Pop Psychology Diagnoses

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In many respects, the landscape of psychiatric classification and diagnosis is a tale of two worlds. One world comprises academic psychiatry and psychology, in which classification systems and the diagnoses they subsume are informed largely (although by no means entirely; see Greenberg, 2013, for withering critiques of the evidentiary basis of *DSM-5*) by systematic research. The other world comprises popular ("pop") psychology, in which formal classification systems are typically absent, as diagnoses are not organized within conceptually or empirically informed subgroupings. Moreover, in this second world, diagnoses are based largely on anecdotal reports, self-help books, and the entertainment media rather than on controlled research. This entry examines the scientific status of influential pop psychology diagnoses.

There is no formal or widely accepted operationalization of pop psychology diagnoses, nor any clear-cut distinction between academic and pop psychology diagnoses. Nevertheless, for the purposes of this entry, we propose the following working definition. Pop psychology diagnoses are conditions that have (a) received considerably more attention in popular psychology (e.g., self-help books, newsstand magazines, television talk shows, radio call-in shows) than in academic psychology, (b) received scant validation in controlled studies, and (c) not been incorporated into formal classification schemes, such as *DSM-5* or *ICD-10*.

As a consequence of (b) and (c), the scientific status of pop psychology diagnoses is controversial at best, dubious at worst. Still, the fact that a condition qualifies as a pop psychology diagnosis does not mean that it is invalidated, only that it is *unvalidated*. As a hoary scientific dictum reminds us, absence of evidence is not evidence of absence. In the case of most pop psychology diagnoses, the problem is more the former than the latter.

Evaluating the validity of pop psychology diagnoses is not a straightforward task, in part because the boundaries between valid and invalid diagnoses are fuzzy. In evaluating the validity of pop psychology diagnoses, we adopt the criteria laid out by Eli Robins (1921–94) and Samuel Guze (1923–2000) in a classic article. There, Robins and Guze (1970) delineated several benchmarks for ascertaining whether a psychiatric diagnosis is valid. According to them, a valid diagnosis should (a) distinguish the disorder from similar disorders (or what psychologists call "discriminant validity"), (b) display a clear-cut pattern of familial aggregation, (c) predict diagnosed individuals' performance on laboratory and psychometric measures, and (d) forecast the natural history (course and outcome) of diagnosed individuals. Although not mentioned explicitly by Robins and Guze, a valid diagnosis should also ideally (e) predict diagnosed individuals' response to treatment. Nevertheless, because a condition's treatment response does not necessarily inform us about its etiology, this fifth criterion should be regarded as a desideratum rather than a formal requirement. Some authors have offered friendly amendments to the Robins and Guze criteria by incorporating additional external validating indicators, such as measures of presumed endophenotypes (e.g., biological markers). Still, the Robins and Guze rubric is a helpful starting point for evaluating the validity of psychiatric diagnoses, including pop psychology diagnoses.

The Robins and Guze framework reminds us that a valid diagnosis must provide us with *surplus* information: knowledge that was not

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available to us before the diagnosis was made. In this context, Millon (1975) distinguished diagnoses from labels, with the former offering surplus information and the latter, being essentially descriptive, offering little or no surplus information. For example, the DSM diagnosis of schizophrenia affords us additional information that we did not have previously; the knowledge that a person meets diagnostic criteria for schizophrenia tells us something new about his or her likely family history, risk for other conditions (e.g., alcohol-use disorder), and probable course and outcome. In contrast, a psychiatric label tells us little or nothing about the person that we did not already know. If we were to identify a distinct class of people who feel compelled to watch baseball games at every opportunity, compulsively memorize baseball statistics, track the results of every major and minor league baseball game, and experience anguish whenever they cannot immediately access baseball news, we could christen their ostensible affliction with the moniker of "baseball addiction syndrome." Yet it is unclear what, if any, new information this new label would provide. The label would be merely descriptive, succinctly summarizing the features of the "condition" without offering surplus knowledge.

Most of the putative conditions reviewed in this entry are probably closer to labels than to diagnoses. In this respect, the phrase "pop psychology diagnoses" is arguably a misnomer, although it is used here for the sake of continuity with previous literature.

There are dozens, perhaps even hundreds, of pop psychology diagnoses. Among those that have received intermittent media attention over the past several decades are Peter Pan syndrome (a label affixed to adults who do not seem to want to grow up), Cinderella complex (a pathological and unconscious desire to be cared for by others), and television intoxication (an all-consuming devotion to the small screen). In addition to these pop-psychology diagnoses are a plethora of informal labels that have been introduced periodically into courtrooms as legal defenses. Among them are black rage (acts of violence perpetrated by African Americans that are apparently triggered by repeated discrimination), road rage (acts of intense reactive aggression directed toward offending drivers), urban survival syndrome (a predisposition toward violence resulting from prolonged exposure to ghetto "war zones"), parental alienation syndrome (the longstanding estrangement of a child from a parent, stemming from the other parent's indoctrination of the child into a negative view of his or her partner), child sexual abuse accommodation syndrome (a constellation of behaviors, such as secrecy and delays in reporting of sexual abuse, that supposedly stem from a child feeling responsible for the abuse), rape trauma syndrome (a presumed distinct reaction to rape marked by puzzling behaviors, such as the victim's continuing to maintain contact with the rapist and neglecting to report the rape), and battered woman's syndrome (a pattern of behavior characterized by learned helplessness stemming from an abusive relationship). The last condition featured prominently in the widely publicized 2013 trial of Jodi Arias, an Arizona woman convicted of murdering her boyfriend. Precious few of these contested legal labels have been the subjects of extensive scientific research (McCann, Shindler, & Hammond, 2003).

Because of space constraints, in this entry we focus on pop psychology diagnoses that have received the lion's share of public and media attention over the past few decades. In each case, we briefly survey the historical origins of the label and the modest research base bearing on its validity.

Codependency

The concept of codependency traces its roots to the field of chemical dependency, and first gained recognition in the early to mid 1980s. This concept grew out of treatment programs for family members of people with alcoholism, such as Al-Anon (Morgan, 1991). At that time, codependency referred to a pattern of behaviors displayed by partners of alcoholics that

was believed to result from living with them. This pattern comprises "enabling" behaviors, in which partners of alcoholic individuals become pathologically dependent on their partner and unintentionally reinforce their dependency. Eventually, the codependency concept expanded to encompass dysfunctional relationships of many kinds, including those in which a partner engages in irresponsible behaviors other than drinking, such as domestic abuse or excessive gambling. Codependent individuals purportedly believe that they should be able to alter their partner's unhealthy behavior, even when this belief is unrealistic (Morgan, 1991).

Cermak (1986) was among the first to propose standardized criteria for "co-dependent personality disorder." First, codependent individuals invest their self-esteem in their ability to control themselves and others. Second, they assume excessive responsibility for others, often to the detriment of their own needs. Third, they possess distorted views regarding intimacy, and experience marked anxiety about separation from others. Fourth, they are involved in relationships with people who suffer from substance abuse problems, personality disorders, or problems with impulse control. Fifth, they exhibit at least three of a constellation of symptoms and signs, including denial, constricted emotion, depression, hypervigilance, anxiety, and substance abuse.

Dear, Roberts, & Lange (2004) attempted to demarcate the core features of codependency. They identified four traits associated with the condition: external focusing, self-sacrifice, interpersonal control, and emotional suppression. External focusing involves the direction of attention towards others. Self-sacrifice entails focusing on the needs of others to the point of neglecting one's own. Interpersonal control refers to the belief that one can fix others' maladaptive behaviors. Finally, emotional suppression involves inadequate attentiveness to one's emotions until they become overwhelming.

Although codependency has been widely discussed in the popular and theoretical literatures for nearly 30 years, it has received minimal research attention. Some evidence suggests that individuals with backgrounds ostensibly linked to codependency (e.g., offspring of an alcoholic parent) are more willing to help exploitative than nurturing individuals, whereas healthy individuals display the opposite pattern. Bradshaw (1988) described codependency as a shame-based condition marked by low self-esteem. Some evidence supports this assertion, as codependency is negatively associated with self-esteem (Wells, Glickauf-Hughes, & Jones, 1999). Nevertheless, numerous psychological conditions, such as mood disorders, are also tied to low self-esteem, so this attribute is unlikely to be diagnostically discriminating. Codependency has been linked empirically to decreased levels of narcissism and emotional expressivity, as well as to increased depression, anxiety, and family dysfunction (Marks, Blore, Hine, & Dear, 2012).

Nevertheless, numerous scholars have criticized the construct of codependency, especially on the grounds of marked heterogeneity and lack of discriminant validity. Some have deemed codependency as a "catch-all" diagnosis for almost anyone trapped in a dysfunctional relationship (Anderson, 1994). Although this criticism may contain a kernel of truth, it is probably too extreme given that some individuals in troubled relationships are psychologically healthy. Another concern is that codependency may be difficult to distinguish from certain personality disorders. In particular, codependency correlates highly with borderline and dependent personality disorders (Morgan, 1991) and displays a similar pattern of correlates to the aforementioned disorders (e.g., rigid and perfectionistic cognitive schemas, proneness to depression).

Behavioral Addictions

In the last few decades, a myriad of proposed behavioral addictions have gained attention from researchers and the media. The concept of behavioral addiction is controversial because

critics contend that it represents an inappropriate extension of the concept of substance addiction to everyday behaviors. These new proposed addictions range from compulsive exercising and tanning (sometimes colloquially termed "tanorexia") to compulsive sex and gambling. In this entry, we focus on three widely discussed behavioral addictions: Internet addiction, sexual addiction, and shopping addiction.

Internet Addiction

Internet addiction has been conceptualized by some as a compulsive-impulsive spectrum disorder (Block, 2008) that manifests in (a) excessive computer use, resulting in a loss of sense of time, a neglect of basic needs, or both; (b) withdrawal symptoms, such as depression or anxiety when a computer is not present; (c) tolerance symptoms, such as a desire to possess the latest technology to maximize hours of usage; and (d) negative professional, personal, and interpersonal repercussions arising from excessive computer use. Internet addiction often overlaps with other behavioral addictions, raising questions concerning its discriminant validity. For example, the advent of the Internet has made it easier for compulsive shoppers to spend countless hours making purchases, and has simplified the process of obtaining pornography for those with extreme sexual urges.

In some parts of the world, most notably parts of Asia, Internet addiction has become a public health concern, with prevalence estimates as high as 13.7% in China. In the United States, credible prevalence rates are lacking. Internet addiction co-occurs frequently with many other disorders, such as obsessive-compulsive disorder, making it difficult to diagnose in isolation. Furthermore, no standardized, mutually agreed criteria exist for diagnosing the condition.

Some researchers argue that internet addiction is a misnomer, as the condition should be conceptualized not as a problem with the internet *per se* but rather with specific activities that are now more accessible as a consequence of the greater availability of the internet. Specifically, skeptics of the internet-addiction label contend that the diagnosed addiction should instead reflect the specific internet-related activity (e.g., gaming, pornography, online dating) in which the individual engages.

Numerous approaches have been proposed for the treatment of internet addiction, although few have been investigated systematically. Most treatment approaches include cognitive and behavioral strategies. For example, clients may be instructed to keep a behavior log, in which they record how much time they spend online. Once a baseline usage time is established, therapists teach clients strategies for decreasing the amount of time spent online. These strategies include creating "external stoppers" (e.g., a timer), as well as reminder cards outlining the benefits of abstaining, and the negative consequences arising, from excessive internet use. When the internet is used to escape reality or as some other coping strategy, it may be necessary to employ cognitive strategies to target negative core beliefs and cognitive distortions associated with compulsive computer use. Although a few studies on the treatment of internet addiction have included control groups, the research literature is too preliminary to draw conclusions regarding the most effective treatment for this condition.

Given its clinical importance and preliminary work on its prevalence (especially in Asian countries), internet use gaming disorder, marked by an excessive preoccupation with online games, was approved for inclusion in Section 3 of *DSM-5*. Nevertheless, this condition requires further research before it can be incorporated into the main body of the manual.

Sexual Addiction

Sexual addiction is a term that encompasses a wide variety of problematic behaviors, including compulsive masturbation, excessive pornography use, cybersex, exhibitionism, and voyeurism. Individuals with this condition report an insatiable sex drive that interferes

with daily functioning, including occupational and social performance. They may spend excessive time planning for or engaging in sexual behavior, which is often performed without adequate regard for physical risks (e.g., sexually transmitted diseases) or emotional harm to oneself or others. Although the original intent for engaging in sexual behavior is typically to relieve distress, this maladaptive coping strategy eventually results in individuals losing control of their actions.

Although originally slated for inclusion in *DSM-5,* hypersexual disorder, which is similar to most clinical conceptualizations of sexual addiction, was not included in the manual. This decision probably reflects the paucity of research demonstrating that sexual addiction is a distinct condition rather than a nonspecific symptom of many extant conditions, such as antisocial personality disorder, bipolar disorder, and impulse control disorders. Similarly, critics have raised concerns that this condition is highly heterogeneous (Gold & Heffner, 1998).

Sexual addictions can be grouped into two categories: paraphilias and nonparaphilias (Coleman, 1992). Paraphilias involve sexual arousal to objects, people, or situations, and are generally considered to lie outside the range of conventional behavior. Conversely, nonparaphilias reflect a range of more conventional sexual behaviors that are taken to an extreme, such as excessive pornography use. The increase in the availability of pornography and cybersex online may fuel compulsive sexual behavior by creating a perception of anonymity and disinhibition (Griffiths, 2001).

Sexual addiction has been treated using multiple approaches, including pharmacotherapy, individual therapy, and group therapy. Although sexual addiction is not traditionally included in the obsessive-compulsive spectrum, there is substantial overlap between sexual disorders and obsessive-compulsive disorder, leading some to posit similar mechanisms of pharmacological intervention (Bradford, 2001). Selective serotonin reuptake inhibitors (e.g., Paxil, Zoloft) have been used for paraphilic and nonparaphilic behaviors, but there is no evidence demonstrating superior efficacy of one medication over another, and no extensive randomized, double-blind placebo-controlled studies have been published (Fong, 2006). Psychotherapy generally focuses on individual therapy, such as cognitive-behavioral therapy, designed to target compulsive sexual thoughts and behaviors or in some cases, marital therapy, which may help restore trust and reduce shame in the relationships of presumed sexual addicts. Nevertheless, these interventions have yet to be evaluated in randomized controlled trials. Support group recovery program options, such as Sex Anonymous (SA) or Sex Addicts Anonymous also exist, as do support groups for partners of sexual addicts (e.g., Co-Sex Addict Anonymous).

Shopping Addiction

Shopping addiction has been discussed in the literature under many different names, including oniomania, shopaholism, compulsive buying, and compulsive spending. The hallmark characteristics of shopping addiction are preoccupations, urges, or behaviors surrounding shopping and spending money, resulting in distress, impairment in functioning, or both.

Research suggests that the urge to spend money compulsively afflicts about 5.8% of the population (Koran, Faber, Aboujaoude, Large, & Serpe, 2006). The age of onset for shopping addiction is generally in the late teens or early 20s, and it is more common in developed countries. This condition co-occurs with many mood and anxiety disorders, as well as with several personality disorders, such as obsessive-compulsive, avoidant, and borderline personality disorders, rendering its differentiation from other conditions unclear. The compulsive act of shopping may, for example, serve as an outlet or stress reliever for individuals who are anxious or depressed.

Proposed treatments for shopping addiction include pharmacological and psychological interventions. One case study reported on the use of Quetiapine, a potent antipsychotic,

to treat bipolar I disorder associated with comorbid compulsive shopping (Di Nicola et al., 2010). Another case study reported a possible successful treatment of shopping addiction with high doses of naltrexone, an endogenous opiate blocker, aimed at reducing urges to shop (Grant, 2003). Pharmacotherapy trials for compulsive shopping are limited and inconsistent, and substantially more research is required before firm conclusions can be drawn. Nonpsychopharmacological treatment options have also been explored. In one study, individuals with compulsive buying exhibited less problematic buying behavior, healthier purchasing patterns, and fewer maladaptive thoughts surrounding buying behaviors following cognitive-behavioral therapy than those assigned to a wait-list control group (Mueller et al., 2008).

Shopping addiction is a relatively new proposed disorder with very little associated research, a lack of clear diagnostic criteria, and limited information on effective treatment. In addition, its differentiation from other conditions is poorly understood. It is therefore too early to include this disorder in the current classification system.

Stockholm Syndrome

Stockholm syndrome (sometimes called "traumatic bonding" and "terror binding") describes the paradoxical emotional attachment that some kidnapping victims purportedly develop toward their captors. This condition owes its name to a hostage situation in the Kreditbanken in Stockholm in 1973, in which the victims became bonded emotionally to their captors, even defending them against accusations after being rescued by the police. Since Nils Bejerot coined the term in 1973, Stockholm syndrome has attracted media attention in numerous television shows and in many kidnapping cases, such as in the Elizabeth Smart and Patty Hearst cases. In the 1974 Patty Hearst case, for example, Hearst (granddaughter of famous newspaper tycoon Charles Randolph Hearst) assisted in committing criminal activities perpetrated by the group that kidnapped her, the Symbionese Liberation Army.

Nevertheless, there is little scientific consensus regarding whether this syndrome qualifies as a distinct disorder. Moreover, scholars do not yet agree on formal diagnostic criteria, and little systematic research on the condition has been conducted. In addition to explaining victims' puzzling behavior in hostage situations, Stockholm syndrome has been invoked to account for why some women remain in abusive relationships, how soldiers respond to traumatic stress in war zones, and why some victims of childhood abuse do not report victimization.

Limited research has attempted to identify Stockholm syndrome in individuals exposed to traumatic situations, particularly those involving abusive relationship partners. In one study (Graham et al., 1995), researchers evaluated a 49-item scale developed to measure Stockholm syndrome in a sample of 764 undergraduate women. Factor analyses identified three well-defined dimensions: core Stockholm syndrome, love-dependence, and psychological damage. The first factor, core Stockholm syndrome, was characterized primarily by cognitive distortions aimed at reducing the stress associated with abuse. Love-dependence was characterized by an inability to imagine being without the partner, and psychological damage reflected victims' feelings of diminished self-worth. The authors concluded that victims of abuse sometimes use love to explain their high arousal state and hopes of escape from their abuser.

Most research on Stockholm syndrome has relied on retrospective questionnaires and case interviews. One notable exception is an investigation conducted by Auerbach, Kiesler, Strentz, Schmidt, and Serio (1994), who exposed participants to simulated hostage situations. One group was assigned to use emotion-focused training, which teaches individuals strategies for detaching from a stressor while (a) focusing on feelings that are inconsistent with the stressor and (b) using feelings of assertiveness to

manipulate captors. The researchers concluded that as hostages perceived their captors to be friendlier and less dominant, the more likely they were to adjust positively to the kidnapping. Another research team interviewed seven victims of a hostage situation, and found that the only individual who developed Stockholm syndrome was a woman who reportedly had the most positive contact with the hostage taker (Wesselius & DeSarno, 1983).

The unclear diagnostic features of Stockholm syndrome, paucity of systematic research, and absence of reliable measurement procedures have precluded this condition from being included in extant classification systems. Researchers must identify mutually agreed symptoms and develop valid measurement tools before this disorder can cross over from the popular psychology realm into the arena of formal psychiatric classification.

Eating Disorder Variants

Largely or entirely unvalidated labels describing a host of disordered eating behaviors are rampant in popular psychology. For example, although chocoholism can refer to a mere proclivity for chocolate, some writers conceptualize it as an addiction to chocolate or its component chemicals. Presumably more serious popular diagnoses include emetophobia, which entails an avoidance of certain foods due to a fear of vomiting or choking, and "night eating syndrome," which involves persistent late-night binge eating.

Orthorexia Nervosa

One popular diagnosis that has been the subject of increasing attention is orthorexia nervosa, more commonly called orthorexia. This condition was first identified in 1997 by Steven Bratman, who described it as a "fixation on righteous eating" that can lead to negative outcomes, such as malnutrition and low body weight. According to Bratman and Knight (2001), individuals who suffer from orthorexia seek perfection and cleanliness in their diets, depriving themselves of foods they identify as "bad." They may rigidly follow diets tied to a certain philosophy, such as veganism, macrobiotic diets, or Paleo diets. The condition is not necessarily associated with a desire to lose weight, but with a desire for biologically pure foods lacking human-made additives and chemicals.

More recently, some scholars have attempted to delineate diagnostic criteria for orthorexia. Vandereycken (2011) argued that orthorexia requires that an individual experience a preoccupation with healthy eating and an abnormal concern regarding physical health. This preoccupation presents itself as an avoidance of all foods or ingredients viewed as unhealthy. This preoccupation must cause significant distress in important areas of life, such as social and occupational functioning. Individuals with orthorexia engage in highly selective eating, which may lead to malnutrition and weight loss. Finally, the symptoms of orthorexia must not be due to other disorders such as anorexia nervosa or illness anxiety disorder (a *DSM-5* condition similar to what *DSM-IV* termed hypochondriasis).

Despite the considerable interest in orthorexia in popular culture, it has been the subject of little research. Catalina-Zamora, Bote-Bonaechea, Garcia-Sanchez, & Rios-Rial (2005) described a case study of the disorder in a 28-year-old woman who experienced severe malnutrition due to an extremely restrictive lacto-ovo-vegetarian diet. Research suggests that the condition is associated with especially frequent exercise and social physique anxiety (e.g., anxiety concerning negative evaluations of one's physique) in women, and an internalization of Western ideals concerning thinness/muscularity in men and women (Eriksson, Baigi, Marklund, & Lindgren, 2008).

Several authors have questioned the discriminant validity of orthorexia from other conditions, especially anorexia nervosa and bulimia nervosa. Nevertheless, proponents of the disorder contend that orthorexics are not concerned with losing weight and do not fear gaining weight, as do individuals with anorexia and bulimia (Zamora et al., 2005). Some

have speculated that personality traits such as rigidness and perfectionism may underlie the development of both orthorexia and other DSM eating disorders.

Muscle Dysmorphia

One of the better researched popular diagnoses in the eating disorders domain is muscle dysmorphia, also known as the "Adonis complex," "bigorexia," "manorexia," or "reverse anorexia." Muscle dysmorphia is characterized by a pathological preoccupation with being lean and muscular. The condition primarily afflicts men and involves a distorted body image—one in which sufferers perceive their bodies as smaller and weaker than they are. Affected individuals become obsessed with exercising, often in the form of weightlifting, and experience considerable anxiety regarding their physical appearance. Some researchers regard the condition as a variant of body dysmorphic disorder, in which the focus is on muscularity rather than on a specific body part (Pope et al., 1997).

Pope et al. (1997) proposed three major diagnostic criteria for muscle dysmorphia. First, muscle dysmorphia involves a pathological obsession with the possibility that one's physique is not adequately muscular. Second, this obsession must create significant difficulties in social, occupational, or other areas of functioning (e.g., the individual misses important activities to maintain a workout schedule, the individual avoids revealing his or her body to others). Third, the focus is on insufficient muscle mass rather than on a specific part of the body or on being obese.

A small but promising body of research has examined the correlates of muscle dysmorphia. In a comparison of weight lifters displaying muscle dysmorphia with normal weight lifters, Olivardia, Pope, & Hudson (2000) found that muscle dysmorphia was associated with increased checking of one's appearance in the mirror, increased time spent exercising, and avoidance of activities due to a perceived bodily defect. The disorder is associated with decreased body satisfaction and body image regarding both overall appearance and muscle tone and weight. Individuals with muscle dysmorphia exhibit higher rates of mood disorders, anxiety disorders, and eating disorders than do individuals in normal weight-lifting comparison groups.

The etiology of muscle dysmorphia is poorly understood, although researchers have proposed a biopsychosocial model that comprises biological features, such as withdrawal and tolerance symptoms, and psychosocial features, such as impaired social relationships (Pope et al., 1997). Some argue that the condition stems from low self-esteem and concerns regarding masculinity. These psychological deficits may stem from social influences, such as pressures to be muscular arising from repeated exposure to muscular action figures and images in the media. In laboratory settings, individuals exposed to muscular male advertisements experience more body dissatisfaction than do individuals exposed to neutral images (Leit, Gray, & Pope, 2001).

Critics have questioned muscle dysmorphia's discriminant validity from, and incremental validity beyond other diagnoses, especially body dysmorphic disorder. Despite these questions, individuals with both body dysmorphic disorder and muscle dysmorphia exhibit a higher prevalence of suicide attempts, substance-use disorders, and steroid use than do individuals with body dysmorphic disorder alone (Pope et al., 2005). On balance, muscle dysmorphia appears to be a promising but provisional diagnosis that merits further research. Although muscle dysmorphia has yet to be recognized as an independent condition in *DSM,* it is now listed as diagnostic specifier for body dysmorphic disorder in *DSM-5*.

Returning to the Robins and Guze (1970) criteria set out at the outset of the entry, few of the pop psychology diagnoses examined appear to satisfy rigorous criteria for validity. In particular, lingering questions remain concerning the differentiation between most or all of these diagnoses and better established and validated conditions. In addition, there is a marked paucity of research documenting

that pop psychology diagnoses are useful for predicting individuals' family history, laboratory or psychometric performance, or natural history. As a consequence, it remains unclear how many of these proposed conditions provide surplus information above and beyond the behaviors they denote. At the same time, several of these conditions, especially sexual addiction, orthorexia, and muscle dysmorphia, warrant further investigation.

In sum, the watchword for pop psychology diagnoses should be "caution." Although several of these diagnoses capture clinically important phenomena and merit additional research, none is ready for inclusion in psychiatric classification systems, and their use in courts of law is premature at best.

SEE ALSO: Construct Validity; Definition of Mental Disorder; *DSM-5*; Robins, Eli (1921–94)

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