

An Evaluation of the DSM Concept of Mental Disorder

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The stated purpose of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is to classify mental disorders. However, no tenable operational definition of mental disorder is offered in the manual. This leaves the possibility open that the behaviors labeled as disordered in the DSM are not members of a valid category. Attempts to define mental illness fall into the category of essentialist or relativist based, respectively, on the acceptance or denial of the existence of a defining biological attribute that all mental disorders possess. However, the disorders in the DSM cannot be accounted for by either of these approaches making it unlikely that they represent a single valid concept. Simultaneous inclusion of brain illnesses and normal behaviors in the DSM are a likely explanation for the disparate nature of DSM disorders.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) stands alone as the world's most utilized psychiatric reference (American Psychiatric Association Publishing, 2006). A total of 365 different disorders are defined within the manual (Houts, 2002). Officially, the stated purpose of the DSM is classification of disorders; in practice, it also constitutes a guide to the behaviors that make up the concept of mental disorder. The framers of the DSM were reticent, however, to explicitly define the term mental disorder. In fact, the manual states that "mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations" (American Psychiatric Association [APA], 2000, p. xxx). Unfortunately, avoiding commitment to an operational definition does not eliminate the need to demonstrate validity. I will argue in this paper that the DSM concept of disorder lacks validity because the behaviors listed as mental disorders cannot be accounted for using one definition of mental illness.

A definition of mental disorder is offered in the DSM. The definition states that a mental disorder is a:

Clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (APA, 2000, p. xxxi)

Additionally, the DSM definition stipulates that a mental disorder is not a culturally expected behavior, simple deviance, or conflict with society. Overall, the DSM definition can be summarized as “statistically unexpected distress or disability” (Wakefield, 1992b, p. 238).

The definition of mental disorder offered in the DSM is not generally used or accepted. Wakefield (1992b) convincingly illustrated that the definition lacks validity and that many disorders included in the manual violate the definition’s premises, but nothing was done to address these concerns in the DSM revisions. Even Robert Spitzer, who was one of the major authors of the definition, has abandoned it (Spitzer, 1999). Furthermore, the authors of the DSM expressed little confidence in the definition stating that it is only included “because it is as useful as any other available definition” (APA, 2000, p. xxxi). A problem arises because although the authors of the DSM insist that mental disorder cannot be precisely defined, they simultaneously assert that the categorized behaviors included in the manual are mental disorders. How is this possible? No evidence is provided in the DSM to support the inclusion of one type of behavior or the exclusion of another. Without an operational definition it is unclear what concept is represented by the DSM; in fact, there is no reason to assume that the mental disorders in the DSM represent any single valid concept.

Even a casual examination of the heterogeneous behaviors listed in the DSM elucidates why encapsulating them into one definition is difficult. The DSM concept of disorder represents wildly different human behaviors. Consider the cases of alcohol-induced persisting dementia and alcohol abuse. Dementia occurs when so much alcohol is consumed that brain damage results. A diagnosis can be made only if memory is impaired and another cognitive deficit such as agnosia or aphasia is present. In contrast, alcohol abuse requires only a pattern of use that causes moderate symptoms of impairment or distress. These disorders differ in terms of severity, etiology, course, prevalence, prognosis, and social relativity, but the DSM classifies them both as valid mental disorders. A single definition of disorder must account for a person whose massive alcohol consumption has damaged his or her short term memory and ability to identify common objects as well as a person who repeatedly has arguments with a roommate when drunk. Thus, the DSM concept of disorder encompasses behaviors that are severe, biologically based, chronic, uncommon, incurable, and universal as well as behaviors that are mild, psychologically based, remitting, common, curable, and culturally relative.

Some assert that behaviors such as alcohol-induced persisting dementia and alcohol abuse should be paired under one definition of mental disorder, and the most common argument relies on a physical illness analogy. Physical illnesses have wide-ranging etiologies, severities, courses, prevalences, prognoses, and social relativities, and there is little concern over their definition. For example, cancer and the common cold are both considered physical illnesses. Therefore, the argument goes, if dramatic variation occurs in physical illness, mental illness should also be expected to vary (Kendell, 2001, 2002b).

There are two problems with asserting that mental and physical illnesses are analogous. First, as a general rule physical illness has an objective biological component, and that is not generally the case with mental illness. Objective physical signs are the unifying structure that allows diverse problems like cancer and colds to be categorized together while alcohol-induced persisting dementia and alcohol abuse lack such an objective link. Second, the concept of mental illness is more susceptible to bias based on values than the concept of physical illness (Fulford, 1999; Widiger, 2002). Although the biomedical values of life and freedom from pain are universal and evolutionarily based, values concerning behavior, cognition, and emotion are less agreed upon and are, therefore, less stable. As such, including a behavior in the DSM as a disorder sometimes involves the application of a cultural value that may change over a short period of time. Because of these inherent differences, the analogy between physical and mental disorder breaks down, and that makes it difficult to assert that the two should logically resemble each other. Consequently, differences between mental disorders cannot simply be ignored due to supposed similar differences between physical illnesses.

Forming an operational definition of mental disorder is legitimately difficult; however, the position taken in the DSM toward that task could be characterized as disinterested and defeatist. Other researchers attempting to define mental illness have not adopted a similar position. In fact, the literature surrounding definitions of mental illness contains suggestions for precise operational definitions (Bergner, 1997; Kendall, 1975; Wakefield, 1992a; Widiger and Sankis, 2000); unfortunately, agreement has been elusive. However, these and other definitions offer a starting point from which to evaluate the validity of the DSM concept of disorder. I will argue that the DSM's disorders are unlikely to represent a single concept because they cannot be accounted for by one definition of mental illness.

Divergent Definitions of Mental Illness

A review and synthesis of approaches to defining mental illness is necessary before using them to evaluate the DSM concept of disorder. The study of psychopathology is plagued by a lack of consensus on the definition of mental ill-

ness. Frankly, the disagreeing sides of the definitional debate are so far afield in their views that the persistent divergence is embarrassing in a scientific sense. To begin with the extremes, on one side of the debate is the neo-Kraepelinian viewpoint that mental illness is real, can be differentiated from nondisordered states, and is best approached biomedically. At the other extreme is the classic Szaszian standpoint that mental illness is a myth (Szasz, 1960); or more clearly, the label of mental illness is placed on problems in living as a social judgment masquerading behind unfounded medical assertions. Gorenstein (1984) attempted to find common ground between these two positions by conceptualizing mental illness as an operational definition with no more or less construct validity than other theoretical concepts. This attempt at unification failed because those with a biological bent criticized Gorenstein (1986) for his lack of acceptance of the reality of mental illness and those with a Szaszian stripe criticized him for his acceptance of the myth.

Despite the dramatic variation in opinion, attempts to define mental illness can be broken down into four basic subtypes: sociopolitical, ostensive, biomedical, and a hybrid combination of the biomedical and sociopolitical subtypes (Kendell, 2002a; Rounsaville et al., 2002). Each of these approaches has been controversial; however, my purpose is to provide an overview rather than an extensive review of each approach's validity. To begin, theories of the sociopolitical subtype define the concept of mental illness based on values or practicality (Rounsaville et al.). For example, mental illness can be defined practically as any devalued condition that is treated by mental health professionals. Such a definition would fit with Gorenstein's (1984) contention that disease is not a scientific concept because it merely describes the expanding list of clinical syndromes that receive treatment. To the sociopolitical subtype I would also add Szasz's (1960, 1974) definition of mental illness as a socially determined metaphor that represents no objective phenomena other than a value judgment about the problematic behaviors it describes.

The ostensive subtype reflects Lilienfeld and Marino's (1995, 1999) Roschian analysis of mental illness. Roschian analysis uses prototypes to define a category. Some instances will be similar to the prototype, and thus, clear members of a category. Other instances share only some of the features of the prototype and seem to be less clear examples of a category. In addition, concepts have fuzzy boundaries, which means that there is no clear demarcation when instances stop belonging to one category and begin belonging to another. Although consensus is far from total (e.g., Read, Mosher, and Bentall, 2004), schizophrenia is a prototypical case that most would agree is a mental illness; conversely, self-defeating personality is quite different from the prototype and is a subject of controversy as mental illness (Lilienfeld and Marino, 1995). To use a colloquial term, the craziness of different examples of the concept mental illness varies just as the bookiness of different examples of the concept book varies (e.g., text-

book vs. phonebook), and no overarching defining feature separates all mental illnesses from all non mental illnesses. Thus, the concept of mental illness will never be scientifically differentiated from the concept of normality without the identification of some correlate that binds the concept to objective reality (Lilienfeld and Marino, 1995).

The biomedical subtype is, arguably, the most popular among current theorists and researchers. Although biological conceptualizations are as old as mental illness itself, psychiatry has been especially important in promoting and utilizing the biological approach. Neo-Kraepelinian psychiatrists have been instrumental in forwarding the idea that mental illnesses are discrete biological entities best treated medically as sicknesses (Blashfield, 1984), and some assert this idea has been encoded into the DSM despite its avowedly atheoretical stance (Blashfield, 1982, 1984; Follette and Houts, 1996). If mental illnesses are biological, their actual definition could occur in several ways. Kendall (1975) defined mental illnesses by the biological disadvantage associated with them. Theorists have more recently claimed that mental and neurological disorders are one in the same and mental illness will eventually be defined and diagnosed neurologically (Tsuang, Stone, Tarbox, and Faraone, 2003). They assert that the complexity of the brain alone has prevented the use of physical signs in defining mental illness (Charney et al., 2002).

A final subtype is the hybrid that combines the sociopolitical and biomedical definitions (Rounsaville et al., 2002). Specifically, the hybrid subtype consists of Wakefield's (1992a) concept of harmful dysfunction. Harmful dysfunction rejects both the sociopolitical definition and the biological definition singularly, but combines them as a unique third alternative (Wakefield, 1999a). Wakefield (1992a) states:

A condition is a mental disorder if and only if (a) the condition causes harm or deprivation of benefit to the person as judged by the standards of the person's culture (the value criterion), and (b) the conclusion results from the inability of some mental mechanism to perform its natural function, wherein a natural function is an effect that is part of the evolutionary explanation of the existence and structure of the mental mechanism (the explanatory criterion). (p. 385)

Thus, mental illness exists when an evolved mental mechanism fails and this leads to a socially disvalued result.

Dividing the definitions of mental illness into four subtypes is instructive, but further reduction leads to a pertinent generalization. The four subtypes naturally break into pairs based on an acceptance or denial of the existence of objective, biological signs of mental illness. The biomedical and harmful dysfunction perspectives are essentialist in that they maintain that mental illness has an essential biological component. Harmful dysfunction, it could be argued, simply made explicit what was implicit in the biological definitions; namely,

when something out of the ordinary happens in the body, or in evolved mental mechanisms as Wakefield puts it, undesirable effects often result and such occurrences are disorders. Supporters of both the harmful dysfunction and biological subtypes agree that all mental illnesses can or will eventually be linked to an objective biological component.

Wakefield (1999b) argues against the notion that mental disorders are strictly physiological and denies that physical lesions are necessary in mental disorders. Thus, there could be some objection in placing harmful dysfunction in the same category as theories explicitly stating that mental illnesses are physical illnesses. Nonetheless, what unifies harmful dysfunction and purely physiological definitions is that they necessitate an objective, biological component. Wakefield states that "disorder is 'biological' in the sense that evolutionary theory must be involved to explain what function a mental or physical mechanism is designed to perform and thus when it can be considered mal-functional" (p. 1009). The evolved mechanisms that fail in cases of harmful dysfunction must exist at the biological level because evolved traits are passed on genetically. While harmful dysfunction does involve more than physiology (i.e., socially determined harm), its reliance on evolution guarantees that it also involves an essential biological component.

Other definitions have embraced the difficulty of discovering an essential component of mental illness. The sociopolitical and ostensive (Roschian) definitions are relativist because they reject the existence of an overarching, essential definitional component. The Roschians would assert that no single biological point of demarcation defines mental illness, and thus, "disorder is a nonscientific concept lacking clear cut natural boundaries" (Lilienfeld and Marino, 1999, p. 417), and Szaszians would argue that mental illness is purely a socially constructed pseudomedical label for devalued behaviors (Szasz, 1974). The Roschians and Szaszians accept that people exhibit real symptoms (e.g., anxiety, sadness), that these symptoms may have biological correlates, and that these symptoms may be categorized reliably, but they deny that mental illness has an essential, objective component. In fact, their similarity has prompted direct comparisons of the Roschians to Szasz (Fulford, 1999; Widiger, 2002).

I have shown that definitions of mental illness can be broken down into two opposing viewpoints: essentialist and relativist. These viewpoints provide a useful tool in evaluating the DSM. I will use the essentialist and relativist conceptualizations of mental illness to assess the validity of the DSM concept of disorder. Specifically, I will review the evidence that DSM disorders are essentialist and relativist concepts; this review will show that neither conceptualization can account for all the disorders currently listed in the DSM.

The Biological Approach: Essentialism is Correct

More than any other factor, brain imaging has validated DSM disorders as essentialist concepts. Discovery of objective differences between the brains of disordered and nondisordered individuals allowed a biological revolution in psychopathology to occur. Brain imaging research is implicated as one of the key answers to the definitional problem posed by mental illness (Kendell, 2002b). Researchers believe that conceptualization and diagnosis of mental illness will eventually be neurological because specific brain regions or circuits mediate all perception, cognition, emotion, and behavior (Epstein, Isenberg, Stern, and Silbersweig, 2002; Tsuang et al., 2003). The inability to find groundbreaking etiological discoveries over the last 100 years should not be discouraging because major brain pathology along the lines of that seen in Alzheimer's disease is not necessary for mental illness to occur.

Bolstered by neuroimaging research, several specific disorders provide evidence for the validity of the essentialist perspective. According to Kendell (2001) "unassailable evidence" has amassed for somatic abnormalities in the case of mood disorders, schizophrenia, and anxiety disorders (p. 491), and these are the very disorders that Nancy Andreasen referred to when she wrote about the "broken brains" (1984) and "brave new brains" (2001) of the biological revolution in psychiatry. According to the framers of the DSM, convincing evidence for physiologically based dysfunction in these so-called mental disorders even led to the removal of the organic/functional distinction from the DSM (Spitzer, Williams, First, and Kendler, 1989; Spitzer et al., 1992). Labeling a disorder as organic once indicated that biology was assumed to be at the heart of the problem while nonorganic disorders were considered to be more "mental" in nature (Beer, 1996). However, Spitzer and colleagues (1989, 1992) lobbied to have the distinction expunged from the DSM. As they put it, by eliminating the organic distinction there would be no need for "reclassifying" disorders when "their specific biological etiology or pathophysiology is discovered" (Spitzer et al., 1989, p. 126).

Although the organic and functional distinction was removed from the DSM, the disorders that were traditionally labeled as organic have remained. Dementia, delirium, and amnesic disorders were relabeled as the cognitive mental disorders. These disorders are often diagnosed in such a way as to indicate the physical illness that exists as the underlying cause. Examples include dementia of the Alzheimer's type, vascular dementia, and amnesic disorder due to a general medical condition. Also included in DSM are disorders with a known substance-based etiology. Examples include substance intoxication, substance withdrawal, and substance induced sexual dysfunction. A defining factor in these disorders is the existence of a known biological etiology. Therefore,

they collectively represent the clearest evidence that DSM disorders fit the essentialist definition.

Every biological development in the study of mental disorders is affirming for the essentialist definition. In fact, the forthcoming DSM-V may include an essentialist definition of mental illness. Wakefield has begun to assert that harmful dysfunction should replace the definition of mental illness currently in the DSM (Wakefield and First, 2003). Furthermore, it seems that DSM architect Robert Spitzer is grooming harmful dysfunction for inclusion into the next edition. Spitzer stated that work should begin towards integrating harmful dysfunction into the DSM because of the theory's "considerable advance" over DSM conceptualizations of disorder (Spitzer, 1999, p. 432). Despite some individuals' confidence that DSM disorders are essentialist concepts, commentators such as Valenstein (1998) have argued that the biological explanations for many disorders are oversimplified and overgeneralized. In short, exceptions and logical problems associated with essentialist definitions exist, and mental disorders can be correctly conceptualized from a relativist position as well.

The Biological Dead End: Relativism is Correct

The time before MRIs and PET scans is often characterized as the psychoanalytic Dark Age, but it must be remembered that the conceptualization of mental illness as biological is as old as mental illness itself. Of course, the biological perspective stretches all the way back to Hippocrates, but it was also prevalent among the very earliest psychiatrists. The opening editorial of the *Archives for Psychiatry and Nervous Diseases* published in 1867 stated that "Psychiatry has undergone a transformation in its relation to the rest of medicine. This transformation rests principally on the realization that patients with so-called 'mental illnesses' are really individuals with illnesses of the nerves and brain" (as quoted in Bentall, 2003, p. 150). This statement could be considered a striking illustration of prescience for 1867, especially considering recent calls to abandon the word mental in the term mental illness (Baker, Kale, and Menken, 2002; Baker and Menken, 2001; Fiskens, 2001). Alternatively, the statement could be construed as a sort of empty biological promise — made by those who study mental illness — that has never been fulfilled.

The plain, cold, hard fact is that there are almost no mental disorders for which a specific biological cause can be pinpointed. Among the few exceptions are drug effects, mental retardation due to a genetic or brain disorder, and cognitive disorders such as those that occur in Alzheimer's disease or brain damage. Only these disorders have clear biological etiologies, and they are not prototypical of mental illness. Even proponents of the biological perspective characterize the current state of knowledge about the biology of mental illness as

“rudimentary” (Charney et al., 2002, p. 33). Furthermore, the grand, simple, biological explanations are probably wrong and there will most likely never be another general paresis-like discovery (Kendler, 2005). Evidently, in many cases there is not a clear biological component that can be used to identify disorder from nondisorder, and this makes it currently impossible to use science in differentiating the concept of mental illness from the concept of normality (Lilienfeld and Marino, 1995). In other words, with few exceptions mental disorders in the DSM best fit a relativist perspective.

Although scientific advancements have not revealed specific causes for the vast majority of mental disorders, this is not the same as arguing that biology does not play a role in the behaviors. All behavior is biological at some level; thus, brain correlates could theoretically be found for all mental disorders. In fact, if Cartesian dualism is rejected “then declaration that a particular psychiatric disorder is biological is a tautology and is as informative as saying ‘This circle is round’” (Kendler, 2005, p. 334). Even the identification of differences between the brains of individuals with and without a particular disorder does not indicate that mental illness is biological. Differences should emerge when studying the nervous systems of people with wildly different personalities or people who engage in behaviors deemed abnormal and those who do not, but such differences alone do not illustrate a failure of biology. The separate neural patterns for thinking in a native or secondary language can be identified (Kim, Relkin, Lee, and Hirsch, 1997), but such findings do not illustrate the normality or abnormality of either behavior. Bentall (2003) offers an excellent summary of the issue by stating:

The problem seems to be that we have no clear *empirical* criterion for deciding whether biological deviations from the norm are pathological and hence evidence of disease. Indeed, it seems that we regard such deviations as evidence of pathology only when the characteristics that they are seen to cause are regarded as undesirable. (p. 315)

The preceding arguments have focused on biomedical essentialism more than the essentialism of harmful dysfunction. Specifically, I discussed the evidence for objective, valid, and reliable physical signs rather than evidence for objective, valid, and reliable failures of evolved mental mechanisms. This is not a problem, however, because such evidence does not exist. Despite the conceptual validity that Wakefield (1999a) claims for harmful dysfunction it is completely theoretical at this point. With the current state of evolutionary psychology, there is no way to determine if a disorder is caused by a failure of an evolved mental mechanism, and alternative explanations for theorized failures abound (Sadler, 1999). Even Wakefield (2002) states that behavioral symptoms must be used as a stand-in for objectively identifiable dysfunction because “we do not really understand how most mental mechanisms work” (p. 155). If the evolved mental mechanisms of most disorders are unknown the

essentialism of harmful dysfunction must be considered as incorrect as the essentialism of the biomedical approach.

Another problem for the essentialist position is the failure of many disorders to be logically consistent with the existence of an essential biological component. Consider the personality disorders. Claiming that biology has failed in some way is impossible if the personality disorders are simply extensions of normal personality traits (Lilienfeld and Marino, 1999). Conversion disorder, which consists of neurological symptoms such as paralysis, seizures, or blindness that have no biological basis, is also problematic. Neural correlates are identified when performing brain imaging on individuals diagnosed with conversion disorder (Vuilleumier et al., 2001; Yazıcı and Kostakoglu, 1998). This could be construed as evidence for a biological dysfunction, but recall that conversion disorder is defined as being nonphysical. Enigmatically then, essentialists are left with a so-called-disease that consists of pseudomedical symptoms or, perhaps, a pseudoneurological neurological disorder (Sullivan, 1990). The essentialist perspective also cannot explain disorders that are products of intact brains engaging in normal learning processes. To illustrate, young people in the United States frequently meet the criteria for alcohol abuse due to the patterns of binge drinking they learn in specific social settings such as college (Slutske, 2005); subsequently, they may end those patterns upon entering new social situations. In the case of these relatively quick transformations from disordered to nondisordered, new cultural expectations and learning are better explanations than healing of broken biology.

Despite the previous arguments against the essentialist position, what the history of mental illness illustrates is that sometimes neurological causes of disorders are found. Nonetheless, Szasz (1987, 1991, 1993) correctly states that once objective biological signs are found disorders stop being mental illnesses and become medical illnesses. Epilepsy, general paresis, and various medically caused cognitive disorders stand out as examples of the conversion of mental into physical illness. Reflecting the essentialist viewpoint, some have argued that the term mental illness should be eliminated because so-called mental illnesses are all brain disorders (Baker and Menken, 2001). The irony of reframing Szasz's claim that mental illness is a myth in its converse has not been lost on commentators (Fisken, 2001). As the preceding evidence illustrates, however, reframing all mental disorders as brain disorders is premature. Nonetheless, there is the possibility that research into some mental disorder will eventually foster a discovery leading to a paresis-like transformation from mental to medical illness. If such a discovery were to occur the status of mental illness as a relativist concept would be unchanged. What would exist is a new neurological disorder and a long list of other behaviors with a family resemblance to neurological disorders but lacking the objective criteria to prove they are as such.

Possible Explanations

I have outlined evidence for the validity of the essentialist and relativist definitions of the DSM concept of disorder. Despite the fact that this was a relatively lenient test of validity, neither operational definition was able to consistently account for the disorders in the DSM. This seems to indicate that the DSM disorders do not represent a unitary concept, which signifies a compromise of its validity.

Two major explanations exist for the inability to account for the disorders in the DSM using one operational definition: brain diseases are included in the DSM and normal behaviors are included in the DSM. These explanations illustrate why the concept of disorder in the DSM fails to consistently conform to the essentialist and relativist definitions. Namely, brain diseases have objective signs that confound the relativist position, and normal behaviors are false positives that confound the essentialist position.

Inclusion of Brain Diseases

A tautology often stated by proponents of the essentialist position is that mind and body are inseparable. This usually precedes a statement on how there is no clear distinction between physical and mental illness. Such logic was cited as the reason for the removal of the term organic in the DSM (Spitzer et al., 1992). It is also given as the reason to rename mental disorders as brain disorders (Baker and Menken, 2001). Unfortunately, claims about the equality of brain and mental illness ignore empirical evidence and are, presumably, based on the promotion of an essentialist ideology. Even a cursory examination of the DSM will show that few disorders have known somatic causes. As such, to assert that mental illnesses are brain diseases ignores the paucity of evidence for such claims when considering all mental disorders. Nonetheless, the DSM does contain brain diseases.

Select brain diseases are included in the DSM as mental disorders, and the result of this inclusion is that some disorders have known biological causes and others do not. For example, the etiology of vascular dementia can be traced to objective somatic signs while the etiology of frotteurism has yet to be systematically researched let alone identified. In other words, physical and mental illnesses are placed in the same category without regard to obvious distinction. The inability to account for the DSM's concept of disorder with either an essentialist or relativist definition becomes understandable when considering this practice. Brain diseases are physical illnesses and can be accounted for using an essentialist definition, but the majority of disorders in the DSM are not physical illnesses and cannot be accounted for using the

essentialist definition. Therefore, the relativist definition must be used for the non-brain diseases contained in the DSM.

Arguing for the distinction between brain diseases and mental illness is not the same as returning to Cartesian dualism. The DSM and some proponents of the essentialist position insist that to strictly separate physical and mental illnesses is a “reductionistic anachronism” (APA, 2000, p. xxx), but this argument is applied too broadly. To argue for such a separation because body and mind are made of different substances is in error. In contrast, it is completely logical and based in empirical fact to argue for a separation between physical and mental illness because one is perfectly correlated with objective biological markers and the other is not. To call physical illnesses and mental illness the same simply ignores and obfuscates the facts. Complicated interactions between physical and mental aspects of disorder undoubtedly exist; however, these interactions cannot change the fact that the essentialist definition functions with all physical illnesses but not all mental illnesses.

Crossing the Boundary with Normality

Debate may occur vociferously among theorists but, practically speaking, the DSM defines mental illnesses. Disorders listed in the DSM are considered official. Although murderers and rapists may be insane in colloquial terms, it is the exclusion of those behaviors per se from the DSM that makes them simply crimes while the included behaviors of pedophilia and kleptomania are mental disorders. A disorder's placement in the DSM lends official status to a mental disorder, but some of these official disorders may not be valid cases of mental illness. Undoubtedly, as the creation, deletion, and amendment of disorders over the years has illustrated, some skeptics are correct: normal behaviors have been mislabeled as abnormal. Without a scientific way to determine if a behavior is a mental illness, false positives undoubtedly occur when ambiguous cases are inaccurately included in the DSM.

Despite the respect that the DSM is given, codifying a disorder in it does not translate into automatic and universal acceptance as a mental illness. Among the most tenacious nosological disagreements are incidences when it is suspected that a normal behavior has been mislabeled as abnormal in the DSM. Recent debates have focused on whether or not gender identity disorder (Bartlett, Vasey, and Bukowski, 2000), acute stress disorder (Harvey and Bryant, 2002; Marshall, Spitzer, and Liebowitz, 1999), and social anxiety disorder (Campbell-Sills and Stein, 2005; Swinson, 2005; Wakefield, Horwitz, and Schmitz, 2005) are examples of mental illness or normal problems in living. Nonetheless, each of these disorders remains in the DSM.

The scope of behaviors included in the concept of disorder has been greatly expanded. Houts (2002) reported a 300% increase in the number of disorder

ders from DSM-I to DSM-IV and asserted that the increase did not result from development of new scientific knowledge but from a host of nonscientific factors. For example, one explanation for the expansion of disorders is their use in an attempt to increase "identification and treatment" of individuals who have problems that are below the diagnostic threshold (i.e., subthreshold) of current disorders but still could benefit from professional help (Pincus, Frances, Wakefield, First, and Widiger, 1992, p. 113).

Acute stress disorder stands out as an example of this process of expansion into subthreshold areas. Acute stress disorder was included in the DSM to acknowledge that trauma could lead to immediate problems and not just the delayed problems associated with post traumatic stress disorder. In addition, the disorder can be seen as a furtive attempt at mental health prevention through diagnosis because it was also developed to predict later, more severe post traumatic stress (Harvey and Bryant, 2002). Some researchers believed that early identification and treatment of acute stress disorder would prevent later cases of post traumatic stress disorder. Such actions are not uncommon in physical medicine where problems such as high blood pressure are identified and treated although they are not diseases in the classic sense.

Arguably, the trend of creating subthreshold disorders is laudable for attempting to increase psychological well-being, but researchers may have expanded the concept of mental disorder too far as an unintended consequence leading to more borderline cases and more false positives. Although the quality of being subthreshold is considered different from being subclinical, new disorders often have lower severity or shorter courses than those already in existence (Pincus et al., 1992). This gives some credence to fears that the DSM is systematically creeping into the realm of normalcy (Kutchins and Kirk, 1997). Furthermore, the idea that mental illness has expanded too far does not seem to be exclusive to the detractors of psychiatry. Psychiatrist Robert Kendell, who was well known for his classic paper defining mental illness as biological dysfunction (Kendell, 1975), recently assessed Thomas Szasz's arguments (Kendell, 2004). He concluded that Szasz's failure was to reject all mental illnesses. If he had only rejected disorders that were of the newly discovered and vaguely supported ilk, Kendall asserted, Szasz would have been widely supported even among psychiatrists. Tacitly, Kendell seemed to be asserting that some disorders are probably myths in the Szaszian sense that they lack biological signs and have been incorrectly labeled mental illness; furthermore, he was clearly stating that this is a popular notion.

The myriad of disorders included in the DSM may breed occasional skepticism, but even individuals who dissent about specific disorders acknowledge the usefulness of attention to and treatment of the problems they represent (e.g., Wakefield et al., 2005). This creates a tension between the value in identifying and treating new potentially harmful or distressing behaviors and

being faithful to the validity of the mental disorder concept. However, if past trends continue the number of disorders will only increase and continue to move into new subthreshold and, possibly, subclinical areas (Pincus et al., 1992). Removal of a disorder from the DSM due to pressure applied by those who do not believe it is a mental illness is a rare event. So, once subthreshold or subclinical disorders are placed in the DSM, they are ensconced.

The concept of mental disorder has undergone an expansion. This has led to disagreement over normal behaviors that have, presumably, been mislabeled as abnormal. An effect of including normal behaviors in the concept of mental disorder is that operational definition becomes impossible. False positives function as noise that distracts from true cases of disorder making it impossible to identify a core concept that all disorders possess. Consider a naïve biologist attempting to define what fish are but unwittingly including sea mammals as examples of fish. The biologist will never produce an adequate definition with these incorrect cases included because the examples of fish to be accounted for are fundamentally different. Analogously, the inclusion of normal behaviors in the DSM obscures a valid definition of mental disorder.

Summary and Conclusion

The validity of the DSM can be easily called into question because it purports to outline and classify disorders without providing a legitimate operational definition of that concept. Little evidence is provided to support the notion that the behaviors contained in the manual are all members of the same category. In fact, the disorders in the DSM cannot be encapsulated using either essentialist or relativist definitions of mental illness. An explanation for this problem is the fact that both brain illnesses and normal behaviors are labeled mental disorders by the DSM, which makes it impossible to unify these disparate entities under one definition.

No solution to the DSM's definitional problem is immediately evident. A new definition that solves the outlined problems is unlikely to emerge. If trends continue no disorder will be removed from the DSM to improve its consistency. Unfortunately, the DSM will probably continue to be dominated by the same nonscientific factors that led to the current problems. Until this trend is corrected, the DSM concept of mental disorder will remain an indefinable and invalid concept.

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