sociology of stress. Many

other conditions in the *DSM-III,* however, could serve as equally valid examples.

The definitions of depression in diagnostic manuals that preceded the *DSM-III* were very general and cursory. For example, the *DSM-II* (American Psychiatric Association 1968) definition reads as follows:

> This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession. (P. 40)

Such a definition provides little guidance about how depression can be measured and is very difficult to operationalize. In addition, the definition contains the etiological assumption that depression is always due to "an internal conflict or to an identifiable event." This assumption was particularly unsuited to the needs of the field of biological psychiatry that was just beginning to emerge during the 1970s.

In contrast, the definition of depression in the *DSM-III* is very specific, easy to operationalize, and involves no etiological assumptions (American Psychiatric Association 1980:213–14). It requires the presence during a two-week period of five symptoms from a list of nine, one of which must be either depressed mood or diminished interest/pleasure in life. Anyone who meets the symptom criteria receives a diagnosis of "major depressive disorder" (with one major exception).[1] People who otherwise meet the symptomatic criteria for MDD should nevertheless not receive this diagnosis if their symptoms result from bereavement, unless their grief lasts longer than two months or involves certain particularly severe symptoms. Yet bereavement is the sole exclusion from a diagnosis of MDD; other stressors that would naturally produce symptoms of depression are not similarly excluded (Wakefield et al. 2007).

The definitions in the *DSM-III* and subsequent manuals enhance reliability and allow their users to know what is meant when they talk about particular mental disorders. Unfortunately, these symptom-based definitions have one major flaw that has come to powerfully influence the mental health professions. The *DSM-II* definition, despite its defects, specifies that only "excessive" responses to loss should be considered depressive disorders. In other words, even if people meet criteria for a disorder, as long as their response is of proportionate, nonexcessive severity and duration to the loss that they have suffered, they do not have a disorder. Even severe losses that result in intense sadness responses are not disorders as long as the response is not "excessive." This distinction between proportionate and disproportionate responses to loss had been part of traditional psychiatric thinking for thousands of years, ever since Hippocrates proposed the first definition of depression in the 5th century BC: "if fear or sadness last for a long time it is melancholia" (Hippocrates 1923–1931, vol. 1:263). For Hippocrates, symptoms alone do not indicate disorder, but only symptoms of disproportionate duration to a person's circumstances. This distinction is not an etiological distinction that specifies a certain type of cause but is what makes the condition a disordered one in the first place.

In purging etiological assumptions, the *DSM-III* went overboard and mistakenly assumed that terms such as "excessive" were also etiological and often purged these as well. This does not seem to have been an intentional decision or even one that the working groups for the *DSM-III* explicitly considered in their deliberations (Mayes and Horwitz 2005; Horwitz and Wakefield 2007). Instead, it was the inadvertent result of efforts to improve the reliability of diagnosis and to rid the manual of psychodynamic tenets (Bayer and Spitzer 1985). The result was that *all* symptoms, whether normal and proportionate responses to stressful situations or inappropriate and pathological signs of dysfunctions, were treated as potential signs of mental illness. This decision, unnoticed at the time, was to have major impacts.

THE CONSEQUENCES OF SYMPTOM-BASED DISORDERS

The *DSM*'s equation of symptoms that arise from internal dysfunctions with symptoms associated with social stressors has had enormous consequences. These consequences are probably minimal in clinical practice settings, however (Horwitz and Wakefield 2006). Patients who seek help are self-selected and typically have already decided that their conditions go beyond ordinary distress to warrant professional treatment (Karp 1996). In addition, clinicians can ignore the official *DSM* criteria and substitute their own judgment when they decide they are dealing with conditions that are connected to social situations and are not mental disorders. Moreover, clinical treat-

ment can sometimes relieve the distress of suffering people who might not have disorders, just as physicians often use anesthesia to numb the normal pain that stems from childbirth. The conflation of normal, distressing emotions and mental disorders, however, has had greater implications for the kinds of issues that sociologists are most interested in, including rates of mental illness in community populations, public policies governing the response to mental illness, and changing social norms concerning the nature of mental illness.

Overestimating Rates of Mental Illness in Community Surveys

One consequence of acontextual, symptom-based definitions has been the overestimation of mental illness in epidemiological surveys (Horwitz and Wakefield 2006). These studies attempt to translate the diagnostic criteria of the *DSM-III* and *DSM-IV* into survey questions as precisely as possible. Unlike the situation in clinical practice, which involves both patient self-evaluation and clinician discretion, survey interviewers are required to strictly adhere to the literal wording of the symptom questions without using flexible probes. All positive responses are taken to indicate a potential symptom of illness, regardless of the relevant context. For example, when asked, "Have you ever had a period of two weeks or more when you had trouble sleeping?" a person who reported a time when ongoing construction outside her home disrupted her sleep would be counted as equivalent to someone whose sleep disturbance resulted from a disorder. Because surveys use comprehensive measures of common symptoms of disorders, they should usually correctly classify people who are truly disordered and produce few false negatives—people who are not diagnosed as disordered but who do, in fact, have a disorder. In contrast, because many affirmative responses can indicate normal distress instead of mental disorder, surveys that rely on acontextual questions about symptoms should produce large numbers of false-positive diagnoses of people who are wrongly diagnosed as having a disorder. Most of the diagnostic errors in epidemiological surveys thus serve to inflate estimates of disorder and are not counterbalanced by errors that operate to deflate these estimates (Wakefield 1999).

The results of these surveys indicate that alarming proportions of people seemingly suffer from mental disorders. For example, the National Comorbidity Study produced the well-known finding that half the population suffers from a mental disorder at some point in their lives (Kessler et al. 1994; Kessler et al. 2003). About 30 percent experience some form of anxiety disorder, about a quarter experience some kind of impulse-control disorder, and nearly a fifth report major depressive disorder. Yet someone who experiences a two-week period of intense sadness and accompanying symptoms after being jilted by a romantic partner, severe anxiety while waiting to see whether a child injured in a major car accident will live or die, or a number of antisocial behaviors after joining a gang for self-protection in a threatening neighborhood (Wakefield, Pottick, and Kirk 2002) could easily meet criteria for major depression, generalized anxiety disorder, or conduct disorder, respectively, despite being psychiatrically normal.

This problem becomes progressively worse when fewer symptoms are required for a diagnosis. Recently, there has been a major trend to lower the threshold of diagnostic criteria and define as disorders subthreshold conditions that have some, but not all, of the symptoms of a full disorder (Judd et al. 1994; Kessler et al. 1997). Consider the most common symptoms of depression: sleeplessness, fatigue, and thoughts of death (Judd et al. 1994). Sleeplessness could easily result from anxiety over an upcoming job talk or a series of loud parties in the neighboring apartment; fatigue could result from overdemanding role obligations or providing care to a newborn infant; and thoughts of death can be related to the occurrence of wars, terrorist attacks, or natural disasters. Remarkably, but perhaps not surprisingly, studies that use both subthreshold criteria and standard criteria can show that more people have mental disorders than those who do not. For example, a study of thousands of Oregon adolescents that measures both subthreshold and full-symptom disorders finds that only about a third of respondents do *not* have some disorder (Lewinsohn et al. 2004). Such findings result from symptoms that neither respondents nor clinicians would see as disordered being counted as potential indicators of mental illnesses in community surveys. It is beyond the scope of this paper to suggest alternatives to purely symptom-based measures that could distinguish distress from disorder; the key, however, is to develop scales that incorporate social context and thus can establish the *proportionality*

of symptoms to the severity and duration of stressfulness in people's actual lives (Horwitz forthcoming).

Public Policy toward Mental Illness

The flawed findings from symptom-based definitions have had effects that go well beyond estimates of how many people presumably suffer from mental illnesses. They have also become the basis for public policies that take these findings—and the accompanying findings that relatively few people who are considered to have mental disorders get treatment for them—to indicate an unmet need for services (U.S. Department of Health and Human Services 1999). These policies emphasize educational efforts to get laypersons and general physicians to realize that symptoms they might think are normal are actually signs of mental disorder. Likewise, direct-to-consumer pharmaceutical advertisements capitalize on symptom-based definitions, stressing that people who have extremely common symptoms such as sadness, anxiety, fatigue, or insomnia should ask their doctors if they might have a disorder. These ads exploit the *DSM*'s lack of contextual constraints by portraying people who have *DSM* symptoms despite the fact that these symptoms commonly arise from normal difficulties in intimate relationships, the workplace, or accomplishing valued goals. For example, one ad for an antidepressant features a list of symptoms drawn from the diagnosis of major depression. The list is positioned between a woman on one side and her husband and son on the other side. The ad implies that the symptoms are the cause, rather than the result, of family problems and that the medication being advertised will help resolve these problems.

These direct-to-consumer ads have been enormously successful: Prescriptions for psychotropic medications have skyrocketed in recent years. For example, the number of people using antidepressants almost doubled from 7.9 million in 1996 to 15.4 million in 2001 (Zuvekas 2005). Especially notable is the rising use of psychotropic medication for children, adolescents, and the elderly, for whom prescription rates increased by 200–300 percent during the 1990s (Crystal et al. 2003; Thomas et al. 2006). Moreover, physicians and psychiatrists have come to emphasize the treatment of symptoms without regard to diagnosis, further expanding the range of conditions that are subject to medication (Luhrmann 2000). The use of symptom-based definitions has transformed the recognition of mental illness and the seeking of help for it, which now take place in a fundamentally altered climate that pathologizes ordinary emotions and urges their treatment through medication (Conrad 2005).

The Expansion of Pathology

The *DSM*'s symptom-based definitions have not just affected what psychiatrists and epidemiologists define as "mental illness" and the kinds of conditions that individuals seek help for. They have also come to fundamentally alter the social norms surrounding mental illness, what Durkheim (1895) called "social facts." Since 1980, putative mental illnesses have become widespread topics in popular magazines, best-selling books, television shows, and everyday discourse, with stories often emphasizing how emotions people might think are normal are actually signs of mental illness (Horwitz and Wakefield 2007). For example, the acclaimed television series *The Sopranos* features as its central character a Mafia boss who has a number of psychiatric conditions and whose consumption of antidepressant medications is a major theme of the show. The Internet also features many self-diagnostic screening scales for mental disorders that typically rely on common symptoms of distress, presented on Web pages that provide direct links to pharmaceutical Web sites. The social space of pathology has significantly expanded, while that of emotions that are unpleasant but normal has declined.

HOW AND WHY GROUPS PERPETUATE THE CONFLATION OF NORMALITY AND PATHOLOGY

The conflation of normal distress and mental disorder was originally inadvertent and was in fact a byproduct of a well-intentioned effort to enhance the scientific status of the psychiatric profession. No evidence indicates that interest groups outside of the working committees that developed the *DSM-III* had a direct impact on the development of symptom-based definitions of disorder (Mayes and Horwitz 2005). Once these definitions were established, however, a number of groups found they derived benefits from the new definitions and began to actively promote their perpetuation.

The psychiatric profession itself is one of these groups. All professions strive to maxi-

mize the range of their legitimate authority (Abbott 1988); symptom-based definitions expand the sorts of conditions that are considered to be in the dominion of psychiatric control. In addition, symptom-based measures justify reimbursement for the treatment of a broader range of patients than might otherwise qualify, because insurers generally will pay to treat disorders but not problems of living (Horwitz and Wakefield 2005). Mental health researchers also find that symptom-based criteria are relatively easy to use and reduce the cost and complexity of research projects. The enhanced reliability they bring to research also confers the appearance of a more scientific approach.

The National Institute of Mental Health (NIMH), one of the sponsors of the development of the *DSM-III,* is also a key promoter of the symptom-based approach. Definitions that consider intense, disagreeable emotions to be "mental disorders" legitimate a broad interpretation of the NIMH's domain and allow it to argue for increased funding on the basis that mental disorder is rampant in the population (Horwitz and Wakefield 2005). Calling unpleasant but normal psychological conditions "disorders" also effectively depoliticizes the NIMH's previous concern with controversial social problems such as poverty, crime, and racism, allowing it to garner political support for fighting problems that threaten public health (Kirk 1999).

Pharmaceutical companies are the most obvious beneficiaries of symptom-based definitions of mental disorder. Because these companies can legally only promote drugs as treatments for specific illnesses, the *DSM* provides them many targets for their products (Horwitz 2002). Capitalizing on the *DSM* approach, these companies can justifiably claim that their drugs only treat conditions that the psychiatric profession recognizes as diseases. Not surprisingly, drug companies relentlessly promote the notion that common emotions such as depressed mood, agitation, anxiety, or inability to concentrate might actually be symptoms of mental illnesses.

The spread of managed care throughout the health system since the 1990s has been another social force promoting the use of medications to treat normal distress as well as mental disorder. Managed care approaches, although diverse, generally rely on strategies that reduce health care expenditures by underwriting the least expensive possible treatments (Mechanic 2006). Many patients still seek help from general physicians for problems of living, and those physicians are likely to prescribe medications regardless of the type of problem they see (Olfson et al. 2002). Because medication therapy takes considerably less practitioner time than alternatives such as psychotherapy, it is more amenable to the logic of managed care organizations, which provide more generous benefits for pharmaceutical responses than for other types of treatment. Medication thus involves lower out-of-pocket costs for patients, which also influences patients themselves to prefer drug treatments to alternative types of responses (Cutler 2004). The result is a further blurring of the boundaries between normal distress and mental disorder, both of which receive medication as the preferred response.

Mental health advocacy groups also find that symptom-based conceptions of illness are useful because such conceptions support their claims that mental illness is a very common condition (Horwitz and Wakefield 2007). These claims, in turn, support advocates' efforts to destigmatize public conceptions of mental illness and to obtain more resources for its treatment. Finally, symptom-based categories have much cultural resonance because many affected individuals find that formulating their problems as mental illness provides them with explanations for their suffering as well as ways of obtaining desired drugs that allow them to regulate their unpleasant emotions.

A large and diverse range of groups and more general social forces thus support the pathologization of normal emotions. A process that unintentionally began with the development of the diagnostic criteria sets in the *DSM-III* is now firmly entrenched and taken for granted in the culture at large (Horwitz 2002).

BENEFITS AND COSTS OF CONFLATING NORMALITY AND PATHOLOGY

Despite their conceptual flaws, symptom-based conceptions have undoubtedly had a number of beneficial consequences for the social response to mental illness. They have helped create a cultural climate more accepting of mental illness, resulting in an increase in the number of truly disordered people obtaining mental health treatment (Kessler et al. 2005). Viewing a broad range of behaviors as legitimate illnesses that are deserving of treatment has arguably reduced the stigmatization of

mental illness and increased the willingness of the public to seek medical care (U.S. Department of Health and Human Services 1999). In addition, it is not necessarily a bad thing that distressed, but not disordered, people are more likely to get professional help and relief for their suffering.

However, much is also lost when we treat normal emotions as pathological. Some amount of suffering is an ineradicable aspect of the human condition, and this part of life is diminished when we call it a "disease" (Elliott 2003). Also, a large proportion of distress stems from stressful social arrangements and can best be addressed by changing these arrangements. Defining conditions as individual pathologies leaves untouched social structures that often do not provide meaningful jobs, a decent living, or equitable social arrangements. For example, new institutional structures that provide effective help with child care could do far more to promote mental health than prescribing a pill to an overwhelmed parent. Focusing on medication or psychotherapy to correct a presumed mental disorder also downplays the importance of social support and positive social relationships in the response to people in distress. Moreover, symptom-based definitions of mental illness produce artificially large prevalence rates and a consequent policy emphasis on unmet need for mental health services. This misplaced emphasis can then have the counterproductive effect of transferring scarce treatment resources from persons with serious mental illnesses to those who are not disordered at all (Lapouse 1967). Policies that focus on persons with severe mental illness, who still are grossly underserved in the mental health treatment system, might provide a more effective and efficient use of resources (Mechanic 2006).

CONCLUSION

Sociologists of stress should avoid the inappropriate medicalization of the psychological consequences of the stress process. Distress—the expectable result of stressful social arrangements—and mental disorder are not different points on the same continuum, with distress being a less serious version of disorder. Both distress and mental disorder might indeed be viewed as continuous in themselves, but they are different continua, with one emerging when nondisordered people confront stressful environments and the other emerging because of some dysfunction in the individual. Since the development of the *DSM-III* in 1980, the mental health professions, epidemiologists, policy makers, advocacy groups, and the media have conflated these two separate phenomena into a single entity, calling both "mental disorders." Instead of showing how individual problems reflect social conditions, the result has been to reduce social problems to individual pathologies that are treated with medication or therapy. The fundamental message of the stress paradigm, in contrast, is that much distress results from stressful social arrangements and is not a mental disorder.

NOTE

1. The current *DSM-IV-TR* definition also requires that the symptoms cause clinically significant role impairment or distress. In addition, the definition excludes people who meet diagnostic criteria for bipolar disorders and those whose symptoms directly result from a general medical condition or use of illegal drugs or prescribed medications (American Psychiatric Association 2000:356).

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