Chapter 4
The Biopolitics of Defining "Mental Disorder"

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What is psychiatry, and how does it relate to other medical and mental health disciplines? Apart from the obvious sociological answer—psychiatrists are physicians who have completed residency training in psychiatry—psychiatry has always struggled to define itself with precision. Unlike pediatrics or geriatrics, psychiatry does not define itself by reference to a specific demographic population. Unlike general surgery or anesthesiology or radiology, it does not define itself exclusively with reference to specific technologies or interventional practices: the majority of psychotropic medications in the United States are prescribed by nonpsychiatrists [1]. Unlike certain medical specialties such as nephrology or cardiology, psychiatry cannot lay exclusive claim to a particular body part or organ system: although psychiatry is often referred to as a "clinical neuroscience" [2], psychiatry at best shares this distinction with neurology, neurosurgery, and neuropsychology. Nor can psychiatry define itself according to a particular institutional structure of practice, since psychiatrists have long shed their historic identification with inpatient institutions and now work within a broad and diverse array of practice settings.

Lacking any more salient identifier, American psychiatry has most consistently defined itself according to the conditions which it treats: a psychiatrist, as the American Psychiatric Association (APA) presently states on its public website, is "a medical doctor who specializes in the diagnosis, treatment and prevention of mental health, including substance use disorders" [3]. Psychiatrists, in other words, are clinicians who (unlike psychologists, social workers, and other therapists) are "medical doctors" and who (unlike other physicians) focus on certain things called "mental disorders." The concept of "mental disorder," then, plays an important role in the way that psychiatry publicly describes itself as a distinct and coherent medical specialty.

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J. Paris and J. Phillips (eds.), *Making the DSM-5: Concepts and Controversies*,
DOI 10.1007/978-1-4614-6504-1_4,

The problem with publicly defining itself in this way is that psychiatry has never been able to settle on a precise and unambiguous conceptual description of "mental disorder." Most of the time, to be sure, this hasn't mattered very much for everyday psychiatric practice: patients come to psychiatrists not because they care about the precise meaning of "mental disorder" but because they want to feel, think, or act better. In this light, specific behavioral, cognitive, and emotional configurations such as schizophrenia, bipolar disorder, and panic disorder are generally accepted as mental disorders which are appropriate objects of psychiatric evaluation and treatment. But in moments when psychiatry's authority or helpfulness has been questioned, the concept of "mental disorder" becomes much more visible and important. At these times—notably in the case of homosexuality [4] but also in the cases of social phobia [5], major depressive disorder [6], certain of the paraphilias [7], and other disorders—critics of the *DSM* often frame their criticism by questioning whether the pathologized experience or behavior is in fact appropriately described as "mental illness" or "mental disorder." Indeed, a large theme of the so-called anti-psychiatry movement of the past 50 years has been that "mental disorder" is itself a circular concept, that psychiatry attains and asserts its power and influence by colonizing particular domains of human life and culture as "mental illnesses" and then by offering itself as the appropriate authority for their "treatment" [5, 8, 9]. In these cases, critics argue, a psychiatric profession which defines itself as the medical discipline which treats "mental disorders" ought to be able to define "mental disorders" as something other than "the conditions which psychiatrists treat."

In the context of such public questioning of psychiatry and the need to position psychiatry as a medical discipline distinct from other medical disciplines, philosophers, psychiatrists, and other mental health professionals over the past four decades have devoted much time, effort, and energy toward the development of a precise, consensual, noncircular definition of mental disorder—a quest which persists to this day in *DSM-5*. In this chapter, I will argue that this quest has little to do with the scientific and pragmatic utility of such a definition—which has historically been nearly irrelevant and in the future is likely to be modest at best—and much to do with the political force of a clear definition. I will argue that the project to define "mental disorder" arose in the 1970s and early 1980s as a way to burnish the authority of psychiatry and specifically of *DSM-III.* I will argue that the project to define "mental disorder" has continued in subsequent editions of *DSM,* including *DSM-5,* primarily in order to persuade internal and external constituents that there exists an appropriate, safe, and nonthreatening clinical "space" within which psychiatric diagnosis and treatment can be rightfully exercised. But I will conclude by arguing that there is no such safe space for psychiatry and that the *DSM* definition of "mental disorder" ought therefore to be discarded.

A Political History of the *DSM* Definition of "Mental Disorder"

Although speculation about the nature of mental illness had ample precedent within psychiatry, the modern *DSM* definition of mental disorder traces its roots to the 1970s as American psychiatry confronted a scientific and social "crisis of legitimacy" [10].

Social trust in psychiatrists' ability to speak authoritatively about human life and suffering was challenged by the countercultural and antiauthoritarian movements of the 1960s and 1970s; these challenges were displayed in specific events such as Thomas Szasz' publication of *The Myth of Mental Illness* [8], Erving Goffman's expose and critique of psychiatric institutions [11], the commercial success and cinematographic portrayal of Ken Kesey's *One Flew Over the Cuckoo's Nest* [12], the publication in *Science* of the so-called Rosenhan experiments in which a group of researchers feigned psychosis in order to gain access to psychiatric hospitals and then were able to gain release only after lengthy admissions [13], and perhaps most notably, the protracted debate within the APA which led to the removal of homosexuality from *DSM-II* in 1973 [4]. In response to these external and internal challenges to psychiatry's authority and legitimacy, empirically minded research psychiatrists began to advocate that psychiatry more closely attend to its status as a modern biomedical discipline: the psychiatry that they envisioned would be less politically engaged and psychoanalytically oriented and more oriented toward traditional medical models of disease, diagnosis, and treatment. The groundbreaking work of the APA Task Force on Nomenclature and Statistics which culminated in the publication of *DSM-III* in 1980 was both the fruit and a catalyst of this movement: with its ostensive commitment to construct reliability and etiological theory-neutrality, *DSM-III* embodied its creators' hope for a psychiatry which was "[reliant] on data as the basis for understanding mental disorders" [14].

In the context of this larger effort to shore up the philosophical and medical legitimacy of psychiatry and to ward off sociopolitical critique of the profession, psychiatrists (along with other physicians) began to think and write more about the concept of disease and, specifically, the concept of "mental illness" or "mental disorder." R. E. Kendell, for instance, while conceding that the concept of disease was unnecessary for most psychiatric practice and that medicine had never organized its nosology around a unified concept of disease, cited the anti-psychiatry movement as justification for the need for a definition of mental illness and modified a prior definition of J. G. Scadding [15] to describe disease as a deviation from a species norm which results in increased mortality or decreased fertility [16]. Donald Klein defined disease as "covert, objective, suboptimal part dysfunction"—linking disease to the loss of "optimal biological functioning, within an evolutionary context"—and defined mental illness as "the subset of all illness that presents evidence in the cognitive, behavioral, affective, and motivational aspects of organismic functioning" [17].

The *DSM* definition of mental disorder emerged in the context of these clinical and philosophical conversations and owes its existence primarily to Robert Spitzer, the chair of the APA Task Force on Nomenclature and Statistics and the principal architect of *DSM-III.* Spitzer had been involved in the *DSM-II* revision process but had gained further stature and visibility within American psychiatry through his politically deft actions to resolve the controversy over the diagnostic status of homosexuality in *DSM-II.* Mindful of the mounting political cost of psychiatry's pathologization of homosexuality and personally sympathetic to the arguments and claims of psychiatrists who described themselves as gay, Spitzer navigated a 1973 compromise in which homosexuality per se would be removed from *DSM-II*

but a residual category, Sexual Orientation Disorder, would remain. Writing later of this process, Spitzer stated that his evolving attitudes regarding homosexuality had been guided by a conviction that mental illnesses either "regularly caused subjective distress or were associated with generalized impairment in social effectiveness or functioning," neither of which applied to homosexuality per se [18]. Spitzer and Jean Endicott (1978) stated that the homosexuality controversy provided the "initial impetus" for the effort to place a definition of mental disorder in *DSM-III*. (Neither *DSM-I* nor *DSM-II* had included any such definition.) They stated that the conviction that a definition was needed grew as the *DSM-III* revision process began in 1975:

> Decisions had to be made on a variety of issues that seemed to relate to the fundamental question of the boundaries of the concept of mental disorder. We believed that without some definition of mental disorder, there would be no explicit guiding principles that would help to determine which conditions should be included in the nomenclature, which excluded, and how included conditions should be defined [19].

Spitzer and Endicott proposed a draft definition of mental disorder at the 1976 APA annual meeting and found that "to our chagrin, the reaction was negative" [19]. Respondents and audience members charged that a definition of mental disorder was unnecessary, that it would unduly restrict the scope of psychiatric practice, and that it would not be effective in guiding decisions about nomenclature. Undeterred, Spitzer and Endicott revised this draft definition and in 1978 proposed a definition of "mental disorder" as a subset of "medical disorder:"

> A medical disorder is a relatively distinct condition resulting from organismic dysfunction which in its fully developed or extreme form is directly and intrinsically associated with distress, disability, or certain other types of disadvantage. The disadvantage may be of a physical, perceptual, sexual, or interpersonal nature. Implicitly there is a call for action on the part of the person who has the condition, the medical or its allied professions, and society. A mental disorder is a medical disorder whose manifestations are primarily signs or symptoms of a psychological (behavioral) nature, or if physical, can be understood only using psychological concepts [19].

Spitzer and Williams report that this definition, too, was received tepidly by the APA Task Force on Nomenclature and Statistics. In addition to this, the American Psychological Association strongly dissented to any concept of "mental disorder" as a subset of "medical disorder" [20, 21]. They write that after an "agonizing _ reappraisal," the Task Force decided to eliminate any referent to "medical disorder" from the *DSM* definition. They report that work on the definition then stopped for several years until "eventually, in the last few months of work on *DSM-III* another attempt was made to define mental disorder incorporating certain key concepts that had been helpful in providing a rationale for decisions as to which conditions should be included or excluded from the *DSM-III* classification of mental disorders and as guides in defining the boundaries of the various mental disorders" [20]. This revised definition appeared in *DSM-III,* following the qualifying statement that "there is no satisfactory definition that specifies precise boundaries for the concept 'mental disorder' (also true for such concepts as physical disorder and mental and physical health)," as follows:

> In *DSM-III* each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.) [14].

This definition by Spitzer and colleagues established the basic definitional form which has appeared in each subsequent edition of the *DSM*. *DSM-III-R* (1987), also edited by Spitzer, revised the definition slightly, adding to "distress" and "disability" the possibility that a person with mental disorder might be at "significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g., the death of a loved one" [22]. The definition of mental disorder which appears in *DSM-IV* and *DSM-IV-TR,* principally edited by Allen Frances, slightly tweaks the *DSM-III-R* definition without changing it substantially. After a lengthy prefatory comment that as with medical conditions in general, "the concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition which covers all situations," the *DSM-IV* authors state that the *DSM-III-R* definition is being included in *DSM-IV* "because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in *DSM-IV*" [23]. The full *DSM-IV* definition reads as follows:

> In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern 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. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above [23].

Despite Frances' avowal around the time of the *DSM-IV* revision process (and in the text of *DSM-IV* itself) that the *DSM-III-R* definition had played some role in the construction of the *DSM-IV* classification, there is little specific evidence of this. Indeed, even at the time of the *DSM-IV* revision process, Frances and colleagues wrote that "the implicit definition of mental disorders and medical disorders—'that which clinicians treat'—is tautological, but other more abstract concepts consistently fail to provide greater explanatory power" [24].

Although the *DSM-5* definition of mental disorder is still being constructed at the time of this writing, it is expected to take the same general form as the *DSM-III* and *DSM-IV* definitions. The final pre-publication draft definition refers to mental disorders as "health conditions" characterized by "dysfunction in an individual's

cognitions, emotions, or behaviors that reflects a disturbance in the psychological, biological, or developmental processes underlying mental functioning." Some disorders, however, "may not be diagnosable until they have caused clinically significant distress or impairment of performance." As in *DSM-IV,* a mental disorder cannot be an expected or culturally sanctioned response to a particular life event and cannot be primarily a conflict between the individual and society, "unless the deviance or conflict results from a dysfunction in the individual" [25].

DSM-5 and the Lure of a Definition

I referred to the previous section as a "political history" of mental disorder definitions to make clear that the *DSM* definition of mental disorder, like the *DSM* itself, did not develop in a historical vacuum; it emerged, rather, at a specific period of psychiatry's history, in response to particular historical events and political challenges, to serve particular functions with regard to psychiatry's relationship to the rest of medicine and to its various constituent groups. Robert Spitzer's extensive engagement in the debate about the diagnostic status of homosexuality forced him (and others) to think critically about the appropriate boundaries of psychiatric diagnosis and convinced him (and some, though not all, others) that a clear definition of "mental disorder" could guide diagnostic decisions in the *DSM-III* revision process. The clear implication of Spitzer's advocacy of a definition of mental disorder was that with the benefit of a well-constructed definition, psychiatry would be less likely to stumble into the politically complicated nosological terrain that had engulfed it in the case of homosexuality.

Despite Spitzer's hope and despite his eventual success in placing a definition of mental disorder in *DSM-III,* it is clear that the *DSM* definition of mental disorder has never played a major role in the revision processes of any edition of the *DSM,* from *DSM-III* to *DSM-5.* Spitzer and Williams (1982) acknowledged this, writing that the *DSM-III* definition of mental disorder was written *after* the major nosological decisions had been made and which at best "[incorporated] certain key concepts that had been helpful in providing a rationale for [editorial] decisions" [20]. Frances and the *DSM-IV* Task Force maintained a decidedly disengaged stance toward the *DSM-III-R* definition, including it with little revision and crediting it only with helping to guide decisions about marginal cases of disorder—though they give no specific examples of how this was done and Frances' more recent writing casts doubt on whether the *DSM-III-R* definition had any effect at all [26].

Despite the functional irrelevancy of past *DSM* definitions of mental disorder for the construction of the *DSM* itself, early discussion about *DSM-5* revived Spitzer's old hope that a clear definition of mental disorder might play an active role in *DSM-5* decision-making. Rounsaville et al., acknowledging the difficulty and complexity of past attempts at definition, express this hope as follows:

> Despite the difficulties involved, it is desirable that DSM-V should, if at all possible, include a definition of *mental disorder* that can be used as a criterion for assessing potential

> candidates for inclusion in the classification, and deletions from it. If for no other reason, this is important because of rising public concern about what is sometimes seen as the progressive medicalization of all problem behaviors and relationships. Even if it proves impossible to formulate a definition of mental disorder that provides an unambiguous criterion for judging all individual candidates, there should at least be no ambiguity about the reason that individual candidate diagnoses are included or excluded [27].

Ten years later, despite some detailed conceptual work on the *DSM-5* definition which was explicitly acknowledged and credited by the DSM-5 Task Force [28], there is no evidence that the *DSM-5* definition has been any more influential in the *DSM-5* revision process than past definitions of mental disorder have been for past editions of the *DSM*. It is notable and ironic, for instance, that Rounsaville et al. grounded the need for a clear definition in "rising public concern about … the progressive medicalization of all problem behaviors and relationships" and that despite this prescient concern, the *DSM-5* revision process has been dogged by a lively and contentious intrapsychiatric debate that *DSM-5* will encourage just this sort of inappropriate medicalization [26]—with no part of this debate influenced by any working definition of "mental disorder." The *DSM-5* Task Force did not act on a public proposal to include a Conceptual Issues Working Group among the other working groups associated with *DSM-5* [29]. As with prior editions of *DSM,* the *DSM-5* definition of "mental disorder" appears to be a late-stage insertion into the manual which, at best, provides some post hoc light on the editorial reasoning of the Task Force. The Task Force could have wrestled deeply with a definition of mental disorder and could have used it as the basis for a substantial revision of the *DSM*—the work of Wakefield, for example, demonstrates how such theory-to-practice critiques might occur [6, 30, 31]—but all indications are that the Task Force did not choose to do so.

If the *DSM* definition of mental disorder has been so marginal in the ongoing revision and articulation of the *DSM,* why should it be included in successive editions of the manual? This is a reasonable question. From a scientific perspective, there seems to be no positive need for a *DSM* definition; if the *DSM* definition were to disappear, very little would change, either in subsequent revisions of *DSM* or in the use of *DSM* by clinicians, researchers, and third-party payers. And it is entirely possible that the definition *will* go away, sooner or later. But for now, in *DSM-5* as in prior editions, the definition remains.

Why does this functionally inconsequential definition of mental disorder remain in the *DSM?* To be sure, no positive reason need exist: the definition may be simply vestigial, carried over from edition to edition because no one has expended the time and energy to remove it. This indeed seems to have been roughly the case for *DSM-IV. DSM-5,* though, is more temporally removed from its predecessor than was the case with *DSM-IV,* and the revision process as a whole has been more open to major structural changes and proposals. Though the definition of mental disorder has not by any account been a large part of the Task Force's work, it has been subjected to critical ongoing revision. In this case, it is reasonable to conclude that it serves some function, either ostensive or implicit, within *DSM-5.* I suggest here that the *DSM-5* definition of mental disorder, like its predecessors in *DSM-III, DSM-III-R,* and

DSM-IV, serves a function which is primarily political. To the extent that the definition exerts influence, I argue, it does so by constructing the way that psychiatry is interpreted as a medical specialty—both by psychiatrists themselves and by the larger communities within which psychiatry is practiced—and consequently by constructing the way that individuals in our culture grant authority to psychiatry and psychiatry's diagnostic language.

Seen in historical and political context, the primary function of the *DSM* definition of mental disorder is not to regulate which disorder categories are included in the *DSM* (since it has never explicitly done that), nor to provide an abstract philosophical account of the sort of thing a "mental disorder" is, but rather to delineate the rough boundaries of a clinical "space" within which psychiatry as a medical discipline exercises proper authority and which does not encroach on territory which is socially and politically controversial. There are three specific ways—one by affirmation and two by exclusion—in which the *DSM* definitions (both in *DSM-IV* and in the *DSM-5* definitions proposed to date) attempt to delineate this safe clinical space.

First, the *DSM* definitions use spatial images of depth and interiority to affirm that mental disorders are interior to individuals and that they somehow underlie the distress, disability, and impairment of function which is associated with them. While each of the *DSM* definitions uses slightly different language to convey this, the structural themes are the same: mental disorders reflect dysfunction *in* an individual (or in an individual's cognitions, emotions, and behaviors) which displays itself through subjective distress and/or dysfunction *of* the individual in particular areas of life. *DSM-IV,* for example, specifies that a mental disorder is "a clinically significant behavioral or psychological syndrome or pattern that *occurs in an individual*" and, later, that "whatever its original cause, [a mental disorder] must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction *in* the individual" [italics added]. This distinction between "dysfunction in" an individual and "dysfunction of" the individual in his/her life pursuits, with the "dysfunction in" somehow underlying or causing the "dysfunction of," is important for distinguishing the mental health disciplines (particularly psychiatry) from nonmedical disciplines which also attend to personal distress and social deviance. If psychiatry understood itself simply as a discipline which attended to persons experiencing distress or disability, the *DSM* definition conveys, then psychiatry would have no definitional means by which to distinguish its role from that of other disciplines which also attend to those matters. But fortunately for psychiatry, this is not the case: "mental disorders" turn out not only to be distressing and/or disabling conditions but also conditions which reflect a deeper "dysfunction in" an individual's mental, emotional, and/or cognitive apparatus. Psychiatry is then able to view this deeper "dysfunction in" as the proper object of its expertise. Whether this "dysfunction in" can be demonstrated or located is inconsequential for the *DSM* definition: that it is *presumed* to exist is enough to justify the safe space in which psychiatry can exercise its proper authority.

Second, the *DSM* definitions reinforce the presence of this deeper "dysfunction in" by specifying that a mental disorder must *not* be, as *DSM-IV* puts it, "merely an

expectable and culturally sanctioned response to a particular event, for example, the death of a loved one." This negative qualification functions to address the longstanding critical concern that the mental health professions have historically expanded their influence and power by medicalizing aspects of life and behavior which were previously interpreted without the aid of medical models. The *DSM* definitions, by excluding ordinary experience from the concept of mental disorder, attempt to lay this concern to rest.

Third and finally, the *DSM* definitions all make clear that social deviance itself cannot be "mental disorder," and that conflicts between an individual and society are not mental disorders unless the deviance or conflict results—here again—from "dysfunction in the individual." This second negative qualification is necessary to address a second longstanding charge of psychiatry's critics, that psychiatric technology and power function as agents of social control. We may note how much has changed in the *DSM* since its first edition in 1952, in which individuals diagnosed with "sociopathic personality disturbance," of which homosexuality was one example, were understood to be "ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals" [32]. And it is further worth noting that in certain cultures psychiatric language and authority has indeed been used coercively to suppress social deviants and political dissidents [33]. But the *DSM* definition attempts to ensure readers that none of this is a concern with modern psychiatry: the *DSM* is concerned not with social conflict and deviance but with the underlying dysfunctions of which such conflict and deviance is, at most, a symptom.

In each of these ways, then—through the distinction of "dysfunction in" an individual from "dysfunction of" an individual in his/her life pursuits, through the exclusion of the pathologization of ordinary life, and through the exclusion of the pathologization of social deviance—the *DSM* definitions seek to delineate and map a safe clinical space within which psychiatry can be practiced and in which its authority can be properly exercised. In this mission, they speak differently to the various constituents of the *DSM*. To psychiatrists, they provide a reassuring legitimation of psychiatric authority and a disciplinary reminder of the degree to which psychiatry must continue to conform to modern medical models of diagnosis and treatment (including the modern focus on the individual as the locus of pathology and of treatment). To all mental health professionals, including psychiatrists, they provide a common organizing language which constructs and defines "mental disorder" as a unifying foe, aligning the various mental health disciplines under a common language and a common clinical project. To current or potential patients, they provide reassurance that the diagnostic constructs of the *DSM* are real and that the distress/disability/functional loss which leads them to consider treatment is somehow reflective of a deeper dysfunction "in" themselves, and that seeing a psychiatrist might help to find a fix for this "dysfunction in." To insurers and third-party payers, they reinforce the status of psychiatry as a medical discipline which, naturally, should be treated just as any other medical disciplines are treated. And to would-be critics of psychiatry, they provide at least ostensive defense against the most common anti-psychiatric critiques.

There is No Safe Space for Psychiatry: Why the *DSM* Definitions Fail

So far in this chapter I have argued that the *DSM* definition of mental disorder evolved in a particular sociohistorical context in which psychiatry was seeking to burnish its credibility as a medical discipline against internal and external critics who were challenging psychiatry's authority and legitimacy. I have argued that Spitzer initially proposed a forerunner of the *DSM-III* definition as a direct result of his involvement in the controversy surrounding the diagnostic status of homosexuality, and with the hope that a clear definition of mental disorder could guide nosological decisions during the *DSM-III* revision process. I have argued that despite Spitzer's hope, no *DSM* definition of mental disorder, including that in *DSM-III,* has ever served the regulative role that Spitzer envisioned; at best, the *DSM* definitions have provided a rough post hoc account of the general nosological commitments of the *DSM* architects. They have not been and are not, by any account, essential to the construction and revision of the various *DSM* editions. They do, however, serve a distinct *political* function: to conceptually delineate a safe clinical space within which psychiatry can exercise its authority.

If the *DSM* definitions were conceptually and logically successful in delineating this safe clinical space for psychiatry, this would be an incalculable gift to psychiatry and to all of the mental health disciplines. If "mental disorder" could be clearly and logically defined, and the proper boundaries of psychiatry's authority successfully demarcated, the long and complex struggle of psychiatry to legitimate itself within the pantheon of medical disciplines and to establish its legitimacy with the broader public would be effectively over. Psychiatry could pursue its proper work—investigating, preventing, treating, and ultimately eliminating "mental disorders"—with boldness and authority. The problem for the *DSM* and for its communities of reception, however, is that the *DSM* definitions of mental disorder do not successfully establish any such safe clinical space. Far from defending psychiatry against anti-psychiatric critique, the *DSM* definitions in fact display the high degree to which psychiatric diagnosis is both value-laden and politically contestable. There are at least three reasons why this is the case.

The first reason that the *DSM* definitions fail to delineate a safe clinical space for psychiatry is that the central distinction which they make—the distinction between the distress/disability/functional loss *of* the individual and dysfunction *in* the individual which causes the "dysfunction of"—is at present indemonstrable with regard to most of the *DSM* mental disorder constructs. The problem is not, of course, a matter of recognizing the subjective distress, disability, or loss of function which brings patients into psychiatric care. That is clearly and self-evidently demonstrable. The problem, rather, is in meaningfully identifying and describing specific "dysfunction in the individual" which correlates to or causes this "dysfunction of." In certain specific psychopathological cases—in Alzheimer's-type dementia, for example (or, in the likely *DSM-5* nomenclature, "Major Neurocognitive Disorder Due to Alzheimer's Disease")—this distinction is clearly meaningful even if the

specific neuroanatomical lesions which correlate with the clinical phenotype of cognitive disorder are not (yet) able to be seen in vivo. In the case of Alzheimer's disease, well-defined, highly correlated neural lesions (whatever their cause) are associated with "dysfunction in" the brain which correlates closely with the "dysfunction of" the person in his/her life projects. But in the case of most current *DSM* mental disorders, there is simply no reliable and noncircular way to identify "dysfunction in" without recourse to the "dysfunction of" which brings a patient into treatment. Sometimes this is because no biomarkers or psychological endophenotypes have been identified for specific disorders. Sometimes this is because particular biomarkers or psychological phenotypes have been correlated with particular disorders, but the way that these markers function is so poorly understood that a judgment of "dysfunction" would be premature and unintelligible, lacking an account of "proper function." Sometimes this is because the teleological frames used to make judgments about dysfunction (such as the evolutionary theory of Wakefield) are themselves speculative and contestable [34].

All of these are, of course, surmountable obstacles—it is conceptually possible (though doubtful, for reasons given below) that a future science of psychiatry will have developed robust bottom-up accounts of biological and psychological function which are sufficient for the identification and recognition of "dysfunction in the individual." But that is simply not how things work right now in the clinical practice of psychiatry. In the modern practice of psychiatry, in most cases, clinicians recognize the presence of distress or "dysfunction of" an individual, *infer* the presence of a "dysfunction in" from this "dysfunction of," and then establish a treatment plan targeted at the amelioration of the distress and/or "dysfunction of" the patient. It is generally not possible to clearly describe a "dysfunction in" which can be distinguished from this "dysfunction of."

In itself, this inability to distinguish "dysfunction of" an individual from an underlying "dysfunction in" an individual is not particularly important: psychiatrists can care well for patients, and patients can flourish, without any need for such a distinction. But if "dysfunction in" cannot in practice be identified apart from "dysfunction of," the *DSM* definitions of mental disorder are rendered powerless to guard psychiatric nosology against the medicalization of ordinary life and of social deviance. The definitions are in fact shown to be absurdly circular. How is it, a critic might ask, that Disorder A is properly a mental disorder and not simply a conflict between an individual and society? The definitions respond: because the conflict results from a "dysfunction in" the individual. But how, the critic might respond, do we know that such a "dysfunction in" exists? The definitions respond: because its presence is inferred from the distress, disability, and "dysfunction of" the person in his/her life context. And so the efforts of the *DSM* definitions to guard psychiatric nosology against the medicalization of ordinary life and social deviance are seen, in many cases, to be circular and therefore vacuous.

The second reason that the *DSM* definitions fail to delineate a safe clinical space for psychiatry is that "function" is and likely will always be a socially contestable concept. Writing about the homosexuality debate of the 1970s, for example, Robert Spitzer recognized clearly that even his proposed definition for *DSM-III* would not

resolve fundamental debates regarding the diagnostic status of homosexuality: it would only help to clarify them. The question of whether homosexuality represented an "impairment in one or more important areas of functioning," Spitzer wrote, begged the question of what the norm of "function" is taken to be. If *sexual* functioning is the norm, without regard to same-sex or opposite-sex preference, then homosexuality per se is no functional impairment. But if *heterosexual* functioning is taken as the norm—as it was, for instance, in the disease model of Kendell [16]—then homosexuality is indeed a dysfunction, and therefore a disorder. Although modern psychiatry no longer debates the diagnostic status of homosexuality, Spitzer's point holds true for all disorder-judgments which make any recourse to normative function: "function" is a teleological (or at least contextual) concept which, when used normatively, calls for an account of how circumstances *should be* or *would be* if a thing were "functioning" correctly [35–38]. Assigning a judgment of "dysfunction," that is, entails some conception of what proper function looks like. This, then, begs the question of authority: who decides what counts as proper function, and how are disagreements about proper function to be arbitrated? Here again, the *DSM* definitions of mental disorder do not rescue psychiatric diagnosis from sociopolitical critique and controversy: rather, in invoking the concept of function, they display the degree to which psychiatric diagnosis depends on normative standards which are themselves socially contestable [39].

Third and finally, the *DSM* definitions fail psychiatry through their consistent stipulation that mental disorders occur "in an individual" rather than in any larger social context. This insistence on methodological individualism is nowhere defended in the definitions nor in the text of the *DSM* itself; it is simply stipulated. This stipulation of individualism is not so much a logical failure as it is an imaginative failure, constraining the ways that psychiatry understands the role of the individual with respect to his/her social environment, and the ways in which mental disorders are framed and conceptualized [40]. Politically, individualism is convenient for psychiatry: it preserves and justifies the dominant dyadic models of treatment, structurally aligns psychiatric diagnoses with other medical diagnoses, and helps to reinforce the claim that psychiatry does not pathologize conflicts between an individual and society unless this conflict results from a "dysfunction in the individual." But in embracing methodological individualism, the *DSM* binds itself to western (and particularly American) models of the self [41] which, in turn, both hinder imaginative conceptual work about the nature of mental disorders and, importantly, leave the *DSM* vulnerable to charges that its diagnostic constructs are themselves culture-bound [42].

How to Go On Without a Definition of Mental Disorder: Toward a Psychiatry Without Foundations

The four-decade-old quest within American psychiatry to formulate a clear definition of "mental disorder" for use in the *DSM,* birthed in the social and political milieu of the 1970s and continued through successive editions of the *DSM,* has in

many ways been a fruitful and useful process. It has rendered psychiatrists more articulate about the thorny conceptual questions which permeate psychiatric research and practice. It has engendered a great deal of thoughtful debate within the psychiatric, philosophical, and psychological literature. But it has not produced—and likely will not produce in the foreseeable future—a definition of mental disorder that successfully demarcates a safe clinical space for psychiatric diagnosis and treatment which is both regulative for nosological decisions and capable of safeguarding psychiatry against social and political critique. Far from fulfilling these tasks, the *DSM* definitions of mental disorder are at best irrelevant and at worst circular, misleading, and constraining. And so, I suggest, they should be retired. Future editions of the *DSM,* at least until the development of much more detailed and robust ground-up accounts of neurobiological and psychological function than we have now, should not include a definition of mental disorder. And if and when any future definition makes recourse to the concepts of "function" or "dysfunction," the manual should make explicitly clear how proper "function" is understood and framed, *who decides* what "proper function" is, and how disputes about the meaning of "proper function" will be arbitrated.

Given the political weight of the present definition within the *DSM,* revocation of the definition of "mental disorder" from future editions of the *DSM* is not a politically appealing prospect. It would surely be seen by some critics of psychiatry as a concession of defeat. It would render the *DSM* more vulnerable to charges that its classification is arbitrary and nonsystematic, and that the *DSM* reflects social judgments about the use of psychiatry more than it reflects any foundational theory of psychiatry's proper role with regard to human suffering. The *DSM* would appear to be an artifact of *bricolage,* a catalogue of conditions in which psychiatry happens to take some interest and which have historically been constructed as proper domains of psychiatry's authority. And it would remove any systematic, a priori way to defend psychiatry against the common charges that psychiatry medicalizes ordinary life and that psychiatry medicalizes social deviance. At the very least, removal of the *DSM* definition would encourage critical thought and analysis as to how this sort of medicalization might occur.

All of this is true—and it would be healthy, both for psychiatric diagnostic classification and for psychiatry as a whole. As I have argued in this chapter, the *DSM* definition of mental disorder neither successfully defines mental disorder nor provides a safe clinical space for psychiatry to exercise its authority. It only *seems* to do so, and therefore serves as a conceptual analgesic which, far from resolving conceptual problems related to psychiatry's proper role, only renders hard and difficult questions less likely to be addressed. But psychiatry can, and should, go on without such a definition. Without the cover of a definition of mental disorder, contemporary psychiatry would neither be discredited nor rendered incoherent. It would simply be seen for what it is: a scientifically, morally, and philosophically complex practice in which practitioners, trained in particular ways of understanding human beings and in the use of particular forms of technique, do the best that they can to attend helpfully to persons whose particular configurations of behavior, cognition, emotion, and experience are judged, by a process of social construction and narration, to

warrant their care and attention. It would be seen as a lively and diverse discipline with no foundational, unifying theory, despite many hard-fought attempts to develop one. Precisely *because* of its scientific, moral, and philosophical complexity, it would be seen as ever-vulnerable to self-aggrandizement and to manipulation by forces external to it, with the consequent need to remain vigilant, self-critical, and responsive to feedback from its various constituents. A psychiatry willing to go on without a definition of mental disorder would be a psychiatry without foundations—but since the present foundations cannot hold the weight placed upon them, that is just where psychiatry needs to be.

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