Mental disorders are messy amalgams of biology, psychology and culture / ‘The Extraction of the Stone of Madness’ (c.1494), Hieronymus Bosch
Over the past century psychiatry has described conditions that would have once been medicalised, moralised, criminalised or perhaps dismissed as harmless eccentricity. The concept of “mental disorder” now contains a centrifugal assortment of ills that number in the hundreds. This expansion has been accompanied by equally significant cultural change. Increasingly, we view suffering and misbehaviour through a psychological lens and speak of them using a psychiatric idiom.

These developments cannot be considered apart from the *Diagnostic and Statistical Manual of Mental Disorders*. Published by the American Psychiatric Association (APA) for the past six decades – its fifth edition appears this month after a 14-year gestation – DSM maps many forms of human misery and dysfunction. But to think of it only as a map – an inert image of the psychiatric landscape – is to misunderstand it. DSM has produced tectonic changes in that landscape and shaped how we think about abnormality. It dictates how treatment is practised and funded, professionals are trained, research is conducted and legal responsibility is assessed. It has been cited in academic literature more often than Marx and has garnered more than $100 million in sales. It has also reaped a bitter harvest of criticism.

Like the internet, the GPS and the concept of “collateral damage”, DSM has its origins in the US military. The ‘War Department Technical Bulletin Medical 203’, published in 1943, served as the foundation for DSM-I, which was published in 1952 and contained 106 diagnoses. That number grew to 182 when DSM-II was published in 1968. DSM-III revolutionised psychiatric diagnosis in 1980, purging concepts judged to carry too much theoretical baggage, such as “neurosis”, fissioning conditions into narrower syndromes and capturing each disorder with strict diagnostic criteria. By splitting existing conditions and opening up new psychiatric territory, such as disorders of childhood, DSM-III’s collection of disorders swelled to 265, rising to 292 in its 1987 revision. DSM-IV, published in 1994, slowed diagnostic inflation, recognising 297 disorders. Its 2000 revised edition, the most recent, lists 365 disorders in its 943 pages.

DSM is often described as psychiatry’s bible. This facile metaphor is correct in only two respects: both books are heavy and multi-authored. No one reads DSM for narrative pleasure or moral uplift. It is a different kind of book, in some ways like a dictionary, but most closely resembling a birdwatcher’s field guide. Field guides and DSM both represent nomenclatures, providing a systematic catalogue of labels. Both define the boundaries of their domain, the set of existing species or disorders. Both offer classifications, respectively arranging birds and conditions into related groups, such as “honeyeaters” and “eating disorders”, and both briefly detail distinctive features (symptoms) to enable correct identification (diagnosis). DSM is a pragmatic document, not an encyclopaedia of psychiatric truth.

Unfortunately mental disorders are not like birds. Birds are biological, tangible entities, whereas disorders are messy amalgams of biology, psychology and culture. Birds fall into nature’s objective and discoverable categories but disorders exist in a world
in which normality blurs into abnormality and one form of abnormality blurs into another. To complicate matters further, although a bird can only belong to one species, a person may suffer more than one disorder. Under these circumstances, the classification of mental disorders is bound to be somewhat arbitrary. That is where the controversy begins for DSM.

The manual has been criticised for its proliferating diagnoses. Is there really one disorder for each day of the year? Few people appreciate the range of phenomena that the concept of mental disorder now covers, and the ways in which that concept has been splintered into hundreds of conditions. Everyone knows depression and schizophrenia, but these are small tiles in a large and colourful mosaic. DSM-IV includes such diverse conditions as mental retardation, disorder of written expression, stuttering, rumination disorder (to do with infant feeding, not adult worry), enuresis (bed-wetting), dementia of the Alzheimer’s type, caffeine intoxication, male erectile disorder, voyeurism, nightmare disorder, pathological gambling and medication-induced postural tremor. DSM’s understanding of mental disorder is far more inclusive than most laypeople’s, trespassing into territory that many would see as belonging to neurology, paediatrics, general medicine, education or, indeed, simple human frailty. As a result critics have often accused DSM of a disease-mongering land grab or, to switch metaphors, of including bats and butterflies in its classification of birds.

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Another critique concerns the place of biology in DSM: critics say that the manual presents disorders as if they were disease entities, no different in kind from cancers or infectious conditions. Although DSM makes no overt claims about biological causation and avoids medically freighted terms like “disease” – “disorder” is intended to be agnostic as to a condition’s cause – many believe it has biomedical undertones. Any such connotations would be highly questionable: no DSM condition has a specific, distinctive biological basis or a unique biomarker, such as might be found by a definitive laboratory test. You can’t send a sample of a client’s experience to the pathologist to locate the organic cause of her misery, as you could a sample of her blood or tissue, so mental disorders are diagnosed purely on the basis of observable patterns of behaviour. Some dream of the day when psychiatric diagnoses will be grounded in brain abnormalities: the current DSM has been compared to the Ptolemaic image of the universe, but a neuroscientific Copernicus is nowhere in sight.

The view that DSM promotes a biomedical understanding of mental disorder is backed by the almost exclusively medical backgrounds of its architects, and their ties to the pharmaceutical industry. The invisible hand of Big Pharma is sometimes claimed to manipulate DSM in order to expand its marketplace. In Shyness, Christopher Lane argues that DSM opened up ordinary timidity to pharmaceutical intervention when it recognised “social anxiety disorder”. Disturbingly, DSM’s new edition claims to have controlled conflicts of interest by requiring that consultants receive no more than $10,000 in annual industry funding.
The idea that DSM medicalises distress is also behind the criticism that it discounts the roles culture and society play. Although recent editions acknowledge cultural variations and list “culture-bound” conditions, like the shrinking-penis anxieties of *koro*, a fear of death-inducing genital retraction that is found most commonly in south and east Asia, critics argue that DSM overlooks how social experience interacts with psychiatric disturbance, and that its disorders lack universality. Seen in this way, the DSM is an almost imperial document that imposes foreign ways of thinking wherever it is adopted, often with baleful consequences. As Ethan Watters, author of *Crazy Like Us*, writes of his homeland, “We are engaged in the grand project of Americanising the world’s understanding of the human mind.” He sees this at work both in the well-meaning but ill-fated effort of foreign aid workers to interpret Sri Lankans’ responses to the 2004 tsunami through the lens of post-traumatic stress disorder (PTSD), and in the rise in east Asia of eating disorders, once arguably the West’s own culture-bound conditions.

The last main criticism of DSM is that it pathologises normal experience. DSM has not merely opened up new psychiatric territory, but may over-diagnose existing conditions. As Allan Horwitz and Jerome Wakefield argue in *The Loss of Sadness*, many people who meet diagnostic criteria for depression are responding normally to life’s slings and arrows rather than experiencing psychological dysfunction. Similar concerns have been raised about false epidemics of conditions such as attention deficit hyperactivity disorder (ADHD). If no clear boundary separates ADHD from healthy rambunctiousness, or neurotic misery from ordinary unhappiness, then it is easy for DSM to set the threshold for diagnosis too low. The concern here is not over-diagnosis itself so much as over-treatment and stigma.

It is into these stormy waters that DSM-5 is launched. This new edition has been drafted since 1999 and $25 million has reportedly been spent on its research and development. Some of the new manual’s features are positive. It was exposed to extensive public consultation. It is better harmonised with the World Health Organization’s International Classification of Diseases rather than going its own American way. It has reduced the number of disorders. It has acknowledged the overwhelming evidence that most mental disorders fall on a continuum with normality. Its very name – DSM-5, not DSM-V – signals a move away from the carved-in-stone authority of its predecessors.

DSM-5’s more contentious developments involve changes to how particular disorders are recognised. To start with the promotions, PTSD now sits proudly at the centre of a new “Trauma- and Stressor-related Disorders” group, having previously huddled among the anxiety disorders. This classificatory upgrade reflects the enormous growth in the study of post-traumatic reactions – which only entered the psychiatric classification in 1980 – and the rise of “trauma” as a culturally sanctioned way of understanding adversity. Another promotion is hoarding disorder, previously just a subtype of obsessive-compulsive disorder but now recognised as a disorder in its own right, coinciding with a popular fascination with the dark side of acquisition.
Turning to the new hires, several conditions appear in DSM-5 for the first time, including excoriation disorder, a skin-picking condition whose animal analogues include self-plucking parrots and self-depilating dogs, and pre-menstrual dysphoric disorder, a cyclic pattern of distress, fatigue and sleep problems that follows ovulation. Other additions include restless legs syndrome, caffeine withdrawal (no relation), and disruptive mood dysregulation disorder, a diagnosis intended to deflect moody children from the troubling epidemic of childhood bipolar disorder.

Numerous disorders, some nominated by the general public and others by DSM-5’s developers, were tested and found wanting. Paraphilic coercive disorder was dismissed after intense criticism that it treated rape as a symptom rather than a crime. Olfactory reference syndrome, a delusion whereby the sufferers are convinced they emit a faecal stench, failed to make the grade. Other failures include internet gaming disorder, a diagnosis that could have opened the door to any number of non-chemical dependencies. Love, sex and shopping addictions are staples of the popular press but have yet to receive psychiatry’s imprimatur.

A few DSM-IV disorders have been pink-slipped. Asperger’s disorder is no more, absorbed into autism spectrum disorder along with three related conditions, including autistic disorder. Although this merger is a scientifically well-justified simplification – the four merged conditions fall along a severity continuum – it has been unpopular within the Asperger’s community. They see Asperger’s as distinct from autism, understanding it as a minority culture rather than a psychiatric condition and worrying that support may be withdrawn. Dependent, histrionic, paranoid and schizoid personality disorders were also slated for removal but retained following objections from researchers.

Many of these revisions have drawn criticism, but the fiercest challenges have addressed the new ways in which DSM-5 might pathologise normal behaviour. This charge has been led by the psychiatrist Allen Frances, primary architect of DSM-IV. His new book, Saving Normal, is published a week before DSM-5. Arguing that the newly minted diagnoses can be as dangerous as new drugs, and admitting that his own more conservative revision enabled the runaway diagnosis of ADHD, autism and childhood bipolar disorder, he fears that DSM-5 will render normality an “endangered species” and create more phony psychiatric epidemics.

Frances may well be right. Take several new DSM-5 diagnoses. Binge-eating disorder involves out-of-control eating episodes without the purging or excessive exercising that characterise bulimia nervosa. Somatic symptom disorder can be diagnosed if a person has a disruptive physical symptom, such as heart palpitations, and is overly anxious about it, exaggerates its seriousness or devotes excessive time and energy to it. Mild neurocognitive disorder refers to a minor loss of cognitive function. These phenomena all cause suffering and disability, and their inclusion was driven by the worthy goal of early identification and treatment. But it also runs the risk of declaring normal experiences pathological and drastically swelling the ranks of the dis-
ordered: unhappy teens who overeat, cancer sufferers terrified of a recurrence, middle-aged adults on the gentle early slope of cognitive decline.

Another troubling example is DSM-5’s removal of the “bereavement exclusion” from the diagnostic criteria for depression. In DSM-IV a person could not be diagnosed with a depressive episode within two months of the death of a loved one because, as Freud noted, mourning resembles melancholia. DSM-5 drops the exclusion for several reasons: grief does not end after two months, many depressions follow adverse events (there is no relationship break-up exclusion, after all), and depression following bereavement can have severe consequences. The removal of the exclusion does not mean, as some critics have shrilled, that DSM-5 calls normal grief a disorder. De-
pression would still be diagnosed only in the minority of the bereaved who fulfil all criteria for depression.

Frances is an incisive psychiatric critic of the new diagnostic regime. Many psychologists have also engaged seriously with DSM-5 despite deep concerns over diagnostic inflation and the neglect of social and cultural influences. Other critics have been entirely dismissive. The British Psychological Society’s response to DSM-5 rejects the very idea of diagnosis – clients should be assessed for specific problems, not assigned to categories – and argues that diagnoses lacking a specific biological cause are completely suspect. It objects to the “medicalisation of ... natural and normal responses ... which do not reflect illnesses so much as normal individual variation” – a point it repeats, mantra-like, 37 times, even though DSM-5 never employs the concept of “illness”.

Other critics play similar terminological tricks, invoking language that DSM explicitly avoids to criticise its medicalisation of mental disorder. In one interview, Christopher Lane claims that DSM-III “defined virtually everything as a ‘disorder’, which connotes an innate, lifelong malfunctioning of the brain”. Yet DSM neither claims nor implies innateness, permanence or a neural basis for disorder. Similarly, the author of a fierce letter to the British Medical Journal argues that it is inconceivable that 25% of the population could have a “mental illness”, as a large 2008 American survey found, and then claims that DSM-5’s model of mental health is “a reductionist biological one” that attributes behaviours to “chemical imbalance” and in which people are “labelled for life as mentally ill”.

Seeing criticisms like these we can almost feel sorry for DSM-5. It’s not the manual’s fault that billions of dollars of psychiatric research have failed to identify simple neuro-biological causes for its diagnoses. It’s not unreasonable for psychiatrists to attempt to classify and diagnose mental disorders in a similar way to their peers in other medical specialties. It’s not obvious why people feel a need to save normality from psychiatry more than from dermatology. It’s also not clear why entirely different principles should apply when we think about physical illnesses and mental disorders: the idea that one is objective and real and the other subjective and arbitrary smacks of an old-fashioned dualism.

Rheumatology, for example, like psychiatry, recognises more than 200 distinct conditions, whose classification is in a state of flux. Two rheumatology researchers could have been writing about psychiatry when they recently observed that for most conditions “we do not understand their [causation], and there are no ‘gold standard’, unequivocal clinical and laboratory features to distinguish one disease from another or even from normality”. Why then are critics not lining up to attack the rheumatological authorities? Where are the activists outraged that rheumatology “pathologises” the creaking joints of normal ageing?

We do see mental disorder as fundamentally different from physical disease. We accept that it is entirely normal for our bodies to suffer illness from time to time but re-
ject the idea, which DSM-5 promotes, that most of us will at some point merit a psychiatric diagnosis. One reason for this discrepancy is that we tend to see a disorder as something a person is (a “schizophrenic”), but a disease as something a person has (a cold). Psychiatric conditions all too easily become defining identities that set some people apart from the rest of humanity, pervading and diminishing their personhood. If DSM-5 adds to the ways in which personhood can be stripped and identity tainted, then it deserves all of its criticisms. Understood correctly, however, psychiatric diagnosis does nothing of the sort. A disorder does not define one’s identity or essence: diagnosing a person is not like identifying their species. A disorder is not even an alien “thing” that a person has, like an illness. It’s merely a set of very human characteristics that bring suffering and impairment. Normality is not defined by what DSM-5 leaves out.

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