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Is the *DSM's* Formulation of Mental Disorder a Technical–Scientific Term?

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Although the "Introduction" to the *DSM* makes it clear that the presence of "clinical" distress or impairment is insufficient for a diagnosis of "mental disorder" (the distress or impairment must be deemed a manifestation of a biological or psychological dysfunction), in practice the clinician is completely unshackled from the conceptual definition and is free to decide on a case-by-case basis if "enough" distress or impairment is present, regardless of circumstances, to judge that "mental disorder" can be diagnosed. It is argued that reference to a biological or psychological dysfunction cannot raise "mental disorder" from a judgment quite like "This is pornography, not literature" to a technical–scientific term because (a) "biological dysfunction" must be tied to an outcome that is itself less ambiguous than "mental disorder," and (b) "psychological dysfunction" erroneously assumes that how people are *supposed* to think, feel, and act, regardless of circumstances, can be as uncontentious as ideas about physical well being, and in addition erroneously assumes that human behavior can be causally explained.

During the first therapy session Jane informed me that had she not been arrested for shoplifting last week she would be dead, because she had intended to leave the store where she did the shoplifting and drive her car at high speed into a wall. The shoplifting was a kind of farewell gesture, she explained, a way of expressing she didn't have to struggle to please anyone anymore. At the time we met she was an almost 21-year-old senior in a local university, living with her parents at home. She was very bright and had a 4.0 grade point average. One of her presenting problems was practically daily binging and purging, but the most urgent and upsetting problem involved her life with her parents. It was her life with her parents that had driven her to the point of suicide. After a few months in therapy she turned 21 and negotiated a deal with her parents for them to partially finance her moving into her own apartment. She figured

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if she worked as much as possible as a personal trainer, which she was already doing as a full-time student, she could more or less pay her bills with some financial support from her parents. During our therapy together she made some effort to cease binging and purging, but she had mixed feelings about it. In one sense it allowed her to triumph over her portly and somewhat gluttonous parents: she could enjoy food as much as she wanted to, then purge and look magnificently trim and fit. Purging gave her a feeling of relief physically and emotionally. She was extremely wary of emotional vulnerability to men and very skeptical of trusting anybody. Unfortunately she stopped coming to therapy soon after she moved into her own apartment. Before she stopped coming to therapy she revealed that binging and purging was her friend and she didn't really want to give it up. She had scoured the internet for advice on how to mitigate the biological consequences of chronic binging and purging.

Does Jane have a mental disorder? The American Psychiatric Association (APA) holds, via its official diagnostic manual, that people can be factually sorted into two categories, namely mental disorder present and not present. Obviously the APA regards "mental disorder" as a technical, scientific term, not as part of the vernacular, and not just a trope. A technical, scientific term, presumably, has a specific, objective, value-neutral, non-contextual meaning (ampere, foot-pound, hematoma, pneumonia, aorta, virus, etc.). The "Definition" section of the *Manual* apparently disagrees: "The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations" (*DSM-IV-TR*, p. xxx). No examples of concepts in medicine or science that lack a consistent operational definition are offered. Perhaps the authors are referring to theoretical terms designed to explain research findings. Operational definitions are anyway not designed to cover all possible situations; operational definitions are designed to limit the field of inquiry. I am sensitive to the objection that a manual may not be the place for lengthy philosophical discussion. None the less, given how conscious everyone is of the existence of doubts and objections to the idea of mental illness no matter what it is called, and given that the "new order" in psychiatry was created in part at least in reaction to criticisms of "mental illness," the reader naturally expects something impressive even in a short statement concerning what mental disorder *is* and how identifying "it" rises above personal judgment. In the absence of an objective, evidentiary method for identifying mental disorder, the naming of disorders and creation of criteria lists amounts to very little, indeed just perpetuate all the familiar anti-psychiatry objections. Actually the *DSM* allows the clinician to identify mental disorder present even if a specific mental disorder cannot be identified (see the "Not Otherwise Specified" [NOS] category discussion, p. 4). If anything, the existence of the NOS category should highlight the necessity for an objective, evidentiary method for claiming mental disorder is present (e.g., as discussed by Frances, Sreenivasan, and Weinberger, 2008, the paraphilia NOS,

non consenting person category is used to civilly commit men to State "treatment" facilities for indefinite periods, a polite way of saying forever).[1]

At the end of the "Definition" section the authors of *DSM* do supply a conceptual definition of mental disorder. But it can hardly be overlooked that the conceptual definition they supply defines one unknown with another unknown, i.e., "primary" (that is, idiopathic) mental disorder is defined as a manifestation of either an unknown biological or an unknown psychological dysfunction. This cannot clarify or even address the actual problem at hand, which is to present an argument that shows why it is necessary to think that some people who are distressed or psychosocially impaired in some manner belong in a separate category, that is, are discontinuous with (qualitatively different than) other people who are distressed or psychosocially impaired in some manner. In short, it is necessary to show why, given the variety of distress and disability in society, some people should be designated as suffering from a mental disorder — *what*, exactly, shows that Jane (above) has a mental disorder? Obviously more is required than committee meetings that result in naming a disorder and a criteria list. The actual committee deliberations that produced *DSM* categories, based on Lane's (2007) review of APA archival material and interviews with key figures, reveal a process that is far from a model of disinterested weighing of available evidence.

The exact *DSM* wording is that a mental disorder must be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. For the present discussion I will consider behavioral and psychological as synonyms. I assume by "considered a manifestation of a biological dysfunction" the authors are referring to a relevant medical disease (e.g., hypothyroidism) that has been diagnosed in the usual manner — in short, a "Mental Disorder Due To A General Medical Condition." This would not be a "primary" (idiopathic) mental disorder. I realize that it is now convention within psychiatry to refer to many or all primary (idiopathic) mental disorders as "neuropsychiatric disorders," despite the fact that diagnosis is made exclusively on behavioral grounds and *no* biological evidence of any kind is relevant, to say nothing of necessary or sufficient, to making a diagnosis. I think it is fair to refer to this practice within psychiatric literature as ideology or propaganda. Pronouncements notwithstanding, a diagnosis of mental disorder on the basis that it is a manifestation of an unknown biological dysfunction presents us with two unknowns — we are no wiser about when or why some distress or disability should be qualitatively separated from other distress or disability.

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[1]A good introduction to the immense anti-psychiatry literature can be found in Cohen, 1990, 1994. On the hopes and goals of the "new order" in American psychiatry, namely *DSM-III* and neoKraepelinism, see Cooksey and Brown, 1998; Kirk and Kutchins, 1992; Klerman, 1978; Wilson, 1993.

What Is Psychological Dysfunction?

As suggested, defining mental disorder as a manifestation of a psychological dysfunction defines one unknown in terms of another unknown. The *DSM* supplies no discussion as to what a psychological dysfunction is supposed to be or how to identify its presence. The concept of a psychological dysfunction, then, is no less vague than mental disorder itself. My impression is that the authors do not expect the term "psychological dysfunction" to provoke critical thought. The concept and identification of pathology or dysfunction in somatic medicine is fairly uncontentious, but that does not insure that anyone knows what the term "psychological dysfunction" is supposed to mean or that it means anything sensible at all. Apparently the authors are proposing the following: "You all know what biological dysfunction means; well, psychological dysfunction means the same thing, except that what is dysfunctioning is the mind."

But this will not do. If we know what biological dysfunction means, it is because we know how we want an organ of the body to function regardless of conditions or circumstances, e.g., we know how we want the liver to function so we feel healthy and comfortable, and any deviation in how the liver functions that causes us to feel unhealthy, no matter what the cause, we regard as pathology or dysfunction. Absent how we regard the matter, there is only how the liver usually functions and deviations from how it usually functions. There is no "proper" function outside of our interests (Sedgwick, 1982; I will return to Sedgwick's decomposition of biological dysfunction into an evaluative component and a causal–explanatory component below). Nature or evolution did not literally design the liver or anything about us for a *purpose*, which is not to deny that our bodies evolved (a machine is designed for a purpose, but it is a mistake to think about evolution as purposive; see Davies, 2001; Fodor and Piatelli–Palmarini, 2010; Gould, 2000; Ingold, 2000; Richardson, 2007; Rose, 2000). The APA in effect conceded this point when it dropped homosexuality as a mental disorder (Bayer, 1987). If we attempt to regard psychological dysfunction as isomorphic with the concept and identification of pathology or dysfunction in medicine, we have this: "We know how we want people to think, feel, behave, and perceive regardless of conditions or circumstances, and any deviation from what we want is pathology or dysfunction."

The above formulation seems without merit. We do not know how we want a person to think, feel, or behave regardless of conditions or circumstances, and we do not know to whom "we" refers in the above formulation. In the case of medicine "we" refers to more or less everyone's common sense idea of physical health and well being, but if the topic shifts to how a person should or is supposed to think, feel, and behave in each and every set of circumstances that might arise, Babel results. Should Jane (first paragraph) be distressed and how distressed should she be about the situation she is in? What even *is* the situation she is in?

One glaring problem with trying to regard "psychological dysfunction" as isomorphic with biological dysfunction is that bodily organs do not operate in a situation or state of affairs as far as *they* are concerned, but people *always* think, feel, behave, and perceive in a situation or state of affairs as far as they are concerned. I will refer to anyone who wishes to depict or explain anything about another person as an "interested party" for the purpose of this essay. An interested party may have the liberty to portray (depict, describe . . .) someone else's behavior as he pleases, but a realistic view of human behavior requires recognition that the person portrayed is an agent in her own right, and this recognition demands attention to the agent's own description of what she is up to as well as the agent's view of her grounds for doing what she has done or is doing. If the person as agent is ignored, travesties like the antebellum diagnosis of drapetomania (the mental disorder that caused slaves to flee to the North) can and will result. I will use drapetomania as a blatant example of indifference on the part of interested parties to the agential status of the person being considered. As discussed below, the *DSM*'s elimination, for the practical purpose of diagnosis, of all considerations other than "present symptoms" removes the person being diagnosed from the category of agent to the category of disease host (as the *DSM* puts it, an individual with "fill in the blank" primary mental disorder).

Agent or Disease Host?

I cannot overemphasize that the issue at hand is when to decide that the person-as-agent perspective has become irrelevant and the facts demand a disease framework of thought in order to realistically depict and explain a person's behavior (as in severe brain damage, advanced Alzheimer's, advanced Huntington's disease, etc.). There are only two short sections in the introduction to the *DSM* that even consider this fundamental matter (i.e., the "Definition" section and the "Limitations" section). In psychiatry journals the issue is invisible; people who are deemed to meet the criteria list for one or more *DSM* diagnostic categories are by definition mentally disordered, and as persons with idiopathic diseases are suitable subjects for biological research. This practice conforms to how the diagnostic manual is written *beyond* the introductory sections. Since the manual proper ignores the issues raised in the introductory sections, it is unsurprising that the field as a whole also ignores the entire issue of what makes more or less matching any criteria list presented in the *DSM* a bona fide mental disorder (idiopathic disease).

The "Definition" section warns that distress or disability by itself does not qualify a person for a diagnosis of mental disorder. In providing a caveat, however inadequately thought through and perhaps actually misleading, the *DSM* does gingerly touch on the fundamental issue that has exercised skeptics and antipsychiatrists (who may themselves be psychiatrists) for at least the past fifty

years, namely on what grounds does a diagnosis of mental disorder rise above the kind of reasoning that produced drapetomania or the *Malleus Maleficarum* (notwithstanding denial on the part of the accused, see Szasz, 1970)? It is worth noting that the "Definition" section has remained basically unaltered since the publication of *DSM-III* in 1980, a clear index of how much progress has been made in putting mental disorder on a scientific footing since the great leap forward. The exact wording of the caveat is as follows: "[regarding the clinically significant syndrome or pattern under consideration] . . . 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" (*DSM-IV-TR*, p. xxxi).

The above statement has withstood three manual revisions since 1980. The very next section, the "Limitations" section, admits that distinct, autonomous syndromes do not really exist in the realm of primary mental disorders, although the *Manual* proper names and provides criterion lists for hundreds. The naming and description of distinct categories are necessary so that psychiatric diagnosis can be consistent with the traditional form "used in all systems of medical diagnosis" (p. xxxi). Notwithstanding the necessity to adhere to the standard form of medical diagnosis, the "Limitations" section advises the reader "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways" (p. xxxi). Moreover, the actual heterogeneity of cases diagnosed as suffering from "the same" disorder "emphasizes the need to capture additional clinical information that goes beyond diagnosis" (pp. xxxi–xxxii). But surely the point of making a clinical diagnosis is to state what the problem is and not just to signal the need to acquire additional information so that the problem can eventually be stated in the form of an individualized narrative. In short, the syndromes or patterns referred to in the caveat are fictions created so that psychiatric diagnosis can look consistent with medical diagnosis. Imagine if research papers in psychiatry journals concerning a specific *DSM* diagnosis reminded the reader of the foregoing "no assumptions."

The idea expressed in the caveat that society has already prepared an expectable and culturally sanctioned response to any set of circumstances an individual might face in the course of living cannot withstand even cursory inspection. For example, what is the expected and culturally sanctioned response on the part of a pre-adolescent girl to being recruited as her adoptive father's sex partner while her biological mother looks on (from a case reported by Goodwin, 1985)? Obviously there is no expected and culturally sanctioned response to events that according to conventional morality are not supposed to occur in the first place. Does anyone know what the girl's response should be? Does anyone know what the girl's response should *not* be — that is, what a pathological or dys-

functional response would be? If the girl came to clinical attention somehow (she came to Goodwin's attention via court referral), how would anyone determine the boundary between the girl's non-pathological response to her situation as a whole and her pathological response to her situation as a whole? Should she be held to a standard set by other girls who have not faced what she has faced? Has any girl faced exactly what she has faced? If not, where would a standard for deciding if her adaptation is pathological or not come from?

There is no question, based on Goodwin's three-fourths page summary of the girl's history, including her current deplorable circumstances at age 14, that she is distressed and a behavioral problem (this means she is a problem for certain people and authorities). The issue being addressed here is not whether she is distressed and a behavioral problem; the issue is the rationale for judging that she is the passive host of an unknown biological or psychological dysfunction. This seems to boil down to whether an interested party finds her thinking and so on compatible with what an agent (a person) might possibly think etc. under the circumstances. Goodwin finds some of the girl's thinking, feeling, and behavior comprehensible or warranted or defensible in light of her take on the circumstances as conveyed by the girl (Jessie). This is not mental disorder as far as Goodwin is concerned. But Goodwin finds other features of Jessie's thinking, feeling, or behavior outside of what is warranted or comprehensible or defensible despite or regardless of what Jessie has conveyed about her circumstances. Goodwin calls such features symptoms of mental disorder, for example, Goodwin apparently finds nothing pathological about Jessie's declared intention never to let a man touch her, but Goodwin regards Jessie's receptivity to "a friend's" offer to make her a porn star a symptom of PTSD ("reliving").

The *DSM* appears to suggest that some symptoms are inherently pathological (under "Criteria for Clinical Significance," p. 8), but can offer no guidelines beyond the observation that this is an inherently difficult clinical judgment. This is hardly surprising because "inherently" means regardless of circumstances, but real people may be in dire circumstance. The very notion of dire circumstances or circumstances at all is anathema to medical psychiatry because it clearly introduces considerations that cannot be addressed within the endogenous disease framework of thought. This is again to point out that passing off psychological dysfunction as isomorphic with biological dysfunction is a veritable clang association. Organs of the body do not operate under "circumstances"; only a person can and must face existential circumstances, and the circumstances you depict, existentially, may not correspond to my description of relevant circumstances.

To repeat, the *DSM* states (p. xxxi) that the distress or disability of the person being evaluated must be considered a manifestation of a biological or psychological dysfunction in the individual in order for a diagnosis of mental disorder to be made. In light of the caveat (discussed above), however badly worded, the *DSM*-guided diagnostician is called upon to make a judgment as to whether or

not the overall existential situation facing the person under consideration places the person's distress or disability in the agential camp or in the host-of-disease camp. Obviously this task cannot be executed in the absence of a serious, protracted, and skillful Axis-IV effort. Confusingly, the *DSM* (p. 27) grants the clinician liberty to delete Axis-IV considerations if the clinician "prefers" not to use the multiaxial system. It is not clear from the wording whether permission is being granted to disregard Axis-IV considerations in making a diagnosis or to not go to the trouble of writing anything with regard to Axis-IV considerations in reporting a diagnosis. In any event, the "Definition" section seems to require a thoroughgoing solicitation and consideration of Axis-IV issues. It would be pointless to do this in a cursory manner. But even if the clinician does become familiar with the personal history of the individual, as in the case Goodwin (1985) reported, the clinician is still in the position of judging whether the individual should be framed in agential or host-of-disease terms. It is clear from Goodwin's summary of Jessie's history that Jessie has been subjected to conditions that most everyone would readily agree should never befall a girl. As mentioned, Goodwin finds some features of Jessie's distress and disability explicable in terms of Jessie's history and situation, while she sees other features that demand a host-of-disease framework of thought. As far as I can tell she has only her intuition and her ability to empathically feel her way into Jessie's shoes. I must remind the reader that the issue at hand is not whether Jessie is distressed or disabled. As the *Malleus Maleficarum* illustrates, codified judgments or criteria do not rise to the level of fact in the absence of objective evidence of validity. Goodwin may think that Jessie's background entitles her to avoid sexual contact with men and does *not* entitle her to be interested in a career as a porn star, but this seems very much like having an opinion that *Lady Chatterley's Lover* is literature but *The Tropic of Cancer* is pornography. She can have her opinion, but what raises it above an opinion? From the summary Goodwin presents I can imaginatively construct a story about Jessie's interest in being made a porn star that has nothing to do with pathology or dysfunction or disease, rather a girl whose interests, values, sensibilities, and view of her options have been shaped by markedly adverse circumstances. Goodwin apparently feels that some features of Jessie's behavior mark themselves as inherently pathological, so there is no obligation to say why these features are considered qualitatively different than other features that are viewed as comprehensibly rooted in Jessie's personal history. The *DSM* can only offer that detecting the inherently pathological is an inherently difficult clinical judgment.

Insider Information

It is pleasing to note that a recent discussion on the part of Allen Frances, Chairperson of the *DSM-IV* Task Force, explicitly admits that the difference

between the diagnosis mental disorder present and not present depends on the deliberately unguided judgment of the individual clinician on a case-by-case basis (Frances et al., 2008). This can usefully be contrasted to the basis on which a physician makes a diagnosis of pneumonia, or even more fundamentally, the basis on which a physician diagnoses somatic disease present (Baughman, 2008). The remarks offered by Frances et al. came in the context of commenting on the fact that a paraphilia NOS, nonconsenting person diagnosis is frequently the legal justification for civilly committing a man to a State institution for an indefinite period. The civil commitment occurs at the conclusion of the criminal sentence; the purpose is prevention of future crimes. Frances et al. acknowledge this as a highly contentious topic, both in law and in psychiatry. What is contentious, they readily admit, is that deprivation of liberty for crimes not committed is based on expert opinion that mental disorder is present, but this cannot be construed as a matter of fact. This renders a finding that "mental disorder is present" a slim basis for the State to deprive a person of liberty for crimes not committed. Having made what would seem to be the pivotal point that mental disorder cannot be diagnosed as a matter of fact, Frances et al. content themselves with advising mental health workers to make their judgments *carefully*, as if that mattered. To dispel any possible misunderstanding regarding the factual status of a diagnosis of mental disorder, Frances et al. disclose the following insider information about the construction of *DSM* standards (to recall, Frances served as Chairperson of the *DSM-IV* Task Force):

> As with the specific criteria sets, the intent for the NOS was to allow clinicians to use their judgment for each individual as to whether the symptom cluster caused enough distress and/or impairment to be a mental disorder. There were no guidelines as to how such judgments should be made and no hard and fast rules; it was left to the clinician to make the determination on a case-by-case basis. This vagueness in guidelines is intentional so as to permit the clinician flexibility in using the Manual. (p. 382)

The above remark omits all reference to the possibility that the person under consideration may be facing or has faced and been impacted by dire circumstances; the only consideration is whether the level of distress or impairment strikes a particular clinician as "enough" to judge that mental disorder is present. The warning in the "Definition" section not to simply assume that marked distress or impairment by itself signifies mental disorder has disappeared. In short, what has disappeared is any recognition that a person is an agent who always thinks, feels, and acts in a context — a context as subjectively perceived and experienced. If a person's status as agent is to be considered trumped or voided by the presence and consequences of disease, objective evidence of disease and its relevance for understanding the behavior of the individual in question must be explicitly presented. Minus such evidence we have drapetomania, witches, and, I submit, all primary mental disorders. Goodwin, for example, appears to

be uninterested in what about being made a porn star is potentially appealing to Jessie. Agential status cannot be legitimately voided simply on the basis of disapproval. Frances et al. have reverted to the conventional medical framework: deviation from valued well-being is pathology regardless of cause because it is unacceptable to *us*. But this formula does not work in the realm of human affairs because no one expects a person to be immune to circumstances, in fact, the ordinary idea of a person depends on it, so there is no facile leap from distress or social impairment to pathology. In order for the *DSM* to maintain a medical stance, the entire issue of circumstances (i.e., the person in the human world) is deleted from the textual discussions and criteria sets for primary mental disorders. This is hardly surprising because discourse about what circumstances might *entitle* a person to think or feel or do cannot be presented as impersonal medical science, or science at all. But people as such disappear when circumstances (situation, context . . .) are deleted. What remains is an *as if* realm in which people are viewed *as if* they were bodily organs with unambiguous functions and thus unambiguous dysfunctions. This is the imaginary realm of the *DSM*.

Bereavement Is the Only Exception

For the practical activity of making a diagnosis the *DSM* disregards circumstances entirely (situation, context, background . . .). The outstanding exception is PTSD, but (a) a case can be made that PTSD was foisted on the APA and the Veterans Administration by pressure from Vietnam veterans and their supporters (Blank, 1985; Scott, 1990); and (b) notwithstanding the formulation that PTSD "symptoms" are rooted in horrendous real-life experiences, PTSD is defined as a mental disorder, once again illustrating the medical–psychiatric view that departures from well-being should be regarded as pathology or dysfunction regardless of circumstances (background, context, personal history . . .). But the diagnosis of mental disorder is not merely an "official" acknowledgment that the person under consideration is suffering or impaired; it is also an assertion of biological or psychological dysfunction — the person diagnosed with PTSD is not functioning as he is supposed to function, thus should be considered a disease host, although in the case of PTSD the cause of the disorder is exogenous. In any event something has caused the individual under consideration to dysfunction, since human beings were designed by Nature to be happy and productive members of society irrespective of their actual experience of the social–interpersonal world. Stated in proposition form, the preceding sentence does sound rather absurd.

The history and politics of the PTSD diagnosis (i.e., as the outgrowth of activism on the part of Vietnam veterans) renders it impossible to simply rule out the individual's experience in the social–interpersonal world and just stick to present symptoms. The necessity in the case of PTSD to acknowledge the

impact and influence of social–interpersonal experience on distress and social impairment stands in potentially dangerous contrast with the *DSM*'s overall position that "clinically significant" distress or social impairment should be conceived in terms of impersonal, albeit unknown, mechanisms and processes, i.e., as in understanding the nature and etiopathogenesis of somatic disease, the individual as agent embedded in and reacting to her environment is really quite beside the point. Thus the elimination of all social–interpersonal considerations from the textual discussions concerning the nature of each primary mental disorder and from the criteria lists. But once the influence of "dire circumstances" is officially recognized as the necessary background for one "mental disorder," what other than ideology makes social–interpersonal experience irrelevant for every other form of distress and/or impairment recognized in the *DSM*?

For example, the textual discussion and criteria list for Major Depressive Episode omits any reference to social–interpersonal experience, as befits a disorder assumed to be a manifestation of an unknown biological or psychological dysfunction. Under the heading "Associated Descriptive Features and Mental Disorders" the reader does find the observation that "Major Depressive Episodes often follow psychosocial stressors" (p. 352), but the manual states (p. 8) that considerations listed under the "Associated" heading are not essential to making the diagnosis (of mental disorder!). Thus no matter how eloquent a patient may be about what has occurred in his personal world, as far as the *DSM* is concerned the patient is suffering from an idiopathic mental disorder. The rationale can only be that, as in the identification of somatic disease, deviation from valued well being is unacceptable to "us" no matter how or why it has arisen, and since the person is not functioning as she is supposed to, some impersonal mechanism or process must be responsible. One highly conspicuous consequence of applying the medical framework to human affairs is that distressed or troubling children are viewed in isolation from the family or broader social environment. I was originally struck by Goodwin's summary of Jessie precisely because Goodwin advised that only knowledge of Jessie's history rendered Conduct Disorder the wrong diagnosis for Jessie, notwithstanding the fact that Jessie met the criteria for Conduct Disorder. Knowledge of Jessie's history does not alter Jessie's behavior in the present, but it does alter the view that Jessie suffers from an idiopathic mental disorder (of course Goodwin argued that Jessie suffered from a *different* mental disorder, namely PTSD).

The point that assigning mental disorder status is not a humane effort to officially recognize a person's distress or psychosocial disability cannot be overemphasized. The cost of such recognition via mental disorder diagnosis is to remove the person so recognized from agential status and from the human world of social-interpersonal events and circumstances. Much of what occurs in the human world is far from pretty. Medicalization renders the human world irrelevant. What becomes relevant in the medical framework is unknown biological dysfunction

or unknown psychological dysfunction, in short, impersonal mechanisms. The agent's personal history (including the present) in the human world is removed from other than incidental relevance; what is relevant is the unknown biological or psychological dysfunction that is really the source of the person's difficulties. Reference to an unknown biological dysfunction ends conversation about the human world. Reference to psychological dysfunction requires making believe that psychological dysfunction is simply a straightforward extension of biological dysfunction. Not only is the psychological dysfunction unknown but what the concept is supposed to mean is also unknown (it cannot, as in biological dysfunction, mean that "we" know what is supposed to occur regardless of circumstances).

In the case of Adjustment Disorder all pretense that the real source of the difficulty is an unknown biological or psychological dysfunction seems to have been abandoned, i.e., ". . . a reaction to a stressor that might be considered normal or expectable can still qualify for a diagnosis of Adjustment Disorder [a mental disorder!] if the reaction is sufficiently severe to cause significant impairment" (p. 679). In other words, actually becoming upset enough by adversity to be noticeably affected in "social or occupational functioning" (p. 679) can be considered mental disorder even if the diagnostician does think the person's reaction is normal and expectable. This seems the moral core of the *DSM* and biopsychiatry, i.e., *no* circumstances entitle a person to become unable to carry on with his duties in the usual manner. The same could be said of PTSD: the only way the medical framework can apprehend becoming a disturbance to others, burdening them with the necessity to provide care, is via the presence of some form of inner dysfunction, either biological or psychological. A healthy organism carries on in the expected manner and does not require care. The conviction that medicine should be the framework for depicting and explaining how a person fares in the human world is a commitment to ignoring the person as such and the human world. One reads the *DSM* in vain for some hint that people who are "clinically" distressed or disabled have personal histories that *matter*. Since Goodwin is addressing how Jessie fits into *DSM-III*, she apparently feels she has to *argue* that Jessie's history should matter for the purpose of formulating what ails Jessie (diagnosis, in short). In my view Goodwin only partly restores Jessie to the status of person. Goodwin decides for herself when Jessie's history ceases to matter. At the point Goodwin decides Jessie's history ceases to matter the conceptual equivalent of drapetomania steps in.

Conclusion

The *DSM* seems to consist of two separate and independent parts: (1) the introduction, in which the concept of mental disorder and the limitations of conventional medical classification when it comes to realistically depicting the difficulties that people have in the psychosocial realm are addressed, and (2)

the "working" manual itself, which simply disregards the issues raised in the introductory (conceptual) part of the manual. As documented above, the "working" part of the manual grants the individual clinician liberty to diagnose mental disorder on a case-by-case basis if she thinks "enough" distress or psychosocial impairment is detected, regardless of circumstances. As Frances et al. (2008) reveal, the absence of guidelines or rules for making this decision was deliberate on the part of the authors of the *DSM* in order to allow the clinician "flexibility in using the Manual" (p. 382). The NOS category was created so that a clinician could decide that mental disorder was present even if the individual being diagnosed did not fit into any described category with its own criteria set. The diagnostician is in practice completely unshackled from the conceptual demands regarding the diagnosis of mental disorder presented in the introduction to the manual (i.e., mental disorder must be considered a manifestation of a biological or psychological dysfunction, not to be confused with the mere presence of distress or disability themselves). The admission that the individual clinician is at liberty to use her own personal judgment on a case-by-case basis is almost comical viewed in historical perspective; after all, the *DSM-III* "revolution" was supposed to get psychiatry on a firm scientific footing by severely limiting the individual clinician's liberty to apply personal judgment (see Kirk and Kutchin's 1992 review of the aspirations set for *DSM-III* and how "success" was announced).

The liberty granted to clinicians in practice to use their own judgment clearly avoids the validity issue that has exorcised psychiatry's critics over the years. Or it might better be said that the liberty granted clinicians to use their own judgment de facto concedes the point that psychiatric diagnosis is no more than an opinion, since there is no question of personal judgment by itself standing as fact (as Frances et al. readily acknowledge). The only question that remains is whether mental disorder as officially conceived by the APA can be thought of as a possibly technical–scientific concept. This would seem to hinge on reserving mental disorder to cases of objectively verified biological or psychological dysfunctions. Is this right?

My impression is that physicians outside of psychiatry do not concern themselves with diagnosing mental disorder present or not present. If a patient's behavior seems strange or problematic, this may instigate a search for somatic disease. If somatic disease is diagnosed, it is diagnosed in the usual manner, i.e., on objective physical grounds. The verified presence of somatic disease does not answer the question of whether mental disorder is present (as, for example, the *DSM* discussion of "Mood Disorder Due to a General Medical Condition," pp. 401–403, makes clear) because the presence of somatic disease does not stand in a one-to-one relation with untoward psychosocial behavior and more importantly because the disease itself cannot judge how the person is doing in the psychosocial realm. Thus the closed circle of mental disorder being a social judgment apparently

cannot be broken by appeal to the presence of verified biological dysfunction (Ross pointed this out some time ago, i.e., 1995). The question "Is mental disorder present?" does not lend itself to a technical–scientific answer any more than deciding who is really mentally retarded lends itself to a technical–scientific answer. The wrong conclusion is that there will be false positives and negatives wherever the line is set. The right conclusion is that this is just not a scientific question. It is no rejoinder to point out that the courts and so on depend on psychiatrists and others to provide an expert opinion on mental disorder present or not present. The APA should give up the idea that verifying biological dysfunction will render mental disorder a technical–scientific term. To put this another way, biological dysfunction cannot be verified by showing it causes mental disorder because "biological dysfunction" has to be tied to some outcome we do not like that is not *itself* so contentious (e.g., Parkinson's *disease* does not depend on its connection to mental disorder). To continue trying to make the same point: I may find *Hustler* magazine blatantly offensive, but that does not make "pornography" a scientific term. If someone is unable to see this point, it is hard to think of what further to say.

The term psychological dysfunction, in my analysis, only has an acoustic connection to biological dysfunction. The *DSM* cannot give an example of a psychological dysfunction, however, it is clear that the authors intend the term "psychological dysfunction" to be read as isomorphic with biological dysfunction, which they neither define nor discuss. Presumably they regard the meaning of biological dysfunction as clear and unproblematic, so anyone should be able to make the leap to what psychological dysfunction means. I draw on Sedgwick's (1982) formulation of biological dysfunction because it is the clearest formulation I have encountered. In his formulation biological dysfunction has two components: (1) an evaluative component wherein we regard a deviation from what we want and value in the realm of physical well-being as unacceptable to us regardless of how the deviation from what we want and desire arose; such deviations are biological pathology or dysfunction; and (2) an explanatory framework wherein it is taken for granted that both desired organ function and pathology or dysfunction are due to the existence and operation of causal mechanisms and processes.

It is hard to see how the above formulation can apply to how a person thinks, feels, or acts. Although it may be easy for people to agree about what is wanted and desired regarding physical well-being without any qualifications at all, the same can hardly be said for emotions, thoughts, and behavior. Is sadness, for example, desired or undesired; is it valued or unwanted? The answer of course is, it depends. It thus becomes apparent that the easy, unqualified consensus that exists when it comes to physical well-being falls apart immediately when the topic is shifted to what people think, feel, and how they behave. Goodwin reports that Jessie spends a lot of time weeping in her room. She also reports

that Jessie has been abused most of her life, including the present, and that she has realistic reason to fear that her "whereabouts unknown" adoptive father is trying to find her and kill her before he can be brought to trial for child abuse. Do "we" demand stoicism or optimism from a 14-year-old girl who has been abused by her own parents all of her life? The answer must be yes if we are to regard her weeping as dysfunction in the same spirit we regard being unable to walk as dysfunction regardless of how this has arisen. It seems a simple extension of the evaluative part of the biological dysfunction formula to the realm of human affairs will not do because thoughts, feelings, and actions are for the most part not straightforwardly good or bad regardless of context.

If psychological dysfunction is to be thought of in the same manner as biological dysfunction, it is necessary to think that what people think, feel, and do, whether positively or negatively evaluated, can be causally explained. Consider the *DSM*'s favorite example of distress or disability, even of clinical severity, that does not qualify for a mental disorder diagnosis provided the bereaved keeps it short, namely bereavement. The event or phenomenon to be explained is grief etc. following the loss of a loved one. In order for this phenomenon to be causally explained, the cause of the phenomenon must be stated in a manner that is independent of the phenomenon to be explained, which is the effect of the cause. This is elementary (e.g., von Wright, 1971). For example, the cause of tuberculosis, infection by varieties of mycobacteria, exists and can be identified independently of the clinical disease (the effect of mycobacterial infection). In the case of someone being bereaved that Charlie has died, the effect, bereavement that the loved one Charlie has died, must be independent of the cause. The connection between cause and effect must be some kind of physical transaction between two independent "things." The cause of being bereaved that the loved one Charlie has died, then, cannot merely be some statement that Charlie was loved by the bereaved. The reason is that stating or noting that the bereaved loved Charlie implies bereavement at Charlie's loss. If not, the conventional idea that Charlie was actually a "loved one" cannot be sustained. By contrast, the existence of mycobacteria implies nothing whatsoever about the human clinical disease, tuberculosis. Could there be a cause of being bereaved that Charlie died that does not imply that Charlie was beloved by the bereaved? If not, then being bereaved that Charlie died is not the kind of event or phenomenon that can be assimilated to causal explanation.

The requirement that what people think, feel, and do must be explicable in a cause–effect framework in order for psychological function and dysfunction to be understood in the same sense as biological function and dysfunction does not seem to be met. This is confusing for people who assume that anything that occurs must admit to a causal explanation. But the fruitfulness of studying the world naturalistically does not automatically mean that our platform for studying the world, namely the human world, can also be studied naturalistically. For

example, as the philosopher Michael Polanyi pointed out some time ago (1958), while it is possible to explain how a machine operates naturalistically, that is in terms of physics and chemistry, it is not possible to draw upon physics and chemistry to determine what a machine is *for* and when it is working properly. This shows in a very simple way that the existence and content of the human world cannot be reduced to physical operations and laws. The philosophies of Heidegger (as explicated by Dreyfus, 1991) and Wittgenstein (1958) in their own ways make the same basic point.

I conclude that the APA's version of mental disorder cannot become a technical–scientific term because (a) it is pointless to search for the biological dysfunction that produces mental disorder when the condition supposedly produced (mental disorder) is itself so contentious. Somatic diseases are identified as disease precisely because the state of affairs they bring about is considered unacceptable no matter what, but in human affairs evaluation depends on context. The point is not that anyone considers emotional distress or psychosocial disability desirable; the point is that distress or disability may be comprehensible under the circumstances, as in bereavement. This critical consideration vanishes if circumstances are deemed irrelevant, but as the example of bereavement illustrates, evaluation stripped of context is ludicrous in human affairs. The relevant circumstances from the point of view of the agent may be challenging to access; (b) to be isomorphic with biological dysfunction, psychological dysfunction must likewise be amenable to causal explanation, but there are compelling reasons to doubt that the human world can be assimilated to a cause–effect framework. Thus there seems little prospect that the APA's version of mental disorder can become a legitimate technical–scientific term.

Until a version of mental disorder appears that can be considered a legitimate technical–scientific term, intellectual honesty should compel the field to acknowledge that at present the term has the same status as the term "pornography." Imagine if mental disorder was unavailable as a way to end examination of social–interpersonal history and present circumstances.

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