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Making Us Crazy. DSM: The Psychiatric Bible and the Creation of Mental Disorders. Herb Kutchins and Stuart A. Kirk. New York/London: The Free Press, 1997, 305 pages, $37.00 hardcover.

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The *Malleus Maleficarum* (James Sprenger and Heinrich Kramer, 1486/1971) was a detailed manual for Dominican witch-hunters. It codified specific criteria for identifying witches and guidelines for their application. It elaborated a system of symptoms that indicated illness caused by witchcraft (Szasz, 1970, pp. 7–8). These symptoms were seen as the visible projections of a vast and complex organization of behavior. Since the existence of witches was presupposed by those who used the manual, its criteria were confirmed repeatedly during the Inquisition. Once the *Malleus* was published, its diagnostic system acquired a momentum of its own and generated its own evidence (cf. Trevor–Roper, 1969, pp. 41–42 and Szasz, 1970, pp. 23, 36). Its authors saw physicians as experts at distinguishing physical illnesses from those caused by witchcraft. The authors began the manual by asserting that belief in the existence of witches is an essential part of the Catholic faith. Priests and inquisitors were not to doubt the existence of witches (Szasz, 1970, pp. 8–9, 115). Like the *Malleus Malleficarum*, the *Diagnostic and Statistical Manual* (American Psychiatric Association, 1994) is a detailed text which codifies specific criteria for identifying people who are seen as abnormal. It codifies guidelines for applying these criteria and elaborates a system of symptoms that indicates illnesses known as mental disorders. These symptoms are seen as the visible projections of a vast and complex organization of behavior. Since the existence of these disorders is presupposed by many of those who use the manual, its criteria are confirmed repeatedly in the diagnostic process. Once *DSM* was published (1952), its diagnostic system acquired a momentum of its own and has generated its own evidence. Its authors regard psychiatrists as experts at applying the manual's criteria. They are also seen as experts at distinguishing mental disorders from other illnesses. Belief in the existence of mental disorders is an essential part of the psychiatric faith.

I have never spoken to a fifteenth century Dominican about the *Malleus*. I have spoken to contemporary psychiatrists about the *DSM*. These conversations have

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revealed to me how many psychiatrists will use an official classification scheme to support a belief that mental disorders are empirically discrete, biological diseases. Having drawn this analogy between *DSM* and the *Malleus*, I should note that Herb Kutchins and Stuart A. Kirk do not use it in their latest book, *Making Us Crazy* (1997). Every analogy falls short of coincidence, and their analysis reveals that the successive editions of *DSM* are essentially ambiguous in ways that even the *Malleus* was not. Kutchins and Kirk present a detailed examination of how psychiatry struggles with political groups "to create categories of mental disorder" and they review as well the "politics and scientific basis of specific diagnostic categories that have created controversy" (pp. 16–17). They also explore the fact that *DSM* is a psychiatric bible by which true believers can adopt a "comforting faith" in the medical model and a "language and set of assumptions, largely weighted toward biological psychiatry, with a minimum of debate and self-examination" (Ross and Pam et al., 1995, pp. 242, 244). Their analysis reveals again the extent to which the developers of *DSM* promote the manual by creating the unjustified impression that its reliability problems have been solved (Kutchens and Kirk, 1997, p. 52; cf. Caplan, 1995, p. 198; Kutchins and Kirk, 1992, 1994). The authors aver a well documented, superbly reasoned critique of the process by which *DSM's* diagnostic categories are created by the American Psychiatric Association (APA).

Although Kutchins and Kirk demonstrate that "one doesn't have to read very far to question whether the diagnostic criteria actually identify valid mental disorders" (1997, p. 249), the fact is that many biopsychiatrists do not raise this question. Nor does the promotion of *DSM* encourage them to do so. In this respect, an analogy between the *Malleus* and the *DSM* has a unique appeal. The former manual was sanctioned by the Catholic Church. The latter manual is sanctioned by the APA. Both manuals are intended inclusively for an audience of true believers. Both define disorders to be diagnosed by designated professionals, many of whom already believe that these disorders exist. Like the *Malleus*, *DSM* can distort questions of empirical verification because one of the mindsets it appeals to asserts the existence of valid mental disorders as a metaphysical posit. Like the true believers who were not to doubt the existence of witches or the text of the *Malleus*, biopsychiatrists are not supposed to doubt the existence of biochemical mental disorders or the definitional categories and symptoms by which they can be diagnosed. An officially sanctioned classification scheme can reinforce an article of faith.

Kutchins and Kirk examine the political process of negotiation by which some of the more notorious definitions of mental disorder were created and then included in, or removed from, the various editions of the manual. This is a crucial step toward piercing the veil of biopsychiatric belief. Unlike the *Malleus*, which was unrevised from its publication and defined the "final form" of an ideology which influenced persecutions for 200 years (Trevor–Roper, 1969, pp. 54, 74), the process of renegotiating changes to *DSM* has become its own growth industry. As Kutchins and Kirk remind us in chapter 1, the APA has revised *DSM* three times over the last eighteen years. Each edition of the manual expands the list of disorders while dropping others as the alleged result of improved scientific research. In fact, published scientific research and improved diagnostic reliability have little to do with it (1997, pp. 15–16). Kutchins and Kirk argue persuasively on the evidence that "the process of developing diagnostic categories has been similar to other types of professional decision making, where status, reputation, and turf are dominant considerations" (p. 18). This insight has been spreading through the ranks for some time now. Even a historian as receptive to biopsychiatry as Edward Shorter admits

that *DSM* leaves psychiatric diagnosis up for political grabs and represents an "underlying failure to let science point the way" (Shorter, 1997, p. 305).

DSM's track record may not sustain a growing flock of true believers indefinitely. But it does not have to, because the manual is not intended exclusively for them. Metaphysical posits aside, you do not have to be a converted biopsychiatrist to use *DSM* for financial gain. *DSM* is a mental health professional's "password for insurance reimbursement" (Kutchins and Kirk, 1997, p. 12). Financial incentives are built into the structure of *DSM*. Consequently, advocacy groups, professional associations and corporations can influence "which human problems get included as mental disorders in *DSM* and who qualifies for the reimburseable diagnostic label" (p. 12). Thus drug companies, which fund a substantial number of psychiatric researchers, have a direct financial interest in the manual because it expands "the number of people who can be defined as having a mental disorder and who then might be treated with their chemical products." Needless to say, some pharmaceutical companies have contributed directly to its development (p. 13). Scientific illusions may elevate *DSM's* prestige but money greases its axes.

In chapter 2, the authors present a theoretical focus for their historical examination of *DSM's* more controversial diagnoses. They describe the organizational structure the APA uses to manage revisions of the manual and explain how *DSM* has achieved its lofty status in the mental health field. They also pay particular attention to the role of classification in science and to "the issue of scientific validity and its neglected role in the invention of diagnoses" (p. 18). Their examination of specific disorders proceeds through chapters 3 to 6 and covers Homosexuality, Post-Traumatic Stress Disorder, Masochistic Personality Disorder, and Borderline Personality Disorder, respectively. Chapter 7 traces the misapplication of psychiatric diagnoses to African Americans from the days of slavery to the present. Chapter 8 concludes the book by diagnosing the manual itself. The postscript informs us that there is already a plan to revise *DSM-IV*.

Kutchins and Kirk are emphatic in their assertion that mental illness is a construct, a shared abstract idea "that is not real in the physical sense that a spoon or a motorcycle or cat can be seen and touched" (p. 23). Fair enough given the failure of biopsychiatry to conclusively substantiate its biological hypotheses. It is an understatement given the way that *DSM's* developers respond to the political marketplace when creating definitions of specific disorders. Hence the authors' own analogy between *DSM* and a mutual fund: "And like a large and popular mutual fund, *DSM's* holdings are constantly changing as the managers' estimates and beliefs about the value of those holdings change" (p. 24).

Consider the manual's track record over its five editions: *DSM-I* (1952–1967); *DSM-II* (1968–1979); *DSM-III* (1980–1986); *DSM-III-R* (1987–1993) and *DSM-IV* (1994). From 1968 through 1994, the number of mental disorders rose consecutively with each edition from 180 in *DSM-II* to 265 (*III*), 292 (*III-R*) and 297 in *DSM-IV* (Kutchins and Kirk, 1992, pp. 118, 199; Kutchins and Kirk, 1995, pp. 4–6; cf. Shorter, 1997, p. 303 at fte. 63). Kutchins and Kirk note that *DSM-I* reflected the ascendence of psychoanalysis in American psychiatry. *DSM-II* continued that tradition but expanded the list of disorders "as a response to the nation's treaty obligation to keep its nosology in rough alignment with the World Health Organization's *International Classification of Diseases*" (1997, p. 40).

Public protests by gay activists, poor reliability, clinical dissatisfaction and the demand from third-party payers for a closer relationship between diagnosis and treatment all increased pressure on the APA to revise *DSM-II* (p. 42; cf. Shorter,

1997, p. 301). The decision to revise the second edition was made by 1973 when the *DSM-III* task force was formed. This group was predisposed to include many new diagnostic categories and was motivated strongly "by the wish to expand psychiatric turf to capture more fiscal coverage from third-party reimbursements, which had become much more important to the financing of mental health care" (Kutchins and Kirk, 1997, pp. 42, 43).

Aside from adding 85 new disorders, many of which applied specifically to children, the third edition expanded the *DSM-II* format of simple, one-paragraph descriptions for each disorder. The main change was a list of criteria that had to be satisfied before making a diagnosis. Post-Traumatic Stress Disorder appeared for the first time. Homosexuality was dropped as a separate diagnosis of Sexual Deviation and replaced with Ego–Dystonic Homosexuality, "a diagnosis for those who are troubled about their homosexual impulses" (pp. 45, 78). Neurasthenia, the world's most popular diagnosis, was dropped. The elimination of Neurosis as an organizing category (it was dropped completely in *DSM-IV*) signalled the start of a major shift from psychoanalytical to biological psychiatry. The appendix contained a 14-page report of the reliability data from the field trials, $8\frac{1}{2}$ pages of which listed the names, degrees and institutional affiliations of the more than 600 participants (pp. 114, 44–45). In a sense, the real story begins with *DSM-III*, since the previous edition garnered little professional acclaim (pp. 41, 57). "Using the appeal of scientific standards, empirical investigation, and hard data, . . . the DSM committees renovated the manual, claiming that henceforth the diagnostic categories would be created not on the basis of clinical whim or theoretical bias, but, rather, on objective evidence that would enable proposed categories to withstand empirical scrutiny" (pp. 149–150). *DSM-III* was weighted toward biological psychiatry and its alleged scientific foundation was seen as returning psychiatry to the medical model. It also downplayed the "vague 'biopsychosocial' model under which so much mischief had occurred" (Shorter, 1997, pp. 301, 302). According to Kutchins and Kirk, this alleged foundation was merely a "scientific patina" (1997, p. 53). The *DSM* committees reduced science to plebiscite.

The revision process began again in 1983, just three years after *DSM-III* was published. The APA was now promoting the development of the manual as an ongoing scientific process. The publication of *DSM-III-R* in 1987 saw the major revision of four of the five diagnostic axes of *DSM-III* and extensive changes to over half of the 265 diagnostic categories. Twenty-seven new ones were added. No new reliability studies or field tests on the revisions were conducted before publication. The decision to revise *DSM-III-R* was made four months after its publication (pp. 46–47).

The procedure for developing *DSM-IV* was essentially the same as the one used for the previous two editions. The APA appointed a task force of experts, most of whom were psychiatrists, to supervise the thousand-odd members of the various advisory committees. These members were all reputed experts in the manual's specific disorders. Their proposals for revising the diagnoses were reviewed by the task force and drafted into the manual's latest version. This draft was reviewed further "by an elaborate hierarchy of committees within the APA, the whole process culminating in the final approval by the association's board of trustees" (p. 48). The 900-page *DSM-IV* is presented as "an evolving scientific document that represents the best from the brightest," despite the fact that the rapid succession of revised editions actually impedes the use of scientific findings to improve the manual (p. 49). Since it takes "years to . . . test the categories in each revised manual, the rapid

changes to *DSM* could not be informed by the careful research that was needed" (p. 48).

Kutchins and Kirk provide a detailed analysis of *DSM*'s pseudoscientific foundations and poor reliability in their earlier book, *The Selling of DSM: The Rhetoric of Science in Psychiatry* (1992). The discussion in *Making Us Crazy* is concise. It affords new readers an effective critical perspective for evaluating the manual's history (cf. Caplan, 1995, pp. 185–225). Scientific validity is less about agreed upon definitions and more about truth. Scientists seek truth. Widespread agreements that ghosts exist or that the earth is flat will not establish the truth of those agreements. While it would be true to say that many people believe that ghosts exist, that belief does not make ghosts exist. Nor does a belief in a flat earth make the earth flat. Likewise, a widespread agreement among psychiatrists that there is a mental disorder which fits their definition of Inadequate Personality will not define that disorder into existence as a proven biological disease. This disorder was defined in *DSM-II* as "ineffectual responses to emotional, social, intellectual and physical demands . . . inadaptability, ineptness, poor judgement, social instability and lack of physical and emotional stamina." That definition is a construct which is held together by agreement. The agreement does not make the definition anything more than a construct. The fact that this disorder was dropped from *DSM-III* reflects merely a conceptual "agreement gone bad" (Kutchins and Kirk, 1997, pp. 28–29). It does not mean that there is one less biological disease in the world. Classification determines whether phenomena have the particular characteristics for membership in a class. But "having an operational procedure for determining whether a phenomenon belongs in a class, such as the checklist of symptoms in *DSM*, does not substantiate what that construct or class is" (p. 28; cf. Caplan, 1995, p. 197).

These are hardly novel ideas, but they lead to a pivotal insight when the authors apply them to *DSM*. On their analysis, the preeminent manual of mental disorders "contains no workable definition of mental disorder" (Kutchins and Kirk, 1997, p. 36). In fact, it did not contain one at all until 1980, when it defined mental disorder as a dysfunction internal to the individual resulting in impairment to an important area of functioning that is not an expected response to events (pp. 30–31). This definition was intended to parallel "our cultural understanding of physical disorders" and to position psychiatry as a partner with other biological medical specialties. By defining disorder as a dysfunction, the manual tries to include "some notion of internal pathology that causes the symptomatic behaviors." This slight of hand fails because defining disorder as dysfunction requires a definition of dysfunction and "DSM does not provide one" (p. 31). This approach to identifying mental disorders requires us to know the natural function of mental mechanisms before we can make meaningful claims about whether those mechanisms are dysfunctional. Since our knowledge of the natural function of mental mechanisms is limited, definitions of mental dysfunction are often confused, tautological and controversial. Consequently, the everyday behaviors that *DSM* uses as criteria for mental disorders may not indicate mental dysfunction at all. The manual contains no comprehensive statement of what the natural functions of our cognitive, emotional and behavioral patterns might be, which is just as well for its developers since such a statement would reveal "huge gaps in our knowledge." Instead, the manual assumes the easier task of targeting "suspicious everyday behaviors" (p. 35). The authors conclude that *DSM* "has no consistent requirement that the everyday behaviors used as diagnostic criteria actually be the result of mental disorder and not the result of other life experiences" (pp. 36–37).

There is another difference between *DSM* and the *Malleus*. Where the *Malleus* was inflexible in citing witchcraft as the cause of demonic possession, *DSM* remains silent on the etiology of mental disorders (p. 32). Still, there has been a clear presumption in every edition since *DSM-III* that identifying "distinct disorders" means identifying "distinct disease entities" (Shorter, 1997, p. 303). *DSM's* diagnostic system continues to be "driven by bioreductionist assumptions and ideology" (Ross and Pam et al., 1995, p. 125).

Kutchins and Kirk have written extensively about *DSM's* diagnostic reliability (1992, 1994). This research is neatly summarized in the latest book. There has been a massive publicity campaign to promote *DSM-III* and its successors as a reliable means of distinguishing mental disorders from other human problems. Despite the fact that claims of greatly improved reliability have been widely (if uncritically) accepted by many mental health professionals, "no study of DSM as a whole in a regular clinical setting has shown uniformly high reliability. And most studies, including the DSM field trials themselves, provide little evidence that reliability has markedly improved, much less been 'solved' as a problem" (1997, pp. 50–51, 52). The "most recent major" field study on *DSM-III-R* (p. 52, fte. 60) was a disappointment even to the investigators. The statistical measures of reliability had not improved upon — and were in some cases worse than — those achieved in the 1950s and 1960s. The study was designed generously to show diagnostic agreement if physicians agreed that the patient they were interviewing was in the same diagnostic class. It did not matter if the same physicians could not agree on a specific diagnosis within that class. Thus a general diagnosis of Personality Disorder would show agreement between the physicians even if they disagreed on which of the 12 specific *DSM* personality disorders they thought the patient had. The study actually showed that there was frequent disagreement among physicians on the general class of diagnosis. Kutchens and Kirk draw the bottom line: "Twenty years after the reliability problem became the central scientific focus of DSM, there is still not a single major study showing that DSM (any version) is routinely used with high reliability by regular mental health clinicians" (pp. 52, 53).

The historical narrative opens with a chapter on the classification of Homosexuality as a mental disorder (pp. 55–99). Its removal as a specific diagnosis of Sexual Deviation from *DSM-III* resulted from a militant strategy of protest that originated outside the APA. The gay activists who led the charge in the early 1970s set a precedent that was later renewed. The inclusion of Ego–Dystonic Homosexuality (EDH) in *DSM-III* was seen as a partial reinstatement of Homosexuality as a psychiatric diagnosis. Ironically, the decision to include this diagnosis was made when pro-gay psychiatrists were more influential in the APA than those who believed that homosexuality was a pathological condition. Gay activists renewed the protest a decade later with their successful campaign to have EDH removed from *DSM-III-R*. Their efforts were again more effective than those of the gay psychiatrists inside the APA (pp. 57, 65–66). Homosexuality lives on in *DSM-IV* as a diagnosis that dares not speak its name. Those who complain of unwanted homosexuality can be diagnosed as having a Sexual Disorder Not Otherwise Specified (p. 91). Kutchins and Kirk conclude the chapter with a further irony. They note the resurgence of the hypothesis that homosexuality results from genetic abnormality. This hypothesis is promoted by the growing, but false belief that some mental disorders have been proven to have a genetic origin. Some of the psychiatrists who are spearheading the effort to prove that homosexuality is genetically predetermined were leaders of the first campaign to rid DSM of homosexuality. "The position taken by some gay psy-

chiatrists . . . may increase the pressure to restore the diagnosis of homosexuality to DSM" (pp. 95–97; 98).

The history of Post Traumatic Stress Disorder (PTSD) provides an interesting contrast since it illustrates the efforts of mental health consumers to seek official recognition of their suffering (pp. 100–125). The successful efforts of the Vietnam veterans and their psychiatric allies to have PTSD included in *DSM-III* led to a series of revisions to the diagnosis which has greatly expanded its scope. PTSD now does much more than pathologize the experience of war veterans. It is one of *DSM's* most frequently used diagnoses and is used primarily to explain the suffering of abuse victims (p. 116). It has become a "catchall category" which pathologizes a wide variety of problems that originate in disturbing life events and are "not attributable to preexisting intrapsychic malfunctions" (p. 117). This means that "normal responses to catastrophic events often have been interpreted as mental disorders" (p. 125).

While I think that Paula Caplan's *They Say You're Crazy* (1995) is the definitive text on the Masochistic Personality Disorder (MPD) controversy, Kutchins and Kirk's chapter in *Making Us Crazy* stands well on its own as an abbreviated account (pp. 126–175). To read it is to understand the tone of indignation that animates Caplan's book. MPD was changed to Self-Defeating Personality Disorder (SDPD) in an attempt to mollify feminist critics (p. 142). Although it was not included in *DSM-IV*, it was included in *DSM-III-R's* appendix of disorders requiring further study. This meant that it "could officially be used with caution" (p. 149). The diagnosis never specified "mental mechanisms that have failed to function properly." Instead, it redefined the social problem of women's subjection as a mental disorder (pp. 134; 138–139). Once again, *DSM's* developers touted the diagnosis as based on valid empirical research. Kutchins and Kirk cut through the scientific mystification and show that the research studies were actually elaborate exercises in begging the question with true believers (pp. 149–158). Data gathered in one research study were used if it came from psychiatrists who believed in the diagnosis and dismissed if it came from those who did not. The "nonbelievers" constituted half of those who participated (p. 159). Shorter is right in saying that "it was not as a result of further study but of political pressure that self-defeating personality was dropped from DSM-IV" (Shorter, 1997, p. 305). Kutchins and Kirk's analysis indicates that it would not have been the result of further legitimate study if it had been included.

The "shaky empirical support" for Borderline Personality Disorder (BPD) was never questioned by advocacy groups (Kutchins and Kirk, 1997, p. 199). There is little evidence that it is a diagnosis that can be made reliably and there is considerable evidence that it is made unreliably. Like many other entries in *DSM*, it is a diagnostic label which is used to explain behavior when logically it can carry no such burden. If we do not know what causes the behaviors we identify as mental disorders, then the diagnostic labels we use to identify them will not explain why people behave the way they do. "A label is simply an attempt to identify a cluster of behaviors, yet it is accepted as a claim that these behaviors constitute a mental disorder" (p. 198). Understood as mental disorders, these labels are used often as fallacious explanations for the behaviors they identify. Using a diagnosis as an explanation for behavior is circular. If impulsivity is used as a criterion for BPD, it gets us nowhere to say that a person is impulsive because she has BPD. This particular diagnosis has replaced "the need for objective evidence and reasoned argument" (p. 198). Shorter is right again in saying that *DSM-III's* embrace of the medical model was in part a denial of the "antipsychiatric" idea that mental illness

is a social construction (1997, pp. 302, 274). It is ironic that this idea's credibility is enhanced by a behind-the-scenes look at the manual which was supposed to deny that very idea.

Chapter 7 (pp. 200–237) examines how a diagnostic system that appears to be free of racism can permit the introduction of racial biases. The authors argue that *DSM-IV* does not recognize the difference between race and culture and ignores "the repeated finding that identical behavior by patients of different races who share the same culture will be interpreted differently." They cite the "convincing empirical evidence" on which they base their prediction that "African Americans will be diagnosed as more severely disturbed than whites who manifest the identical symptoms" (pp. 229, 237).

In chapter 8 (pp. 238–265) Kutchins and Kirk reiterate a major point of their critique. "*The failure to adequately distinguish mental disorder from other problems that manifest in the same behaviors is the central failure of DSM's diagnostic criteria for many disorders*" (p. 251). They conclude with some "bitter medicine" for the APA. First, *DSM* should narrow its definition of mental disorder and its diagnostic criteria to cover only those conditions for which there is "substantial scientific consensus" around "evidence of an internal mental dysfunction." Second, even with a narrowed scope, *DSM*'s developers should be "much more modest" in their proclamations about the alleged scientific basis of the manual. Third, "clinicians should use DSM honestly, refusing to compromise their integrity and their clients' medical records and avoiding the practice of forcing personal and social troubles into ill-fitting categories of mental disorder" (p. 264). It would be wrong to accuse Kutchins and Kirk of being politically naive here. They are only guilty of taking the high road and trying to be constructive. The fact that their critique avoids cynicism is downright admirable.

Kutchins and Kirk also avoid shrill polemicism. This makes their personable prose style and steady acumen well-suited for the general readership they aim to reach. Deconstructing a text of *DSM*'s complexity is no easy task, let alone tracing the history of diagnostic labels through its various editions. While I think that this book is an excellent introduction to the definitional vagaries of *DSM*, I suggest that its format could have been slightly more accessible than it is. The history of the four diagnoses would have benefitted from a concise summation at the start of each chapter. The narrative detail behind the histories of Homosexuality and MPD and the changes in nomenclature from *DSM-III* to *DSM-IV* are sometimes difficult to follow. It is important to determine where one edition ends and another begins. I would have welcomed the inclusion of more charts which could have distilled this information. I would also have welcomed a concise summary of the numerical growth of diagnostic labels through each successive edition. This would have avoided some minor confusions about how many disorders the authors are really writing about. For example, we read at page 30 that *DSM-III* lists 300 disorders and at page 45 that it lists 265. At page 52 we move from *DSM-III*'s reliability to a discussion of "the most recent major" reliability study. This discussion concludes on page 53 with the statement that clinicians in the community "are as likely to agree as disagree on which of the *over 300* [italics mine] DSM disorders is present." While we can trace footnote 60 to page 272 and learn that the study applies to *DSM-III-R*, which is only supposed to contain 292 disorders, these points could have been made easily in the narrative. The authors precise count as to the number of disorders contained in each edition is available elsewhere (Kutchins and Kirk, 1992,

pp. 118, 199; Kutchins and Kirk, 1995, pp. 4–6; cf. Shorter, 1997, p. 303 at fte. 63) but it could have been presented to cogent effect here.

There are also some minor inconsistencies in chapter 3. The authors cite homosexuality as a specific *DSM-II* (1968) diagnosis of sexual deviance at page 57. They then note the 1973 proposal for replacing it with Sexual Orientation Disturbance at pages 69 and 71. By page 76, the proposed revision is referred to first as "sexual orientation disturbance" and then as "Sexual Orientation Disorder." By pages 77–78 we read that the leading *DSM* developer was "dissatisfied with the definition of mental disorder he had used to justify *replacing the psychiatric diagnosis of homosexuality with Sexual Orientation Disorder in DSM-II*" (italics mine). We are reminded again on page 79 that Sexual Orientation Disorder originated as a label to replace homosexuality in 1973, five years after *DSM-II* was published. Finally, the authors conclude the chapter by claiming that while "the struggle over the inclusion or exclusion of homosexuality from DSM" had little to do with scientific research, the "*decision to eliminate DSM [sic] had a major impact on psychiatry*" (p. 99; italics mine). Indeed it would have.

Kutchins and Kirk do not say "that there are no such phenomena as mental disorders, that their existence is all a myth or psychiatric hoax" (p. 264). Given their obvious sympathy for legitimate and rigorous scientific research, they would be the first to remind us that we are free to hypothesize that mental disorders are biological diseases with neurochemical origins. But until we obtain scientific confirmation of the etiology of mental disorders, we cannot define alleged biological diseases into existence as if they are proven facts. Further, tacitly ignoring etiology does not allow us to define mental disorders into existence by negotiating a professional agreement that they are real. If the behavior which constitutes a mental disorder cannot be distinguished adequately from everyday behavior, then we might as well be deciding that the earth is flat, or that ghosts can dance on the head of a pin. But none of this matters to the true believers who think that *DSM* is a catalogue of valid illnesses that can be used with diagnostic reliability. For them, it affirms the existence of the APA's official mental disorders as a metaphysical posit. The "belief system" of improved reliability has been planted firmly (p. 51). *DSM*, like the *Malleus* before it, promotes its own reality. These true believers are with us still. One can only hope that Kutchins and Kirk will succeed in reducing their numbers.

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