Diagnostic Sedition: Re-Considering the Ascension and Hegemony of Contemporary Psychiatric Diagnosis

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Given the almost ubiquitous unquestioning acceptance of contemporary psychiatry's views of so-called mental illness and disorders, it may be somewhat surprising to learn that the latest classification manual, the fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* or DSM-5, is merely the latest in a long line of failed, misplaced nosological attempts. What may be of even more significance is that each of these attempts at classification not only gave rise to a range of ostensible treatments and claims of cure, but also are all, thankfully, consigned to the annals of history.

Consider for example, that for Willis (1684, cited in Whitaker, 2002), the "insane" had lost their ability to reason (such ability was widely accepted by scientists and philosophers of the time as that which separated humankind from animals). Thus, for Willis, the logical response was that such "brutes" needed torture, torments, discipline, threats, fetters, and blows (Whitaker, 2002, p. 6). Ponder also during the period of time when American doctors were struggling to develop an academic foundation and credibility to their discipline, that Benjamin Rush (widely regarded as the father of American psychiatry) advanced a nosology of madness based on the belief that it resulted from "morbid and irregular actions in the blood vessels of the brain" (Whitaker, 2002, p. 14). The corresponding variety of techniques for bleeding a patient and blood-letting, pioneered and advocated by Rush and those converted by his

proselytizing, are well-documented and, interestingly, are one of the first psychiatric exports from the US to Europe. As a final example, consider what can be considered psychiatry's most repugnant nosological attempt, one which resulted in barbaric, compulsory mass sterilization adopted by over 30 US states: deeming the so-called mentally ill to be a degenerate strain of humanity who bred at alarming rates; thus arose the unholy alliance between American psychiatry and the Eugenics movement (Kaelber, 2012; Stern, 2005; Whitaker, 2002). It is worth reminding ourselves that each of the ideas listed above were widely accepted and regarded as cutting edge by leading physicians and thinkers of their respective times.

And although twenty-first century psychiatry is content to pat itself on the back and congratulate itself on having forsaken such nosologies from its chequered past, even proponents of the current psychiatric nosology, such as Kendler (2009) acknowledge the "under-emphasized historical contingent nature of our current psychiatric classification" (p. 1935) and, thus, tacitly at least, concede the epistemological house of cards upon which modern day psychiatric diagnostic classification attempts are built. Accordingly, what we aim to do with this article is illustrate the evolution of psychiatric diagnostics and, with apologies to Darwin (1871) in so doing, advance the argument that contemporary psychiatric diagnosis, bears in its nosological framework the indelible stamp of its lowly origin. We also link the expansion of psychiatric diagnoses with the unwarranted medicalisation of everyday life. Then, we point out some of the arguments against the latest iteration of the DSM (DSM-5) and exhort our colleagues to consider the chorus of dissenting voices and guard against premature and misplaced diagnostic certainty (Lakeman & Cutcliffe, 2009), considering instead more sophisticated and useful ways to account for the kinds of problems that they assist people with in their professional lives.

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HISTORY OF PSYCHIATRIC TAXONOMY

Psychiatric diagnoses as we understand them are a relatively recent invention. In the asylum-building era the concern was with categorising and differentiating individuals who may be able to recover and be employed from those that could not (Conrad & Schneider, 2010). Thus, a legal distinction was made between "lunatics," "idiots," "imbeciles," and "inebriates" in most of the western world and those categorised were provided for differently. The former (which takes in the broad category of mental illness) were thought to have periods of lucidity and have a high probability of full recovery. As Kendler (2009) notes, there are parallels between the beginnings of biological taxonomy (the classification of flora and fauna) and modern psychiatric nosology with both largely beginning with "experts" attempting to categorize classes in terms of the essential features as these experts observed them. There has been differing views about what those essential features ought to be and differing emphasis on aetiology, course, and phenomenology as defining features (American Psychiatric Association [APA], n.d.).

Historically, to name things as mental illness was to claim medical authority over the management of the person so diagnosed (although there were few specific treatments). Some attempts appear absurd. For example Rush cast a very wide net and saw madness in behaviour which did not comply to his world view. He coined a diagnosis called revolutiona, which he applied to those who opposed the American Revolution (Reiss, 2008). Other diagnoses have had greater longevity. For example, Emil Kraeplin observed the "natural histories" of asylum inmates and radically changed the classification of mental illness (considering course and phenomenology essential), offering two major categories of mental illness: dementia praecox (the forerunner to schizophrenia) and manic-depressive psychosis (now bipolar affective disorder). Eugen Bleuler, in 1911, observed that people with dementia praecox did not necessarily deteriorate and created a new category: schizophrenia.

For most of the twentieth century there was little consensus around the essential features of most mental illness beyond a few organic and neurological conditions. In the practice of psychiatry this was not especially problematic as the primary treatments were non-specific. However, it posed a particular difficulty for researchers who often used differing definitions of mental illness in their research, and it made international comparisons of prevalence, or even conversations about treatment, difficult. The first edition of the DSM (APA, 1952) reflected the influence of Adolf Meyer who believed that mental disorders represented reactions of the personality to psychological, social, and biological factors (APA, n.d.). The next edition (DSM-II; APA, 1968) was similar in style and weight, reflecting the psychoanalytical understandings of aetiology of the time, which were losing favour by the time the DSM-III was being formulated.

THE SUCCESS OF DSM-III

The DSM-III (APA, 1980) reflected a radical change, eschewing any reference to aetiology and with the quite explicit aim of improving the reliability of diagnoses, which it did by constructing criteria and categories of "disorders" by consensus in everyday colloquial descriptive language. That disorders were, and continue to be, created by a consensus of experts rather than by scientific discovery has long been an issue of critique and a foundation for arguments that the categories lack validity (see, e.g., Szasz, 1974). The DSM-III and subsequent iterations reflected a practical kind of model for disorders rather than an essentialist kind (whereby members of a class share an essence from which their defining features arise) or a socially constructed kind (bound by cultural context) (Kendler, Zachar, & Craver, 2010). A disorder is simply whatever is defined in the manual. Thus, someone may be diagnosed with major depression if they have the requisite number of symptoms for a period of time, regardless of the cause, known or unknown. Other nosologies based on cause recognise different types of depression (e.g., endogenous, post-traumatic depression, situational depression, or attachment- or abuse-induced depression) (Wehrenberg, 2012). The DSM-III thus broadened the reach of many diagnoses to those who would previously have not met such criteria.

The manual also increased the number of so-called disorders. DSM-I (APA, 1952) had 106 disorders listed over 130 pages. The DSM-III (APA, 1980) listed 265 over 495 pages. Each subsequent edition has become larger again. The use and significance of the DSM now extend well beyond psychiatrists and mental health specialists: It has been argued that a diagnosis could be arrived at by a primary care physician within an eight-minute consultation with a great deal of inter-rater reliability (Spitzer et al., 1994). The reliability of diagnoses, such as schizophrenia, has been found to be poor with large regional variations in rates of diagnosis (McGrath, 2006). Nevertheless, since the publication of the DSM-III the number of people diagnosed with mental illness (and medicated) has grown exponentially, giving rise to concern about the role of diagnosis in the medicalisation of everyday life (Lakeman & Emeleus, 2014).

Medicalisation, or defining a problem in medical terms (usually as an illness or disorder) and then using a medical intervention to treat it, has long been an object of interest; the story of psychiatry is replete with examples of the creation of new medical categories and the expansion of medical jurisdiction. Early studies of medicalisation (see Conrad & Schneider, 2010) emphasised medical imperialism, social movements, and lobby groups as the key drivers of medicalising issues such as alcoholism. Conrad (2005) suggests that since the 1980s (and publication of DSM-III) there has been a shift in the engines that drive medicalisation to biotechnology (particularly the pharmaceutical industry), consumers, and managed care. Commercial interests now have a greater impact on medicalisation than professional claim makers. Allen Frances (2013), who was the editor of DSM-IV (APA, 1994) and one of the most sustained critics of the DSM-5, has suggested that diagnostic inflation and the lobbying of the pharmaceutical industry has extended psychiatry to the worried well to their detriment and shifted resources from those most in need. Whitaker (2010) goes fur-

ther by suggesting that the exponential rise in the diagnosis and treatment of mental health problems has actually contributed to an epidemic of iatrogenic disability.

The medicalisation of everyday life (particularly in the western world) has been so successful that it is almost taken for granted that variations in mood, perceptual disturbances, and even common behaviours such as sexual promiscuity or drug or alcohol use are forms of mental illness. It has long been recognised that this has served to benefit pharmaceutical companies and their shareholders to the point that in the last 50 years the pharmaceutical industry jostles for the position of most profitable in the world (Klass, 1975) despite virtually no new discoveries in the field for decades. As the World Health Organisation (WHO; n.d.) notes, the global pharmaceutical market is expected to hit US $400 billion in the next few years, and pharmaceutical companies currently spend one-third of all sales revenue on marketing their products. Such has been the pace of medicalisation of all manner of human experience in the west that it seems unremarkable to suggest that one in four or five people have a mental illness (WHO, 2001).

The marketing of mental illness for profit is perhaps best illustrated by the experiences of the marketing of depression and antidepressants in Japan. Until the late 1990s the public's attitude towards depression in Japan was unfavourable and the term for clinical depression, utsubyou, was rarely used outside of clinical psychiatry and then only in relation to the most severe form of depression (Ihara, 2012). In order to increase the acceptability of pharmacological treatment of mild to moderate depression, pharmaceutical companies orchestrated a public education campaign and coined the catchphrase, "kokoro no kaze" or "a cold of the soul;" antidepressant sales increased six-fold between 1998 and 2006. Incidentally, this period was associated with a steep rise in the rate of suicide in a country with historically and relatively high levels (Motohashi, 2012).

REJECTION OF DSM-5 BY THE HIGHEST ECHELONS OF ACADEMIC PSYCHIATRY

There has been a sustained critique of psychiatric diagnosis from outside of psychiatry and from individuals within (e.g., Szasz, 1974, and subsequent prolific publications), who have often been labelled (in part to discredit them) part of the anti-psychiatry movement. However, the development and release of the fifth edition of the Diagnostic and Statistical Manual (DSM-5; APA, 2013) has been accompanied by unprecedented criticism from within psychiatry and mainstream medicine. For example, recently Allen Frances, the editor of the DSM-IV, was an outspoken critic of the validity of the diagnostic categories, the process of their formulation, and the unintended consequences of medicalising ordinary life (Frances, 2013). At much the same time, Peter Gøtzsche (2013), one of the founders of the highly regarded Cochrane collaboration and a champion of evidence-based practice, was even more scathing in a polemic against the role of the pharmaceutical industry in subverting re-

search for its own ends and ultimately promoting products such as antidepressants that were not only ineffective but also dangerous.

Perhaps even more damning of the DSM was the rejection by the United States' National Institute of Mental Health (NIMH) of the DSM-5 in future research endeavours. As Insel (2014) notes, the diagnostic manuals to date have contributed to increased reliability and utility in identifying symptoms, but have not led to the elucidation of a single biomarker for any mental disorder. Indeed, widespread commentary suggests the plethora of clinical syndromes in either the International Classification of Diseases (ICD) or the DSM lack validity as disease entities (Carpenter, 2013; Nardi et al., 2013).

The NIMH instead have launched the Research Domain Criteria (RDoC) project in an effort to create a bottom up approach to research, that is, using, as a first step, genetics, imaging, and cognitive science to identify markers of pathology. Discarding the diagnosis will, it is presumed, liberate scientists to begin to isolate discrete pathology and enable practitioners to prescribe meaningful treatment. As it stands, most psychiatric diagnoses are, at best, agnostic about pathology; for example, depression and anxiety, much like chest pain, might be caused by all manner of things. An argument can be constructed that suggests, just as in medicine, it is imperative to explore the idiopathic causes of chest pain and treat accordingly. So it is with psychiatric symptoms and syndromes. The NIMH, the largest funder of mental health research in the world, has therefore dispensed with diagnosis altogether and is no longer funding research explicitly exploring diagnoses. For example, instead of exploring posttraumatic stress disorder as defined by the diagnostic manual, research might instead focus on neural circuits implicated in fear-potentiated startle and other conditioned responses (Sisti, Young, & Caplan, 2013).

Additionally, for mental health nurses (MHNs) at least, another argument has advanced the view that DSM diagnoses might be largely irrelevant to how MHNs respond to and care for clients with mental health problems. The MHN is concerned with the nature of the problems and the needs with which the client presents and what might be offered in terms of help, support, and treatment. In such a model, assigning unreliable, unscientific, and artificial diagnostic labels is, at best, irrelevant and, at worst, damaging (e.g., see the work on labelling theory and mental health, Angermeyer & Matschinger, 2003; Link, Mirotznik, & Cullen, 1991; Scheff, 1974). The present diagnostic clusterings are convenient, but for the most part have not led to a greatly improved understanding of pathology.

PSYCHIATRIC/MENTAL HEALTH NURSES' RESPONSES TO DSM-5: GRAVEYARDS, CRICKETS, AND OTHER "SOUNDS OF SILENCE"

In the light of the public rejection of DSM-5 by some of psychiatry's luminaries, perhaps one might expect a corresponding rejection authored by psychiatric/mental health nurses. Alas,

this is not the case, although a few notable exceptions that adopt a critical stance do exist, see for example, Flaskerud (2012), van Meijel (2014), and Adam (2014). Further, the special edition of *Issues in Mental Health Nursing* (volume 33, issue 9), that focuses on the DSM-5 is worthy of mention. There also are some articles authored by MHNs that do not adopt a critical stance (see, e.g., Fitzgerald & Morgan, 2012; McEnany, 2012). But, for the most part, the response from the psychiatric/mental health nursing community to the process of producing and subsequently publishing the DSM-5 has been silence.

Mental health nurses have, for many years, depicted themselves as advocates for their clients, so much so that such views are invariably reinforced in contemporary nursing codes of conduct, codes of ethics, professional associations' position statements, and competency standards that govern practice (see, e.g., Jugessur & Iles, 2009; Vaarito & Kilpi, 2005). Some MHNs uphold views that supersede and surpass basic ideas of advocating for another and represent themselves as champions of the oppressed. Indeed, Altschul (1997) declares this as a defining characteristic of psychiatric nurses, per se, stating that, "What many [psychiatric nurses] have in common is a commitment to the underprivileged, the poor, the homeless" (p. 6). Yet, it is hard to square depictions and assertions of client advocacy or serving as some form of a twenty-first century Chevalier for those with mental health problems, with tacit or explicit endorsement of DSM-5. For instance, how does one reconcile the notion of client advocacy with compulsory detention and compulsory treatment orders based on the shakiest of diagnostic labels? Still other extant theories and models of psychiatric nursing, such as the Tidal Model (Barker, 2001; Buchanan-Barker & Barker, 2008), emphasise giving precedence to the client's story (or valuing the client's voice), not to labels or professional narratives. Psychiatric diagnosis, on the face of it, would seem largely irrelevant to good mental health nursing and even a potential impediment to fostering a curiosity and facilitative atmosphere in which to encourage the person to express him- or herself in his or her own language.

More recently, another banner around which psychiatric mental health nurses have rallied is that of evidence-based or evidence-informed mental health care (Hatcher, Butler, & Oakley-Browne, 2005; Peterson et al., 2014). Leaving aside, for now, the unresolved debates around evidence-based mental health care (EBMHC) and accepting the idea that practice should, where possible, be informed if not driven by evidence, then it is difficult to reconcile MHNs' tacit endorsement (by their silence) of the DSM-5 with the tenets of EBMHC. Sorboro's excellent article on the foibles of DSM-5 offers searching remarks concerning the lack of evidence to support the diagnostic categories therein, stating,

> The DSM as a scientific text and almost every diagnosis found within it suffer from the same sort of problem as the concept of someone actually being a witch: Validity. Even if we accept the DSM as 100% reliable, which of course it is not, that does not make it valid. . . .The incredible recent advances in neuroscience, molecular

biology, and brain imaging that have taught us so much about normal brain functioning are still not relevant to the clinical practicalities of everyday psychiatric diagnosis. The clearest evidence supporting this disappointing fact is that not even one biological test is ready for inclusion in the criteria sets for DSM-5. (2010, pp. 46–48)

Or consider the comments of Locke (2011) who refers to the "deeply flawed DSM-5 containing many changes that seem clearly unsafe and scientifically unsound." Such views are by no means fringe, or espoused by the heretical, angry voices of a disgruntled few. The open letter representing the views of 120,000 US-based counsellors stated, "While we appreciate APA's commitment to quality research, counselors are concerned that a number of the DSM-V proposals have little basis in empirical studies" (Locke, 2011, p. 1).

A further defining characteristic of MHNs, if not mental health practitioners per se, is the disinclination to accept what is experienced at the surface level and instead, recognize and work with what is going on below the surface. Consider how mental health practitioners are mindful of the often-touted models of personality, which typically compose multiple layers or components of personality (e.g., the persona, the self, and the unconscious processes). Or, when mental health practitioners are analysing communication and looking past the overt message and content to contemplate ulterior or duplex transactions (Berne, 1964; Rungapadiachy, 1999). Or, indeed, when mental health practitioners examine texts and adopt a deconstructive approach (Derrida, 1978) wherein deconstruction is used in a specific way as the work of exposing multiple meanings, inconsistencies, contradictions, and hidden agendas in texts (see also Cutcliffe, Stevenson, & Lakeman, 2013). In each of these cases, mental health nurses are exhorted to look more deeply and not merely accept the surface manifestation. This then rather begs questions as to why this more discerning approach does not appear to be applied commonly to DSM-5; why the unquestioning acceptance by MHNs? And yet, peel away or draw back even the most threadlike of veils and you find numerous problematic issues and unanswered questions. For example, how has the now well-documented yet highly ethically problematic relationship between big pharma and psychiatry effected the construction of DSM-5? How, if at all, has the APA dealt with major criticisms of DSM-5—criticisms with disparate origins that yet have a high degree of convergence? How was the evidence that points to the lack of reliability of psychiatric diagnosis (described by a psychiatrist as "an everlasting problem in psychiatry;" Aboraya, 2007, p. 22) handled by the DSM-5 committee? How was the absence of any biological test in the criteria sets addressed?

CONCLUSION

Such are the vested interests in the diagnostic system as it stands that we are unlikely to see the demise of descriptive psychiatric diagnosis any time soon. Phillips (2014) suggests that a stable diagnostic system is necessary for a range of stakeholders (particularly funders) and is integral to the maintenance of health

systems (although such are the flaws in the system that it hardly appears stable). Some have suggested that psychiatric diagnoses are a kind of convenient fiction to enable communication, collaboration, and care, and to facilitate or exclude individuals from accessing particular services and benefits (Pickersgill, 2013). A major problem is that rather than treating diagnoses as such, they have become reified (Hyman, 2010). That is, lay people, professionals, specialists, and non-specialists have come to consider them real entities, with clear boundaries, common aetiologies, and specific treatments. All of these assumptions have proven to be false.

Projects such as the Research Domain Criteria project assume that mental disorders are primarily disorders of brain circuitry (Insel & Cuthbert, 2010) and it is hoped that a new taxonomy will emerge, over time, that will be grounded in research evidence, rather than the consensus of experts prone to influence by interest groups. At the present time it remains something of an article of faith that neuroscience will deliver a more valid diagnostic taxonomy and precise medicine for those who present with the vast spectrum of psychosocial and mental health problems (Lakeman, 2013). In the interim (which may be some considerable time), clinicians and service users must still communicate with each other, find ways to make sense of problems as best they can, and implement solutions.

In the face of such overwhelming criticism of the DSM-5, professional nursing bodies and individual nurses need to be pragmatic and honest in their dealings with patients and not fall prey to misplaced epistemological certainty (Lakeman & Cutcliffe, 2009). They might, for example, acknowledge that a particular diagnosis simply means that a person has a particular cluster of symptoms and acknowledge that this does not imply that the cause, treatment, or prognosis can be derived from the diagnosis. A well-crafted formulation (Crowe, Carlyle, & Farmar, 2008; Rainforth & Laurenson, 2014) arrived at through careful listening and judicious consideration of research and theory is what care and treatment ought to be based, not a psychiatric diagnosis. Nursing organisations ought to align themselves with other professional groups such as the British Psychological Society (2013) which, in a strongly worded position statement, called for a paradigm shift away from diagnosis and toward an approach that is multi-factorial, contextualises distress and behaviour, and acknowledges the complexity of the interactions involved in all human experience. Amongst the recommendations, they argue for promoting biopsychosocial formulation.

Since the beginning of the modern enterprise to create a psychiatric taxonomy embodied in the diagnostic and statistical manuals there have been critics of the way that diagnosis can obscure, rather than enhance, our understanding of people while securing the interests of particular professional groups to the exclusion of others. As this article commenced with a brief histiography of diagnosis in psychiatry, it is fitting to end with a quote from Sullivan (1953, p. 7) whose interpersonal theories of mental health were perhaps most influential (via nursing

luminaries such as Peplau) in shaping twentieth century mental health nursing theory and practice:

> Of course every science has to have its technical language. But since this is a study of living and since it has the difficulties I have already stressed, why add to the certainty of confusion and the Tower of Babel phenomena by putting in a lot of trick words? for these trick words, so far as I can discover, merely make one a member of a somewhat esoteric union made up of people who certainly can't talk to anyone outside the union and who have only the illusion that they are talking to one another.

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