

The Social Construction of the DSM-5 & its Impact on Patient Dignity

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Abstract

The Diagnostic and Statistical Manual for Mental Disorder (5th Ed. or DSM-5) represents a foundational text within the psychiatric and mental health field, a document that is historically and socially positioned within the field as beyond the reach of question and critique. Yet multiple forms of criticism have been levelled against the DSM-5 highlighting concerns around its underlying ethnocentric positioning as well as scientific concerns around the reliability and validity of different diagnoses. This study explores the current state of the DSM-5 and seeks to understand how the development of the DSM-5 has developed and promoted a variety of discourses and how these discourses have had a significant impact on the dignity and day-to-day functioning of millions of patients, both younger and elder, for whom it has been conceived to offer therapeutic interventions. Drawing on the work of Michel Foucault to conduct this analysis of the DSM-5, I identify the many dominant discourses of the DSM-5, as well as the discursive rules reinforcing these practices. The dominant discourses identified as being promoted through the DSM-5 include expertise, medicalizing normality, conceptualizations of culture, and control.

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Chapter 1: Introduction

Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important mental health information. (American Psychiatric Association, 2013b, p. 5)

Medical diagnosis and the ability to differentiate one disorder from another are at the core of clinical practice, and the field of psychiatry is no different. This science of disease classification is referred to as 'Nosologies' and has been an integral part of medical practice for centuries (Demazeux, 2015; Frances, 2013a; Gaines, 1992; Paris, 2015; Suris, Holliday & North, 2016). Within the field of mental health, the history of nosology is more recent in the United States, which initially lagged behind Europe in the field of nosology and developing diagnostic criteria for mental disorders (Gaines, 1992; Paris, 2015; Suris et al., 2016).

In the early days of psychiatry, mental illness was seen more as a societal failing than a medical concern, and many countries enacted pieces of legislation to remove these elements of society from general view in the interest of public safety and societal benefit (Kelly, 2015). However, in the late 1800s, medical science was beginning to make great strides in identifying and understanding the origins of many different types of medical illnesses, including some mental disorders (Gaines, 1992; Suris et al., 2016). Through the work of two German physicians, Kraepelin (1856-1926) and Alzheimer (1864-1915), a method of identifying and distinguishing separate neurological causes of diseases began, which led to the organization of a framework of psychiatric disorders based on systematic criteria (Gaines, 1992; Suris et al., 2016). This work was ignored initially within the United States and it wasn't until the early to mid-twentieth century that American psychiatry began to be a dominant force in the field of nosology, primarily through the work of the American Psychiatric Association (APA) (Demazeux, 2015; Frances, 2013a; Gaines, 1992; Suris et al., 2016).

The Diagnostic & Statistical Manual of Mental Disorders 5th Edition

The APA, which represents the interests of tens of thousands of psychiatrists and medical professionals in America and around the world, has engaged in a systematic process of psychiatric practice and research shaping the field and culture of clinical mental health since the 1840s (APA, 2019a; Greenberg, 2013; Waldram, 2004). This organization, from its early beginnings as the Association of Superintendents of American Institutions for the Insane, has a long history of 'discovering' and 'diagnosing' mental illness, which over the past 70 years has led to it becoming one of the most prominent and influential bodies within the field (Greenberg, 2013). Arguably, its most impactful contribution to the field is the Diagnostic and Statistical Manual of Mental Disorders (herein referred to as the DSM). The DSM is currently in its 5th edition and has been used, in various capacities, by clinicians, researchers, health care professionals, as well as lawyers, insurance companies, governments and the public (Khoury, Langer, & Pagnini, 2014; Demazeux, 2015; Frances 2013a; Poland, 2014).

Like other texts, the DSM appears to the layperson as just one of the many tomes that line the bookshelves of psychiatrists, psychotherapists and mental health professionals, with only its purple cover helping it to stand out. Yet, due to the popularity of the DSM and its various editions within North America, it is a book that has appeared on the New York Times Best Seller list (Greenberg, 2013). The DSM's many iterations have shaped the face of mental health research for over 60 years (Frances, 2013a; Poland, 2014), and it has been responsible for the diagnosis of millions of patients (Khoury et al., 2014; Demazeux, 2015; Frances 2013a; Poland, 2014).

Containing over 540 specific disorders, the current face of the DSM was launched in 2013, after a development process spanning 14 years and involving over 500 mental health

professionals, 13 working groups and 2 public consultations which saw over 10,000 comments submitted to the APA (Blashfield, Keeley, Flanagan & Miles, 2014; Greenberg, 2013). This process was unlike any previous DSM development, as it placed a large portion of the consultation process squarely in the public domain and opened up the publication to a level of scrutiny that the APA had not previously faced. This most recent edition is also based on over a century's worth of work by psychiatrists and mental health professionals from across the globe (Blashfield et al., 2014; Greenberg, 2013). Since its inception following the Second World War, the DSM has gone through six separate revisions, and with each subsequent revision, the number of mental disorders discovered has increased. However, there have been many concerns that while the number of diagnostic conditions has increased, the reliability, validity, and clinical utility of the DSM has failed to keep up with the demands of the clinical profession (Frances, 2013a; Greenberg, 2013, Young, 2010).

It was during the mid-1980s that the DSM began to be referred to as the "the bible of the clinician" (Fleming, 1985, p. 122) in journals such as 'Psychiatry' because of its reputation within the field. More recently, within popular culture, we have seen an increase in the use of the psychiatric bible, discussed within traditional and digital media to reflect on what makes people tick (Frances, 2013a). One of the more famous instances that demonstrates this, takes the form of YouTuber, Shane Dawson and his documentary 'The Mind of Jake Paul', where he uses the DSM-5 and the analysis of 'experts' to diagnose aspects of fellow YouTuber Jake Paul's personality (Todd, 2018). In using the term 'bible' to describe this publication within the psychiatric and mental health profession and popular culture, a narrative was constructed around the DSM that imparted a sense of reverence amongst those within the profession (Frances, 2013a). This reverence also appeared to be held outside of the psychiatric and mental health

profession, such as within the U.S. legal system where legal expert Teneille Brown (2015) from the University of Utah highlights how

reliable labels are useful for mental illness diagnosis, and to a lesser extent, to guide our legal decisions. Even so, and despite its clinical utility, it seems that judges and lawyers are being far too deferential to the DSM—to the exclusion of everything else. (p. 744)

This statement alludes to the power that the DSM has in its ability to define and label experiences and behaviours, and which attributes are considered normal versus abnormal. This constructionism is highlighted by Atwood Gaines (1992), who states,

the distinguishing of the normal from the abnormal is the ‘key’ problem of any ethnopsychiatry. In its concern for the abnormal, an ethnopsychology becomes an ethnopsychiatry, for there the border between normality and abnormality is drawn and redrawn, the acceptable sorted from the unacceptable, the insane placed apart from the sane. (p. 4)

Brown (1995) echoes this sentiment and goes on to state that

Diagnosis locates the parameters of normality and abnormality, demarcates the professional and institutional boundaries of the social control and treatment system, and authorizes medicine to label and deal with people on behalf of society at large. This labeling is often enough the legal basis for provision of health services, welfare benefits, unemployment certification, worker's compensation claims, and legal testimony. (p. 34)

A concern lies in the influence of the DSM to draw, erase and then redraw the line between what is considered normal and abnormal, and that its reach extends beyond those who are authorized to practice psychiatry. As such we see individuals quoting and referencing the DSM-5 and diagnosing their symptoms and the action of people around them, such as celebrities and political leaders within newspapers, YouTube videos, social media and even TV shows and movies (Frances, 2013a; Todd, 2018). Psychiatrists have even reported patients regularly coming in to see them for an appointment with pre-fixed ideas around their symptoms, complete with a list of criteria from the DSM to prove their own diagnosis (Demazeux, 2015; Epstein, Wiesner and Duda, 2013).

The Current Study

This Major Research Project aims to provide the reader with an overview of the history of DSM-thinking, the current state of the DSM-5, and its creation through social, cultural, political, and disciplinary frameworks. Its goal is not to classify the DSM-5 as either inherently ‘good’ or ‘bad,’ likewise, it is not a study that identifies the effectiveness of diagnostic criteria within the field of mental health. Instead, this paper is a discursive analysis of a foundational text within the psychiatric industry, a document that is historically and socially positioned within the field as beyond the reach of question and critique. Through the use of Foucauldian discourse, I intend to follow the advice cited in Mills (2004),

All my books...are little tool boxes ... if people want to open them, to use this sentence or that idea as a screwdriver or spanner to short-circuit, discredit or smash systems of power including eventually those from which my books have emerged ... so much the better. (p.17)

While acknowledging that the DSM-5 has had a positive impact on the mental health landscape within North America, this paper seeks to demonstrate the significance that the language used within the DSM-5 has in terms of power dynamics, personal dignity, and identity, asking questions about who ultimately benefits the most from the DSM-5 – the individual or the psychiatric and mental health profession?

Chapter Outline

In addition to this introduction, five chapters make up the work of this MRP: theoretical orientation, methodology, literature review, findings, and discussion. In the first chapter, I explain my theoretical orientation, situating this paper within Social Constructionism and theories of Power and Dignity. Within this discussion, I look at the social construction of mental health and its impact on the experiences of those living with mental illness and their support networks. From there, I provide a brief overview of the French philosopher, social theorist and

historian, Michael Foucault and, in particular, his thoughts on power and how disciplinary power and control have developed within medical practices. Finally, I move into a discussion surrounding the concept of dignity and how this concept has been advanced and discussed within the medical and mental health community as a malleable commodity that has varying levels of value, dependent on the individual's perspective. This leads to my second chapter, which focuses on the methodology used in this research paper. I begin with an overview of discourse analysis and how it has been influenced and utilized by those within the social construction movement. I then locate my work within the two main approaches used in discourse analysis, micro and macro analysis, and discuss how this methodology informed the collection of data from a variety of sources and the thematic analysis that took place to identify my findings.

The third chapter of this MRP focuses on a historical overview of the development of the DSM-5 following the principles outlined in my methodology section. I highlight how the DSM-5 has developed, as well as how changes in the psychiatric and psychological professions have transformed the scope and aims of this text. Through reviewing both positivist and critical literature of the DSM-5, I discuss how the DSM-5 has been celebrated through its impact on expanding the scope of psychiatric diagnosis alongside critiques about its ethnocentrism and over-inclusiveness of diagnoses. This overview leads to my findings within the fourth chapter, which have been elicited through a thematic analysis of the DSM-5. This chapter is organized into several sections to address the following research questions: 1) how has the DSM-5 been influenced through various frameworks?; 2) what are some of the dominant discourses present within the DSM-5?; and 3) What is the DSM-5's potential impact on human dignity and the interests of the patient? Finally, in my concluding chapter, I explore these findings within the context of Foucauldian discourse analysis and social construction. I examine the implications of

these findings within the broader psychiatric field and discuss several themes that appear within the literature regarding recommendations for the potential next edition of the DSM, and its current method of providing rolling updates to the DSM online via the APA's website. I conclude with reflexive thoughts about this research and possible directions for future works in nosology and diagnostic practices.

A Note on Numbering Conventions

Within this paper, the reader will see that the fifth edition of the DSM is referred to in two different ways – DSM-V and DSM-5. These notations are not the fault of poor proofreading, but due to a distinct change in naming conventions announced in 2010 by the APA (Demazuex, 2015; Greenberg, 2013). In March of 2010, the APA announced that their new revision would no longer be called the DSM-V but the DSM-5. This change from Roman to Arabic numerals was one sign, of a profound historical change and proof that this new version would become a living document with future revisions to be identified as 5.1, 5.2, as necessary (Demazuex, 2015; Greenberg, 2013). This change in numbering also brought the DSM in line with the International Classification of Diseases (ICD) published by the World Health Organization (WHO) which has always used Arabic numerals in their naming. As a result, researchers, psychiatrists, and other health care professionals refer to this publication as either the DSM-V or DSM-5, sometimes using both descriptors within their work. Both forms are also used, as stated by Bob Spitzer (cited in Greenberg, 2013, p.129), "because old habits die hard." In this paper, I will follow the APA's convention in using "DSM-5," except when citing directly from others work.

Chapter 2: Theoretical Orientation

The theoretical framework for a research study provides a foundational platform for the analysis that is to take place and provides the researcher with the scope needed to focus on

specific elements within the research. This study, at its core, uses social construction theory and related ideas to understand how elements such as historical norms and values (Berger & Luckmann, 1966) have influenced the development of diagnostic tools within the field of psychiatry and psychoanalysis (Gaines, 1992). It also explores theories and concepts surrounding power dynamics and human dignity to understand the potential impact of these tools on those that rely on them – the patient. This individual, often defined by Michael Foucault (1998) as the “object-subject”, takes a dual-facing role within the treatment process and so understanding patients’ experiences is of value for both researchers and clinicians.

Social Constructionism

When American sociologists Berger and Luckmann first published their treatise in 1966, exploring the historical underpinnings of the sociology of knowledge, they discussed the concept of reality and how it changes based on the perception of the individual. In this text, they describe concepts of reality, for example, "What is 'real' to a Tibetan monk may not be 'real' to an American businessman. The 'knowledge' of the criminal differs from the 'knowledge' of the criminologist" (p. 15). Examples cited by the authors are formed based on the social context of the individual and what they take for granted in terms of their knowledge and expands on the work of other theorists such as Marx (1818-1883), Scheler (1874-1928), and Mannheim (1893-1947). These theorists were all concerned with the sociology of knowledge and how this type of knowledge impacted human ideation. Berger and Luckmann (1966) expanded upon how human actions and actors could produce or construct social phenomena that become embedded within institutions. They highlight,

If the integration of an institutional order can be understood only in terms of the 'knowledge' that its members have of it, it follows that the analysis of such 'knowledge' will be essential for an analysis of the institutional order in question. (p. 82)

These questions are examined further in this text by the authors as they dive deeper into the institutions surrounding psychiatry and psychology and the realities that they construct.

Ultimately, they concluded,

In the process of transmission of the symbolic universe from one generation to another. Socialization is never wholly successful. Some individuals 'inhabit' the transmitted universe more definitely than others. Even among the more or less accredited 'inhabitants', there will always be idiosyncratic variations in the way they conceive of the universe. (p. 124)

Because the transmission of these concepts and cultural knowledge is not a seamless process between generations, it is in these rough spots that we begin to see people challenge and confront 'official' institutions. Within Berger & Luckmann's text, we see examples such as the introduction of the Greek patriarchal mythology and early Christianity. Within other works, such as Kenneth Gergen's (1985) article on the 'Social Constructionist Movement in Modern Psychology,' we see this in the challenge raised against modern Western science and the narratives constructed around it. Gergen, the President of the Taos Institute in Chagrin Falls, Ohio, a non-profit association focused on exploring social constructionist ideas, discusses how language, in particular, has been used in the West, mainly Western Europe and Northern America, to develop informal rules within communities that shelter and protect them.

The Social Construction of Mental Health

Related to the views shared by Gergen, Michael Walker (2016) in his text 'The Social Construction of Mental Illness and its Implications for Neuroplasticity' discusses how

The entire clinical worldview of the mental health profession, including the idea of "mental illness" is a construction in language, a vocabulary. The clinical vocabulary's (aka medical model's) pseudo-link with science does not exempt it from being a cultural artifact, i.e. being one vocabulary among others. (p. xi)

The above passage is similar to the words used by Thomas Insel, Director of the National Institute of Mental Health, a former partner in the development of the DSM-5. In speaking with Gary Greenberg (2013) about the language used within the mental health profession, Insel states,

Psychiatrists were tired of being trapped by the DSM. We are so embedded in this structure... we actually believe they are real. But there's no reality. These are just constructs. There's no reality to schizophrenia or depression. We might have to stop using terms like depression and schizophrenia, because they are getting in our way, confusing things. (p. 340)

This sentiment is a view oft-repeated by individuals within the psychoanalytic community, post-modern theorists, and other critics of diagnostic systems in North America, as they are highly interpretive (Brown, 2015; Frances, 2013b; Gergen, 2007; Moss & Petrie, 2005). As Demazeux (2015) contends in his text surrounding scientific progress and the DSM,

Many categories listed in the DSM may not be true diseases after all. This skeptical claim does not necessarily involve any form of anti-psychiatrist stance. It just reminds us that the question "what is a mental disorder?" has never reached any consensual solution and continues to divide philosophers and clinicians. (p. 21)

Members of the APA also have difficulty in defining what constitutes a mental illness or disorder, and their core definition of 'mental illness' has been in flux for several decades. For example, within the DSM-III, in their definition of a 'mental disorder', it was stated that

Each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more areas of functioning (disability). (APA, 1980, p. 6)

This definition left the clinician with the assumption that even if harm or impairment was not present, the individual should still be evaluated (Cooper, 2015). In 1987, however, when the DSM-III-R was released, it was stated that there was a direct relationship between harm and the diagnoses, removing this grey area for clinicians (Cooper, 2015) until 2013 and the launch of the DSM-5, where the pattern or behaviour became "usually associated with significant distress or

disability in social, occupational, or other important activities " (APA, 2013b, p.20). This change brought back the flexibility to the clinician to freely evaluate patients. Despite this attempt at a 'definition,' even the DSM-5 states, "no definition can capture all aspects of all disorders in the range contained in the DSM-5" (APA, 2013, p. 20). As with the concepts of the 'ideal child', or the 'perfect family', mental illness as defined by the DSM-5 is an abstraction, a production of psychiatric study and theory that 'discovers' the symptoms of the illness and then defines it with no (identifiable) cause at its basis (Coppock, 1997; Frances, 2013a; Walker, 2016). It is for this reason that critics declare that there can never be a definitive version of the DSM, as mental disorders will always be pluralistic concepts that will vary dependent upon the context the individual finds themselves in, and any attempt to define it with a single definition will be by their very nature contradictory (Blashfield et al., 2014; Gergen, 2007). Although Frances (2013b), in his article 'DSM in Philopshyland,' somewhat tongue-in-cheek, defines mental disorders as "what clinicians treat, and researchers research and educators teach, and insurance companies pay for " (p.99), emphasizing yet again how attempts to define mental illness and disorders are unstable and rooted in contextual factors that vary from the individual to societal context

Further to the difficulty of defining mental disorders comes the issue of how clinicians and practitioners treat mental illness. Unlike many areas of medical science where a definitive cause can be demonstrated for an illness or symptom, within the mental health field, there are very few examples of these causes (Frances, 2013a, Gergen, 2007; Greenberg, 2013; Walker, 2016). It was only recently, for example, that specific genomes such as C4 and Neuregulin 1 have been attributed as a potential reason for increased risk of schizophrenia in individuals. However, this has yet to be fully confirmed, and what studies do exist only show a 1% increase

in risk (Brown, 2015; Rettner, 2016). For decades, psychiatry, through tools such as the DSM-5, has been presenting statistically based abstractions as truth, knowing full well that the validity and reliability of such abstractions are weak. Brown (2015), in discussing the use of constructs and diagnosis within the DSM-5, states,

As two researchers put it when explaining that the DSM contains labels and not valid theoretical constructs: "the word unicorn is in the dictionary and we all agree on the concept and description of a unicorn, but this surely does not document the existence of unicorns." The same is true with diagnoses that appear in the DSM. (p.750)

Because the existence of unicorns has been presented by experts, it has cultivated a belief that this is, in fact, reality, which is then used to train clinicians and educate the public. The reason why it is so easy to buy into this reality is that, despite their imperfections, these constructs are an indispensable way of making sense of and organizing a set of phenomena that can be hard for individuals to understand (Walker, 2016).

Foucault & Power

One of the reasons that the social knowledge surrounding mental health continues to pervade society, despite criticisms and viewpoints to the contrary, is due to the level of power that is wrapped up within the development and history of the institution that is the DSM. The French philosopher, historian of ideas, and social theorist, Michael Foucault, saw power in a variety of modes, but the one that he felt most closely mirrored many of the functions and processes within medicine, and in particular, the field of mental health, was disciplinary power – which he refers to in several of his works as 'Panopticism' (Roberts, 2005). This form of power originates from Bentham's 'Panopticon,' an architectural model of a prison, where all that is needed is...

...a supervisor in a central tower and to shut up in each cell a madman, a patient, a condemned man, a worker or a schoolboy. By the effect of backlighting, one can observe

from the tower, standing out precisely against the light, the small captive shadows in the cells of the periphery. (Bentham as cited in Roberts, 2005, p. 34)

This type of control, according to Foucault, is visible and unverifiable. Visible, in the sense that it is always present (in the form of the central tower) and unverifiable, in the sense that the individual, whether madman, convict or schoolboy, knows they are being observed (through the use of blinds, for example). This example contrasts with the restrictive nature of sovereign power, for example, as it is a much more efficient and productive form of power. Foucault himself saw how the disciplinary power of the 'Panopticon' did not reside with a single person, but was 'deindividualized' and allowed for constant accessibility. As such, within the context of mental health, we see how mental health care monitoring and observation of a client can include

any number of people, including doctors, staff-nurses, community psychiatric nurses, nursing assistants, social workers, assistant social workers, occupational therapists, psychologists, psychotherapists, counsellors, and so on. Indeed, a client may not even know what individuals or what agencies are monitoring them; rather, they are subject to what Foucault refers to as a 'faceless gaze.' (Roberts, 2005, p. 36)

The number of individuals that are involved in this process leads to the visible and unverifiable level of control within 'Panopticism' as patients can never be sure who is involved in their case and who is monitoring their interactions or not.

Further to these concerns around control is the influence of the DSM-5 as the authoritative text within clinical practice (Warelow & Holmes, 2011) and how it has defined mental disorder and what behaviours and experiences are considered abnormal versus normal. Due to the role of the DSM-5 in informing and shaping public perception, policy, and identity around mental health, the DSM-5 and previous iterations have formed such a significant portion of the training and professional knowledge surrounding mental health professionals. As such, any changes, big or small, that take place from edition to edition can have significant ramifications across the industry and beyond (Frances, 2013a; Poland, 2014).

A prime example of how changes to the DSM reverberate throughout various disciplines, has been the classification and then subsequent reclassification of Asperger's syndrome (Frances, 2013a; Greenberg, 2013; Ninnis, 2016). This specific diagnosis, which broadened the overall classification of autism, was introduced in the DSM-IV (Frances, 2013a), and as a result, a large number of individuals began to identify with this diagnosis and developed a community around it (Bagatell, 2007). However, in 2013, with the launch of the DSM-5, this specific diagnosis was incorporated within the classification of 'Autism Spectrum Disorder' (APA, 2013b) and, as a result, the diagnosis of Asperger's, which had shaped a community, was diminished to nothing more than a brief note within the text highlighting the change to this diagnosis. This move triggered a great deal of controversy from all quarters, but especially from those whose identity was shaped around the diagnosis and felt lost without it (Ninnis, 2016). This level of impact on a group of individuals was framed by Foucault in his conversations around power dynamics and the subjectification of patients within medical practice. In his treatise on Madness, he discusses the forming and transforming of individual identities through a set of external discourses, with little to no regard for the individual's agency or freedom (Ninnis, 2016).

Power Relationships

While Foucault acknowledges that humans will never be free from any power-knowledge relationships, he does reiterate the possibility of resistance. Not only does he see power and resistance as being tied together, but he views them as a struggle that can be grasped by both the dominant party and those resisting control (Jørgensen & Phillips, 2002; Mills, 2004). Berger and Luckmann (1966) discuss this type of power dynamic by comparing two competing societies:

Two societies confronting each other with conflicting universes will both develop conceptual machineries designed to maintain their respective universes. From the point of view of intrinsic plausibility the two forms of conceptualization may seem to the outside

observer to offer little choice. Which of the two will win, however, will depend more on the power than on the theoretical ingenuity of the respective legitimators. (p. 126-7)

Foucault highlights how these specific power levels are displayed, often within texts that do not originate from a single author but from those that sanction or sponsor it (Mills, 2004). For example, the Indian Act, developed by the Canadian Government in 1876, was used to enforce control over indigenous groups and ultimately "encourage the legal termination of Native peoples" (Chrisjohn, McKay, & Smith, 2014, p.100). Similarly, the DSM has been developed to shape the landscape of mental health diagnoses across North America and beyond (Blashfield et al., 2014). We also see this form of struggle played out within conversations surrounding the support and critique of the DSM-5 as both sides seek to use the language and meaning within the text to further their arguments and highlight the dominance of one particular perspective over the other.

Moving to the level of the individual, Foucault & Gordon (1980) believed that a part of this resistance between different parties was in the return of knowledge, and specifically the "insurrection of subjugated knowledges" (p.81). Specifically, he talks about how through the

re-emergence of these low-ranking knowledges, these unqualified, even directly disqualified knowledges (such as that of the psychiatric patient, of the ill person, of the nurse, of the doctor-parallel and marginal as they are to the knowledge of medicine-that of the delinquent etc.)... that it is through the re-appearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work. (p.82)

One form of embedding this type of knowledge is in the process of the patient inscribing themselves within the power-knowledge relationship, which many mental health professionals seek to embody. Not only does this allow the patient to become the driver of their treatment plan but it empowers them to monitor and reflect on their thoughts and feelings throughout the treatment process to help those involved in the care plan to understand what is normal and

abnormal in regards to the patients circumstances, which helps to safeguard the patients dignity in the process.

Dignity

While the concept of dignity forms one of my key findings within this research paper, it is necessary to understand where this term comes from and what it means within the field of mental health. The concept of dignity has been around in literature for centuries and typically focuses on a person's position in terms of society or divine intent (Bachmann & Nascimento, 2018; Loughlin, 2016; Steinmann, 2016). For many, 'dignity' remains a reasonably ambiguous concept tied up in faith and legend (Marcovitz, 2015). It was in 1790 when the German philosopher, Immanuel Kant, developed his work on the 'Metaphysics of Morals' that we begin to see a change in the concept of dignity from an external focus to an internal reflection on the notion of humankind and dignity. In this work, Kant sought to separate it from the divine and talks about how

only humanity has "dignity" because humans are capable of living an ethical life [Sittlichkeit], which means that each and every human exercises morality by virtue of his or her practical reason and deserves to be elevated above any price on the basis of his or her membership in humanity. (Kant cited in Bachmann & Nascimento, 2018, p. 43)

This notion that human dignity is not a gift, nor can it be traded for a specific value stems from Kant's perception of humankind's innate capacity for moral reasoning (Loughlin, 2016). Conflict resolution specialist, Donna Hicks (2011), highlights how dignity is an instinctive concept within individuals, which, while we may have difficulty describing it, is an essential aspect of our humanity. Similar to how our heart or brain are essential aspects of our physicality and biology, researchers within the fields of neuroscience, human development and evolutionary biology all recognize that as human beings, we are hardwired for social connections and that we respond to

threats to our dignity or self-worth in much the same ways as we do to physical threats (Hicks, 2011).

Due to the widespread belief in human dignity within numerous fields of inquiry, it has had a significant impact on ethical and legal theories within the West (Steinmann, 2016), as well as in politics, conflict resolution and business (Hicks, 2011). One such impact is in the field of mental health care, as out of all medical specialties, psychiatric clinicians have both historically, and more recently, been empowered to treat patients in ways that go against their civil rights in the interests of personal safety. This type of empowerment is exemplified best by Frances and Ruffalo (2018) who share,

The father of modern psychiatry, Philippe Pinel (1745-1826), freed his patients from chains...220 years ago, he established a centuries-long precedent of attempting to appropriately balance the civil rights of the mentally ill with the occasional and carefully considered need for involuntary treatment. (p.14A)

Even agencies, such as the American Psychological Association, whose ethical principles focus on rights and dignity, have condoned and aided the U.S. government and military in practices that directly violate these principles (Levine, 2015b). This balance surrounding civil rights and liberties also extends to the issue surrounding society and public safety, as Kelly (2015) highlights,

With regard to public safety in particular, there has been a long-standing perception that people with mental disorder presented a substantial risk to public safety, despite the fact that, at population level, the proportion of violent crime attributable to mental disorder is extremely low. (p. 31)

While many will say that there are cases where the violation of an individual's rights to safeguard the public has taken place, this does not necessarily mean that there has been an impact (significant or otherwise) on that individual's dignity. Others, such as conflict-resolution expert, Donna Hicks, disagree. In her research, she has identified that "repeated violations of our dignity

undermine not only our self-worth but our capacity to be in relationships with others in ways that bring out our best and their best" (2011, p. 20). Many in the psychiatric and mental health profession recognize how minor interactions can have an impact on feelings of self-worth and that even the very act of deciding to enter into therapy or seek help for a suspected mental disorder can be a source of violation of a person's dignity (Kluft, 2015). Already acknowledged within the act of seeking help is the relationship that exists between patient and clinician, which can be fraught with intricacies and differences in knowledge, power, and prestige (Foucault & Gordon, 1980; Gambrill, 2014). Practicing psychiatrist and psychoanalyst, Richard Kluft (2015), highlights how

The patient is asked and helped to yield many characteristic forms of conscious control, and to allow defences to be challenged in order to permit the exploration of what is generally withheld from the view of others, and often from ones' self as well. (p.142)

The level of trust required to do this on behalf of the patient is immense, especially when one considers the risk of endangerment or violation of the patient's dignity that may occur. This risk is particularly high when one considers the long-standing opinion within the psychiatric and mental health profession that while the patient is respected as an individual, they are still the patient, and as such, are beneath that of the `expert` (Kelly, 2015; Levine, 2015a). It can be at this point, however, where the clinician, out of the desire to do good, can begin to cause minor chips in an individual's dignity due to their perceived superiority and innate 'rightness' (Gambrill, 2014; Kelly, 2015; Kluft, 2015; Saxena & Hanna, 2015). It is in this context of 'rightness' that critics of the DSM-5 state that the language used within this system demeans the individual and lessens the value of their experiences, which has an impact on their dignity (Greenberg, 2013; Murphy, 2015; Walker, 2016). However, supporters of the DSM-5 highlight how, in Section 1 of the DSM-5 (APA, 2013b), there is a strong focus on obtaining a "careful clinical client history"

(p.19) focused on the client's cultural and social context, which should protect and enhance the client's dignity.

In addition to the concerns outlined above, the language used within the mental health profession has self-fulfilling consequences, in that when someone is told they are sick, they will then act sick, and other people around them will treat them as if they are sick (Frances, 2013a). In discussing mental health diagnosis, in 1990, R.D. Laing (cited in Roberts, 2005), suggested,

A person is not thought to have schizophrenia while remaining 'essentially' the same; rather, schizophrenia is thought to 'split' or 'fragment' the very 'essence', the very being, of a person. To give a person a diagnosis of schizophrenia therefore is not to give a person one identity amongst others; instead, it is to suggest that a person is schizophrenic, that schizophrenia determines the very being of that person. (p. 38)

As soon as an `expert` provides a patient with this label, then this label becomes the lens through which they see themselves through and adds to the marginalization of that individual and fractures the personal dignity that they have developed (Demazeux, 2015; Frances, 2013a; Walker, 2016). As Hicks (2011) highlights,

To be judged a lesser person because of an inherited characteristic inflicts a wound that is especially pernicious. Inherited characteristics are used to justify not only myriad harmful behaviours but the perpetrators' sense of superiority. Anything can be justified in the name of superiority, especially the moral exclusion of "inferior" beings from one's sphere of concern. (p.36)

Psychiatrist and psychoanalyst, Thomas Szasz, considers this further in contending that these labels trap individuals, highlighting that "the languages of psychiatry, psychoanalyses and psychotherapy ... are necessarily anti-individualistic, and hence threats to human freedom and dignity" (cited in Gambrill, 2014, p.29). This marginalization of individuals that are responding to mental health challenges, as a result of their 'inherited characteristic,' dehumanizes them instead of providing them with the opportunities they need for freedom, growth, and dignity as an individual.

Chapter 3: Methodology

Research Questions

During the process of this research paper, I will be guided by the following research question:

How has the DSM-5 been influenced in its development through social, cultural, political, and disciplinary frameworks?

In recognizing that the goal of this research paper is not only to analyze the DSM-5 as a set text but to also look at how it has been produced and further reproduces specific systems of knowledge and power, I draw upon the following sub-questions to obtain more detailed information:

1. To what extent (if any) does this publication perpetuate specific discourses?
2. How do these frameworks promote the rights of the patient vs the interest of the publisher (or other agents)?
3. What impact might the language used within the DSM-5 have on human dignity?

Approaches to Discourse Analysis

The methodology used within this study was conducted from a Foucauldian discourse analysis perspective of the DSM-5, which regards language as a form of social construction rather than as an individual activity (Foucault & Gordon, 1980). Since the language and terminology used within the DSM-5 has been carefully crafted over a number of years to address the "vested guild and economic interests" of the American Psychiatric Association (Poland, 2014, p.11), utilizing this style of analysis is meant to lead to a clearer understanding of what discourses are conveyed to its readers, both clinicians and the general public. This style of

analysis, which focuses on an understanding of the historical and social contexts of the text at hand, also reveals how relationships and behaviours are constructed through discourses.

In examining the historical definitions and development of discourse analysis, feminist linguist Sara Mills (2004) identifies that discourse cannot be tied down to one meaning or definition due to its different uses by theorists throughout the ages. Psychologists, Willig and Rogers (2008) also highlight how "discourse analysis can mean very different things and often subject to competing interpretations" (p. 91), primarily when different desires, problems and demands have shaped the conditions of analysis. Even Foucault, whom Mills cites as one of the most frequently referenced theorists surrounding discourse analysis, provides a range of meanings with which to define discourse analysis. Within his text, 'The Archaeology of Knowledge,' Foucault writes how

Instead of gradually reducing the rather fluctuating meaning of the word 'discourse', I believe I have in fact added to its meanings: treating it sometimes as the general domain of all statements, sometimes as an individualizable group of statements, and sometimes as a regulated practice that accounts for a number of statements. (cited in Mills, 2004, p. 6)

This particular definition also shows both the flexibility and malleability of the term 'discourse analysis,' which has been employed by Foucault, amongst others (Jørgensen & Phillips, 2002; Mills, 2004; Willig & Rogers, 2008). A further element that is common across different views of discourse analysis is that discourses tend to organize around the practice of exclusion and control (Mills, 2004). van Dijk (1993), in discussing the subject of control and how it connects to public discourse, highlights how

Members of more dominant social groups and institutions, and especially their leaders (the elites), have more or less exclusive access to, and control over, one or more types of public discourse... Those who have more control over more – and more influential – discourse (and more discourse properties) are by that definition also more powerful. (p. 356)

Foucault also references this issue of control stating that

in every society the production of discourse is at once controlled, selected, organized and redistributed according to a certain number of procedures, whose role is to avert its powers and its dangers, to cope with chance event, to evade its ponderous, awesome materiality. (Foucault, 1972, cited in Willig & Rogers, 2008 p. 102)

As a result, any discourse analysis focusing on groups such as medical professionals or the institution that has developed around the DSM-5 (Walker, 2016), will explore the power relations that underpin the field of mental health, its knowledge and practice, and more importantly, the structures that are used to maintain these institutions.

Foucauldian-Informed Discourse Analysis

In reviewing what a Foucauldian-inspired discourse analysis looks like, Willig and Rogers (2008), in a similar vein to Mills (2004), highlight how there are no set rules for conducting this type of analysis. However, they do highlight three separate dimensions that should be incorporated into any Foucauldian analysis of discursive practices. These three areas include a historical inquiry of the subject matter, recognition of the mechanisms of power and finally, the issue of subjectification or the practices in which subjects are formed. Foucault's historical analysis of discourses surrounding madness and sexuality recognized how these discourses came into and out of being, were shaped and reformed and were linked to power relations (Mills, 2004). In taking this historical approach, he was looking at the conditions of possibility for the emergence of these discourses but also the insurrection of subjugated knowledge (Foucault & Gordon, 1980; Mills, 2004; Willig & Rogers, 2008). This knowledge is described as "the historical contents that have been buried and disguised" (Foucault & Gordon, 1980, p. 81), virtual bits of knowledge that have been disqualified as inadequate compared to dominant discourses and, as a result, have been lost due to the production and reproduction of these dominant discourses.

It is in this analysis of subjugated knowledge that the complexity of knowledge and power appears, as it is through both power and knowledge working together to perpetually create 'truth' that discourses are formed and spread (Foucault & Gordon, 1980). In addition to understanding how power helps to shape knowledge, in his text, 'The Archaeology of Knowledge' (1972), Foucault discusses how an essential element of his analysis of discourse is in identifying the support mechanisms that keep such a statement in place and give them their power. As noted earlier, he identified that discourses are organized and controlled through multiple procedures as well as social groups and institutions. These institutions refer not only to physical institutions or disciplines such as medicine, psychiatry or science, but also to specific practices through which subjects are formed (Willig & Rogers, 2008). Foucault, Faubion & Hurley (2001) identified that the subject is not necessarily a thing, but a position (or multiple positions) maintained by an individual's relationship to different forces. Within the context of mental health, he highlights that

The degenerate subject is one which is to be returned to an idealised state—one that in theory has the relationship of an identifiable nosological abnormality to a normative ideal state as one object to another, and which in practice is the relationship of doctor to patient as one subjectivity to another. (Foucault as cited Ninnis, 2016, p. 129)

In this state, the individual is both the object and subject of discourse, and in this particular case, Foucault is highlighting this discourse of madness. In looking at this statement, it is crucial to understand not just the discourse being discussed, but the systems of power supporting and perpetuating this discourse.

In looking at the reproduction of discourse, one of the principal methods of reproduction is through the use of texts (Foucault & Gordon, 1980; Willig & Rogers, 2008). Texts, such as books or other printed materials, are, at first glance, simplistic as they have an absolute economic

value and, in most cases, a set beginning and end. Upon closer inspection, though, this is not the case. In discussing the material unity of a book, Foucault & Gordon (1980) asks,

Is this the same in the case of an anthology of poems, a collection of posthumous fragments, Desargues' *Traité des Coniques*, or a volume of Michelet's *Histoire de France*? Is it the same in the case of Mallarmé's *Un Coup de des*, the trial of Gilles de Rais, Butor's *San Marco*, or a Catholic missal? (p. 23)

In a similar vein, he contrasts the discursive value of many texts, highlighting that something, such as the name of the author (whether real or pseudonym), can have an impact on the reader's perceived value of the text. Texts within Foucauldian discourse analysis are typically drawn from five key sources: spatiality and social practice, political discourse, expert discourse, social interaction, and autobiographical accounts (Willig & Rogers, 2008). Of these texts, items of expert discourse tend to include, what Willig and Rogers (2008) refer to as "intellectual texts, like official publications, research and empirical findings" (p. 102). In taking the approach of analyzing the DSM-5, which is an official publication of the APA, as the object of inquiry, this Major Research Paper fits well with Foucault's method. Not only does this research focus on the DSM-5's location as an influential text within the field of mental health, but in defining how mental disorders and the barrier between normality and abnormality have been constructed, it draws attention to the differences in power attributed to these constructions. It is worth noting that when analyzing texts through discourse analysis, there are two different approaches often used, one at the macro-level and the other at the micro-level.

Macro & Micro Approaches to Discourse

Historian Jan Ifversen (2003), in his article, 'Text, Discourse, Concept: Approaches to Textual Analysis' discusses the micro and macro approach to textual analysis and highlights how

There are, however, many approaches to textual analysis. Some are more contextualist, others more formalist. Some approaches tend to work at a micro-level, where the role and

meaning of the singular text become important. Other approaches are oriented towards a macro-level where many texts are studied in order to make wide-ranging claims about a certain period or a certain society. (p. 68)

This multitude of approaches to analysis not only helps researchers to examine a variety of different elements within a single subject but can also help to identify the position they take within the formation of discourse (Foucault, 1972; Ifversen, 2003). This approach also ties into Foucault's structuralist way of approaching discourse analysis, as he focuses explicitly on the relational aspects of elements within discourses. As one of the aspects of his archaeology is the way that concepts within a discourse interact with one another and with other discursive elements. van Dijk (1993) encapsulates this in stating how "the macro and micro level (and intermediary mesolevels) form one unified whole" (p. 354).

Macro analysis, in particular, has developed out of Foucault's work on discourse analysis and focuses on discourses that operate across a variety of institutional and cultural settings, the production of these discourses, and how they can exert power over other discourses (Mills, 2004). With this type of analysis, it is essential to understand intertextual relationships that exist, for example, within the various editions of the DSM, as well as taking into consideration the societal, political and historical events that are influencing the text being analysed (Foucault, 1972; Mills, 2004; van Dijk, 1993). In comparison, a micro-analytical approach to discourse analysis looks at the semantics of the text and how it is used to accomplish specific goals either between individuals or society at large (van Dijk, 1993). In this research paper, due to my focus on the development of the DSM-5 as the latest in a series of texts and their influence on systems and institutions (i.e., the mental health field), I would be viewed as taking a macro-level approach, especially in looking at how this text has evolved and how previous editions have impacted it. However, acknowledgement of the impact of dignity through the use of language

within the DSM-5 would best fit the description of discourse analysis at a micro-level. This combination of two different levels illustrates the malleability of discourse as a fluid concept and its suitability for use in studies of this nature.

Data Collection Procedure

To begin my work, I conducted an extensive literature review of academic literature and texts about nosology, diagnostic systems and the DSM system to understand the history of the DSM and mental health diagnosis within North America. Included in this literature review, I made use of approximately 25 texts and articles that outlined the development process of the DSM-5 and the DSM system as a whole. These texts provided a behind the scenes look at the development process, which was not provided by the APA. Following this, I then chose my sources for the discourse analysis that I would carry out. These sources include:

- The Diagnostic & Statistical Manual of Mental Disorders 5th Edition (APA, 2013b)
- American Psychiatric Association Fact Sheets; and,
- The American Psychiatric Association Website (2019a).

Except for the DSM-5, which one must pay to access, all of these sources are available to members of the public. While there are seven different editions of the DSM system, the focus of this particular research project is the 5th edition, which is the most recent since the DSM-IV-TR was published in 2000. The two supplementary readings I include are relevant to the critical focus of this analytic work because their existence highlights the narrative presented by the APA surrounding the development of the DSM-5 and its ‘approved’ usage amongst clinicians, mental health practitioners and front-line workers. My express goal in analyzing these documents was to determine the discourses that make up the DSM for clinicians, the subject positions they generate, and their modes of reproduction.

Analytical Procedure

Utilizing the methodological concepts and approaches I have outlined previously, I began my analysis with an initial reading of the sources, making observational notes on connections between these texts and the literature review I had conducted surrounding mental health diagnoses and nosologies. Following this, I embarked on a close reading of the DSM-5, as this style of reading is a common approach utilized when looking at literary texts. It allows the reader to understand the structure and pattern of the text and the anomalies that exist apart from this structure (Lockett, 2010). Lockett (2010) describes close reading as “the detailed analysis of aspects and features within a specific pitch, not the pitch positioned in relation to the mountain range or global tectonics” (p. 400); in my case, this pitch relates to discourses found within the text. In my close reading, I focused specifically on the following sections of the DSM:

- Preface
- Section 1 – DSM-5 Basics;
- Section 3 – Emerging Measures and Models; and
- Appendix

These sections were chosen because they not only highlight the development process of the DSM (APA, 2013c), but also provide a practical guide to using the DSM-5 (APA, 2013b). These sections are also highlighted by practitioners as the best way to understand “organizational changes and the expanded conceptualization of mental disorders” (King, 2013a, p. 18) within the DSM-5. During my first close reading exercise, I sought to avoid focusing on specific discourses, instead, highlighting keywords that I considered to be important. From there, I divided these keywords and phrases into separate themes based on apparent similarities or differences between the words. Following this, I systematically combed through the different

sources to find referential statements that fit into these common themes. Through this procedure, a set of discourses surrounding the DSM-5 began to emerge. I then began a review of material from different sources to facilitate my understanding of these discourses and to develop a working understanding of how discourses within the DSM-5 impact patient dignity

Reflexivity

As mentioned earlier, Berger and Luckmann (1966) discuss the importance of understanding how society and social institutions shape human ideation and can, in turn, how human ideation impacts society. As such, in determining my social location, I need to reflect on how my history and interaction with society and social institutions will impact my methods of study. Mauthner and Doucet (2003) discuss how the problem of reflexivity arises as a result of social researchers being integral to the social world that they study, and as such, there is a connection between them, recognized or not. Similarly, Denzin and Lincoln (2000) talk about the importance for researchers to share their perspectives in order for the reader to understand their place in the study both from a theoretical perspective, but also from a knowledge base perspective. Added to this is the importance for researchers to understand how their emotions can shape their interpretations of the data they are analyzing, whether it is quantitative or qualitative (Denzin & Lincoln, 2000; Mauthner & Doucet, 2003).

Social-Location & Privilege

Within my research, I will primarily focus on the deconstruction of the DSM-5. However, as mentioned, this text does not stand alone. The DSM is a document that has been constructed and reconstructed over many decades (Blashfield et al., 2014; Greenberg, 2013) and is, as I will argue, constructed through a particular ethnocentric lens. However, in reviewing the construction of this text, I need to recognize, if only to myself, that the categories I use for this analysis are

also influenced by historical and social realities (Berger & Luckmann, 1966). As such, I need to acknowledge that I approach this research from a place of privilege. As a white, cis-gender male, I am dealing with a subject that has historically not included other perspectives outside of these privileged identities in order to shape an institution that has wielded influence over individuals, including women and children, often from minority groups (Waldram, 2004). I also acknowledge the fact that having worked in government-funded organizations for a significant period of my working life, I possess an institutional mindset (Mauthner & Doucet, 2003) that causes me to look at these types of documents, which can inform systems and institutions in a certain way based around my role and experience. Therefore, when conducting this research, it is essential for me to be aware of how I approach the text and to examine how my views and identities might affect my interpretation of the material.

Locating this Work

I am a student of Social Justice and Human Rights at Brock University and have also worked in the landscape of career development and post-secondary education, where mental health is an ever-present topic. I initially became interested in the nosology of mental health by witnessing the experiences of clients who have received various diagnoses and seeing the impact, both positive and negative, that these diagnoses have had on their lives. I have also been involved in providing strategic support and guidance to a mental health support agency and understand the challenges and restrictions within this field. This includes understanding how tools, such as diagnostic systems, have had an impact on developing targeted remediation and treatment plans to support individuals facing mental health challenges.

Finally, it is important to acknowledge the emotional connections I have to the material at hand. In 2007, a close personal connection was diagnosed with schizoaffective disorder based on

the criteria defined in the DSM-IV (APA, 2000). This diagnosis not only impacted her health, but resulted in significant hardship to her family, especially her children, who were almost removed from her (and her husband's) custody based on this diagnosis. In addition, I have worked and volunteered in several industries where I have come into contact with individuals who have received a variety of mental health diagnoses. While listening to their stories in the process of seeking and receiving a diagnosis, I have come to understand how dignity has been impacted and degraded through their experiences with individuals within the mental health profession. These experiences have shaped my perspectives of the climate surrounding mental health policy within Ontario, as well as increased my curiosity to learn more about how systems of power, such as those surrounding the DSM, have impacted policies and attitudes towards mental health.

Chapter 4: Literature Review

In this chapter, I present an overview of the development of the DSM system leading to the eventual creation of the DSM-5. Following the principles outlined within Foucauldian discourse analysis, I outline how changes within the psychiatric and psychological professions have transformed the scope and aims of the DSM system in addition to the influence of other internal and external bodies. I then turn to a review of the literature that critiques the DSM-5 and concerns that have been levelled against it.

Developing the 'bible'

The DSM-5 was not created overnight, and this most recent edition comes on the heels of over a century's worth of work in nosologies and clinical practice/research (Blashfield et al., 2014; Greenberg, 2013). In line with the goals of Foucauldian analysis that seek to understand the elements that surround and support specific discourses (Foucault, 1972), in order critique the

language and frameworks used to develop the DSM-5, we first need to understand the development of these frameworks and the influence over time by the various winds of change that have shaped the landscape of mental health diagnosis (Blashfield et al., 2014; Tsou, 2015). Since its inception, the DSM has gone through six separate revisions, since it was first launched, and with each subsequent revision, the number of mental disorders discovered has increased to over 540 (Khoury et al., 2014). In the words of researcher and academic, Gerald Young (2010),

the successive versions of DSM manuals that we use in diagnosis should keep improving its scientific basis, reliability, validity (relevance), and clinical utility, in order to help us meet the requirements of our professional training and practice, and the needs defined by our legal cases. (p. 320)

However, this has not been the case throughout the history of nosologies and has in part, been identified as a failure on the part of science and research which has not moved nearly as quickly as the clinical profession demanded (Frances, 2013a), but also due to an association criticized for not maintaining a consistent level of standard in its research (Frances, 2013a; Greenberg, 2013; Poland, 2015)

The DSM & the Military (DSM I & II)

In the early years of the DSM's history, the demand for clinical utility was high on the agenda. From a military perspective, the nosology work that had been completed on behalf of the U.S. Government and the American Medico-psychological Association (another precursor to the APA) had been limited to a civilian perspective (Demazeux, 2015; Gaines, 1992), and lacked any scientific rigour (Greenberg, 2013). This lack of rigour was of concern to the military,

Because the classification was based upon experience with disorders found in civilian chronic wards, military clinicians in the 1940s found that it was of little use to them. They needed to account for the acute disturbances, psychosomatic and personality disorders that they encountered in service personnel during World War II. (Gaines, 1992, p. 7)

As such, both the Veterans Administration and the Navy developed classification systems (Gaines, 1992), and each branch of the military increased the ranks of their psychiatric staff to meet these needs (Demazeux, 2015). In addition to the hope that the military had in classification systems to address the issues faced by their personnel, there was hope amongst those who identified as part of the American Psychiatric profession in finally making their mark on the psychiatric landscape (Demazeux, 2015). As Steeves Demazeux (2015) explains,

Until World War II, almost all the most influential psychiatrists, laboratories, and scientific journals were European. American psychiatry did not yet have an identity of its own. It was, at best, a borrowed psychiatry... very heavily influenced by European psychiatrists (p.xiii)

Following the Second World War, not only had the number of American psychiatrists increased, but having been tested in wartime, the psychiatric profession had gained a prominent presence in civilian life and, as such, blossomed (Frances, 2013a). With the launch of the DSM (which was later named the DSM-I) in 1952 (Blashfield et al., 2014) by the Mental Hospital Service of the American Psychiatric Association (Gaines, 1992), a sense of order was imposed on the profession within the U.S. (Greenberg, 2013). It also demonstrated that American psychiatry was no longer borrowing from its European brothers, but was launching out on its own (Demazeux, 2015).

This independence was further evidenced in 1968 when the APA launched the DSM-II, in part, because of growing dissatisfaction with the World Health Organization's ICD-8 (Khoury et al., 2014). Noted cultural anthropologist, Attwood Gaines (1992), highlights how

The APA developed DSM-II because U.S. clinicians felt that the ICD did not make appropriate distinctions and omitted important disease entities. This situation developed even though the U.S. produced the DSM almost conjointly with the W.H.O. and its work on the ICD-8. U.S. clinicians maintained that certain disorders existed, but clinicians in other societies had not found them. (p. 8)

The World Health Organization (W.H.O.) and other institutions have raised similar concerns with regards to disorders that exist outside of the U.S., but which are conspicuously absent within the DSM system. While the DSM-II increased the number of proclaimed disorders from 108 to 182 (Khoury et al., 2014; Blashfield et al., 2014), it stifled itself as a result of the limited scientific evidence available to support and guide its recommendations (Frances, 2013a). Despite this, the DSM-II retained, at its core, the influences of William Menninger and Adolph Meyer, that "mental illnesses were symbolic expressions of hidden psychological (or psychosocial) realities (Gaines, 1992, p. 8).

DSM-III – A New Paradigm

In the early 1960s, Thomas Kuhn in his text, 'The Structure of Scientific Revolutions,' coined the term 'paradigm' to refer to "universally recognized scientific achievements that for a time provide model problems and solutions to a community of practitioners" (Kuhn, 1970, p. viii). In 1980, the APA launched the DSM-III which represented their attempt at a significant paradigm shift within psychiatry from its founding fathers (APA, 1980; Gaines, 1992; Frances, 2013a), as "the main authors of the DSM-III were the leaders of a group that has become known as the neo-Kraepelinians" (Blashfield et al., 2014). It also helped to resolve one of the main problems with the DSM-II, which was the accuracy of American practitioners in diagnosing mental disorders raised by experiments from the likes of Rosenhan in 1973, Overall and Woodward in 1975, and the US/UK International Diagnostic Project in 1977 (Blashfield et al., 2014). At the heart of the DSM-III was Bob Spitzer a psychiatrist and professor of Washington University, who introduced diagnostic criteria, a tool used initially within research, as something that could be used by clinicians within their general practice (Frances, 2013a). Supporters of the DSM system felt that this new criterion...

...Was an important revolution in psychiatric classification and that the classification system is an invaluable tool in clinical practice and scientific research. Critics, on the other hand, argue that neither of these claims is defensible that the DSM is profoundly flawed, and that DSM-III ushered in three decades of non-progressive research and misguided clinical practice. (Poland, 2014, p. 1)

Regardless of its impact, one thing that the DSM-III did provide was hope that the field of American psychiatry could finally affirm itself as not just a medical discipline, but could contribute and benefit from medical science (Brown, 2015; Demazeux, 2015; Frances, 2013a). This change to requiring clinicians to match their patient's symptoms directly to specific diagnostic criteria was revolutionary, as before this, most individuals were diagnosed based on the clinician comparing written descriptions from previous editions of the DSM (Gaines, 1992). In doing so, it restored confidence both within the U.S. and internationally in American psychiatric practices, as it was no longer basing its credence on the opinions of a set number of clinicians, but rather, a core set of scientific principles (Demazeux, 2015; Frances, 2013b; Greenberg, 2013).

Additional changes from the DSM-II also included the use of a multiaxial approach to diagnosis, which represented five distinct clinical foci and, as such, five diagnoses that a clinician might decide to make (Gaines, 1992). Another difference was Spitzer's use of 'Kappa', a standard of reliability based on a series of field trials (Greenberg, 2013). This new level of reliability caused supporters of the DSM-III to claim that this edition would serve as a critical tool in terms of scientific research and clinical practice (Greenberg, 2013; Poland, 2014; Poland, 2015). Once again, there was hope on behalf of the APA and the field of psychiatry, that new (at the time) scientific methods, such as neuroscience and genetics, would be able to shine a light on the causes of these specific disorders (Frances, 2013a), and that the research conducted in

creating the DSM-III would be used as a starting point for this research (Poland, 2014). It did not.

Shortly after the DSM-III launched, a series of articles was published comparing the DSM-III with the Research Diagnostic Criteria, also developed by the DSM-III's chief architect, Bob Spitzer, showing several flaws within the criteria (Blashfield et al., 2014). In part, this was because, in establishing the reliability of the Kappa,

the DMS-III field trials did exactly that, in no small part because the patients were preselected for the likelihood that they would qualify for the diagnosis and the researchers were drilled on the criteria and on a clinical interview that left little to chance or imagination. (Greenberg, 2013, p. 226)

These critiques prompted Spitzer and others to start developing a revision to the new DSM-III that would address these flaws (Blashfield et al., 2014). However, at the time of its release in 1987, the DSM-III-R had not only increased the number of specific diagnoses from 228 to 253, but introduced a new classification system (Khoury et al., 2014; Blashfield et al., 2014; Gergen, 2007). This version also indicated that this was not a definitive work and that there were certain disorders (located within the appendix) which were under construction and would appear in future editions (Gaines, 1992). Despite this, the DSM, as a result of this updated version, gained dominance in the field of nosology as Demazeux (2015) states,

The DSM quickly supplanted most national classifications, wiped them from memory, and contributed to an unprecedented homogenization and universalization in the practice of psychiatry. It even influenced the WHO's ICD, which, from 1992 on, came to adopt a structure and methodological principles that are very similar to the DSM's. (p. XV)

It was also at this time that people began referring to the DSM as the `bible` of psychiatry (Khoury et al., 2014; Demazeux, 2015; Frances, 2013a; Greenberg, 2013; Kirk, Cohen & Gomory, 2015; Walker, 2016), further cementing the narrative of the importance of this document and its relationship to the field of psychiatric medicine.

DSM-VI – Stabilizing the Profession

By the time the DSM-III-R was published in 1987, many researchers and clinicians were concerned about the rate of change promoted by the APA through the DSM system. Blashfield et al. (2014) highlights how

Researchers needed stability in the definition of categories in order to perform useful studies of psychopathology. Clinicians, likewise, were confused by and had difficulty adjusting to changes in the fundamental terminology that organized the diagnostic process. Additionally, the rate of scientific discoveries did not support the rapid changes. (p. 37)

As such, the goal of the DSM-IV was to provide stability to both the content and psychiatric profession, allowing researchers to perform useful studies and give clinicians time to adapt to the diagnostic processes (Blashfield et al., 2014; Demazeux, 2015; Frances, 2013a). The person chosen to lead this task was Allen Frances, an individual who had served in a variety of capacities within the DSM-III and DSM-III-R task groups (Greenberg, 2013). Not only did he direct his workgroups to keep changes between the DSM-III and -IV to a minimum, but any changes or additions that were to be made had to be justified by empirical evidence (Demazeux, 2015). In addition to this focus on evidence-based decision making, Frances had other goals that included:

better attention paid to clinical utility (the DSM-IV sought to become “more user-friendly”) and to all the “unintended consequences” of the DSM on the psychiatric field, like the risk of overmedicalizing mental suffering. In a nutshell, DSM-IV sought to be more conservative and at the same time more consensual than its previous manifestation. (Demazeux, 2015 p. 14)

Part of this was ensuring that the DSM-IV provided enough flexibility to enable the clinician to exercise their judgement (Warelow & Holmes, 2011; Demazeux 2015). Even though this revision of the DSM was supposed to be more methodological than substantial, the DSM-IV added 130 diagnoses to its (over 880) pages (Blashfield et al., 2014), a point which Allen

Frances (2013a) has since conceded was too many. While the text revision of the DSM-IV (DSM-IV-TR published in 2000) changed only minor items, perhaps the most prominent item of note was that the cost changed from \$48.95 for the DSM-IV to \$74.95 for the DSM-IV-TR (Blashfield et al., 2014). This price increase was one of the first signs that the DSM publication had a second market aside from supporting clinicians, but to finance the work of the APA (Blashfield et al., 2014; Brown, 2015; Demazeux 2015; Frances, 2013a; Greenberg, 2013; Kirk et al. 2015). While at present, revenue amounts for the DSM-IV-TR and DSM-5 have not been published (Blashfield et al., 2014), considering the revenue derived from the DSM-IV was \$120 million, we can expect to see increased figures for these later editions.

DSM-5 – Another Paradigm

The launch of the DSM-5 in 2013 should have marked the second revolution in psychiatry and nosology, one that would have pushed the field towards a classification system informed by modern science (Poland, 2014; Brown, 2015; Tsou, 2015). Unfortunately, like the hope presented by the DSM-III, it did not work out quite as expected by the APA and those in charge of the DSM-5 development team. The DSM-5 had four main goals:

- Sharply decrease NOS diagnoses through greater criteria specificity.
- Add dimensional assessments, where appropriate, to diagnostic evaluations so that clinicians could evaluate the severity as well as the presence of symptoms.
- Better align DSM with the World Health Organization's ICD-11.
- Ensure that both the definitions and diagnostic criteria for DSM disorders reflected the strongest scientific evidence. (APA, 2013b, para. 8)

From the perspective of the APA, the DSM-5 was successful in meeting the majority of the goals that it initially set out to achieve and created a tool that improved clinical utility and acceptability

(King, 2013a). However, the DSM-5 received a lacklustre reception from the psychiatric and mental health community, and the collective opinion was that it did not go far enough in creating this new revolution (Demazeux, 2015). One of the principal revolutionary elements to the DSM was to be the incorporation of dimensional models that would focus on measuring the severity of symptoms (Blashfield et al., 2014; Greenberg, 2013). According to Darrel Regier – Vice-Chair of the DSM-5 Task Force,

The single most important precondition for moving forward to improve the clinical and scientific utility of DSM-V will be the incorporation of simple dimensional measures... Their prominent use would be one, if not the major, difference between the DSM-IV and DSM-V. (Regier as cited in Greenberg, 2013, p. 127-128)

However, as soon as these changes were suggested, opposition quickly appeared both within and outside of the APA (Blashfield et al., 2014; Tsou, 2015). As a result, some elements of this dimensional model developed by the APA were included, and others, such as the final unified model, were not (Blashfield et al., 2014). Despite this opposition, the DSM was successful in decreasing the number of diagnostic categories while at the same time increasing the number of diagnoses to 541, an increase from 158 in the DSM-IV (Blashfield et al., 2014). While this may seem drastic, the DSM leadership task force argued that this increase was in response to the diverse ways that members of the public would want to be seen by a frontline mental health worker (Tsou, 2015).

Critiques of the DSM-5

While some form of criticism, stemming from internal politics and dynamics, is typical of any significant revision of well-established texts, it was the level of external criticism directed towards the DSM-5 that was certainly not anticipated by the APA, especially criticism from individuals who had previously been supporters of the DSM (Kirk et al., 2015). Included amongst these critics were Bob Spitzer, Head of the DSM-III task force, Allen Frances, Head of

the DSM-IV task force, the American Psychological Association, the British Psychological Society, and former partners in the original development of the DSM-5 – the National Institute of Mental Health (Blashfield et al., 2013, Demazeux, 2015, Greenberg, 2013, Kirk et al., 2015).

What was also surprising was the amount of criticism against the accomplishments of past DSM volumes by the APA itself (Demazeux, 2015). All of this was played out across the internet for the world to see and comment on, which many members of the APA were unsure of how to handle (Blashfield et al., 2014; Greenberg, 2013). The three main critiques that have been made against the DSM-5 is its approach to the medicalization of normality, the influence of pharmaceutical companies, and the validity and reliability of its diagnostic criteria.

Diagnostic Inflation

“Medical research has made such enormous advances that there are hardly any healthy people left” - Aldous Huxley

A large part of the commentary surrounding the DSM-5 has been around the issue of diagnostic inflation and medicalizing normal behaviour and responses (Greenberg, 2013). This was partly why individuals such as Spitzer and Frances gave their voice to the mounting criticism of the DSM-5 (Frances, 2013a; Greenberg, 2013). While many supporters of the DSM-5 highlight how "these changes to the criteria are designed to make the criteria considerably more specific than the DSM-IV-TR criteria" (King, 2013b, pg. 20), Allen Frances, a lead figure in this critique,

was astounded by the unrestrained loosening of criteria for current diagnosis and the invention of new ones in the DSM-5, all of which would undoubtedly result in the pathologizing and unnecessary medicating of tens of millions of normal people in America. (Walker, 2016, p. 92)

Frances was also concerned because he had seen how Big Pharma had taken what he considered to be, at the time, very stringent criteria within the DSM-IV and used them to promote a variety

of pharmaceutical drugs. For example, in discussing the growth in diagnoses of social anxiety disorder, he talks about how

The statistical normality of shyness was exactly what gave the drug company a big fat marketing target. There is no clear boundary separating normal shyness from the mental disorder social anxiety. So the company began an all-out campaign to convince all shy people that they are sick and will miss out if they don't take the cure. (Frances, 2013a, p. 153)

In speaking with individuals who were involved in the process of developing the DSM-V (as it was referred to at the time), Frances saw how, in their excitement, they were more concerned about the need to "add to the DSM-V many new mental disorders and to loosen the rules on how to diagnose the existing ones" (p. xiii, Frances, 2013a). This concern was further echoed on a global stage by the British Psychological Society (cited in Kirk et al., 2015), which accused the APA of

"medicalization of . . . natural and normal responses" of people, "which do not reflect illnesses so much as normal individual variations." Further, it argued that DSM-5's putative diagnoses are based largely on social norms, with "symptoms" that are subjective judgments, with no confirmatory physical "signs" or evidence of biological causation. (p. 70)

Asserting that a range of human behaviours can be considered medical diseases, without substantial evidence to support these claims, has been decried as the height of scientific conceit (Kirk et al., 2015; Waldram, 2004; Warelow & Holmes, 2011). Critics also state that this is

characteristic of the past several revisions of the DSM that categories with no demonstrated validity when they were introduced in DSM-III in 1980 have been continuously grandfathered through on the grounds that there is no substantial evidence to justify their removal, and that their removal would be too disruptive of ongoing clinical and research practice. (Poland, 2015, p. 35)

As such, the question that continues to be asked with each successive revision of the DSM is not what these new diagnostics *should* be, but whether these diagnoses will aid patients or cause them harm (Frances, 2013a; Levine, 2015a).

Big Pharma

Another significant area of criticism within the DSM-5 is the pharmaceutical industry's influence on its development. What exacerbated these concerns was the realization that many of the task force members for the development of the DSM-IV and -5 had ties to the pharmaceutical industry (Kirk et al., 2015). Because of this scrutiny, in 2006, the APA Board of Trustees declared that members of the DSM-5 task force could only hold a maximum of \$50,000 of company stock and had to limit industry earnings to \$10,000 per year (Greenberg, 2013). While this, to some people, may seem a great deal of money, it is nothing compared to what some individuals can make conducting research and publishing data or participating in conferences sponsored by specific drug companies (Coyne, 2005; Schafer, 2004). Further to this limited financial recompense, it was the first time in the development of a DSM that the APA asked task force members to disclose all their sources of income – in addition to those received from the pharmaceutical industry (Demazeux, 2015).

Monetary considerations were not the only concern regarding the pharmaceutical industry's level of involvement. Concerns were also raised about the influence that the industry has had on individuals over their careers and what biases or beliefs have been developed due to these relationships (Coyne, 2005; Schafer, 2004; Walker, 2016). Many individuals within the psychiatric profession receive training from pharmaceutical companies on their products, are asked to conduct research on their behalf, write articles or act as `thought leaders` to the rest of the profession (Coyne, 2005; Frances, 2013a; Greenberg, 2013). Added to this are the contributions made by pharmaceutical companies to universities, research institutes and publications that enable psychiatrists to conduct their research (Coyne, 2005; Greenberg, 2013; Schafer, 2004). In his book, 'Saving Normal,' Allen Frances (2013a) shares the concerns he has

regarding those in the psychiatric industry who are wittingly or unwittingly becoming involved in the push by pharmaceutical companies to promote their research. Frances speaks about this with authority, as he was once a pharmaceutical `Thought Leader` for over 30 years and, upon reflection, states how “in retrospect, it was unseemly to have participated in so many activities that could be constituted as indirect drug marketing. And I saw the slippery slope facing those who had a deeper involvement and fewer scruples” (p. 94). While he doesn't believe that the sponsorships he received restricted his work, based on various conferences and presentations where he actively criticized pharmaceutical companies, he also recognizes that his actions, and those of his colleagues' in relation to the development of particular diagnoses within the DSM-IV opened the door to the over-diagnosis and pharmaceutical treatment of mental health conditions such as autism, amongst others; a practice which has become a go-to for individual practitioners in the field (Greenberg, 2013).

Clinical Validity & Reliability

From a medical standpoint, which provides the foundation of modern psychiatry and psychology (Walker, 2016), there is also considerable concern regarding the reliability and validity of categories within the DSM-5 (Poland, 2014). These concerns, in large part, are due to the field trials conducted by the DSM-5 task force (Frances, 2013a; Greenberg, 2013). When reliability data was published, it became apparent why the DSM-5 Taskforce "issued a confusing and convoluted statement arguing that reliability standards for DSM-5 should be lower than those established for DSM-III" (Kirk et al., 2015, p. 68), as only a handful of disorders (such as Post-Traumatic Stress Disorder [PTSD]) scored a Kappa score above 5.0 on this scale (Greenberg, 2013; Kirk et al., 2015). Two of the mainstays of the psychiatric and mental health profession profession, Major Depressive Disorder and Generalized Anxiety Disorder, scored a

.32 and .20, respectively (Greenberg, 2013; Kirk et al., 2015). Considering that it was actual clinicians and mental health professionals, such as Greenberg (2013) and King (2013a), who were involved with these trials, significant concerns were raised regarding whether or not these diagnoses were agreed upon or warranted. Greenberg (2013) declared:

Something had gone terribly wrong. Those two diagnoses were the Dodge Dart and Ford Falcon of the DSM, simple reliable and ubiquitous, and if clinicians were unable to agree on who warranted them, there were only a few possible conclusions: that the DSM-III and IV had been unreliable from the beginning, that the DSM-5 was unreliable, or that the field trials were so deeply flawed that it would be impossible to say with any kind of certainty just how reliable the new book would be. (p. 313)

Greenberg's questions about the unreliability of the DSM may be the most logical rationale, as previous reviews of the DSM-IV have highlighted concerns about the reliability and validity of DSM categories, including a 2012 study by Blom and Oberink (cited in Khoury et al., 2014) which found

that the construct validity of DSM-IV post-traumatic stress disorders (PTSD) in children and adolescents varies among different criteria: where some are highly valid (e.g., stressor criterion), while others are not (e.g., avoidance, detachment from others, and difficulty falling or staying asleep). (p. 2)

Another example that demonstrated concerns about validity was for diagnoses of Borderline Personality Disorder (BPD), which had a reliability score of .75 from CAMH in Toronto, Ontario. This score was exceedingly high compared to other disorders, and particularly to the score that was recorded at the Menninger Clinic in Houston. This clinic found a reliability score of only .34 for BPD, even though both clinics used the same criteria (Greenberg, 2013).

Connected to this is the question of whether mental disorders should be classified in a theoretical or descriptive manner?

Prior to the publication of DSM-5, there were some indications that DSM-5 would mark psychiatry's second revolution in classification by ushering a paradigm shift away from the DSM's purely descriptive approach. In particular, some reports from the DSM-5 taskforce, chaired by David J. Kupfer, indicated that DSM-5 would move the DSM away

from the neo-Kraepelinian approach towards a theoretical and etiological approach to psychiatric classification informed by sciences such as genetics and neuroscience. (Tsou, 2015, p. 44)

Despite this, the current DSM-5 still relies upon a heavily descriptive approach that is only partially useful for research and treatment. In addition to the description mentioned above of what constitutes a mental disorder, when describing symptoms, the DSM-5 uses the term ‘clinically significant.’ However, nowhere is this clearly defined within the text. Even in the section entitled ‘Criterion for Clinical Significance’ the DSM-5 states,

A generic diagnosis criterion requiring distress or disability has been used to establish disorder thresholds, usually worded "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." (APA, 2013, p. 21)

As such, clinicians are required to use their best judgement when reviewing these diagnoses to see what fits based on the evidence presented by the patient. In his critique of the DSM-5, Greenberg (2013) talks about how

...the symptoms are ‘clinically significant’ but the book doesn’t define that term and most psychiatrists have decided to stop fighting about it in favor of a I-know-it-when-I-see-it definition (or saying that the mere fact that someone makes an appointment is evidence of clinical significance). (p. 20)

While this approach may give the clinician agency to be more flexible in their decision making, such decisions are neither scientifically nor medically driven and lead to inconsistencies in how patients are responded to and treated by practitioners within the psychiatric and mental health profession.

Chapter 5: Findings

The findings in this chapter represent a deconstruction of the DSM-5 using the Foucauldian-informed discourse analysis methodology discussed in chapter 3. In seeking to answer the research questions which have guided this study, I have organized the findings into

three corresponding sections. The first section looks at some of the internal and external factors that have influenced the development of the DSM-5. I then explore several of the dominant discourses that are currently being perpetrated by the DSM-5 and how these discourses elevate or impact the rights of the patient versus their impact on other agents connected to the DMS-5. Finally, I examine the impact of these discourses and the language used within the DSM-5 on the dignity of the of the patients this text is intended to support .

Deconstructing the DSM-5

Since its launch in 1952, the DSM and its subsequent editions have been criticized within the scientific and public sphere on a number of grounds including cultural, theoretical, and even administrative (Frances, 2013a; Frances, 2013b; Gaines, 1992; Greenberg, 2013; Kirk et al., 2015; Mitchell, 2003; Waldram, 2004). In his book, `Saving Normal,` Allen Frances (2013a) is honest about how factors such as the internal politics of the APA, Big Pharma and the Psychiatric profession as a whole have used the DSM as a way of changing diagnostic cycles and placing more emphasis on fads and trends within society, rather than on long-term research into critical areas that can help the individual (Frances, 2013a). The DSM-5, it appears, has come under even more scrutiny, in-part, because of the public nature of its development, where draft copies of the DSM-5 were made available online for review and feedback from the psychiatric and mental health profession and the public at large (Blashfield et al., 2014). In addition to what could be called familiar, scientific, clinical and methodological criticisms (Frances, 2013a; Greenberg, 2013), the DSM-5 also faced more severe criticisms around the politics of the APA and the perceived financial agenda surrounding the DSM and its development. Furthermore, concerns were raised again regarding how the new edition is targeted towards specific demographics within the United States and how other demographics, such as youth, First Nations

people and cultural groups could be let down or misdiagnosed by the DSM (Frances, 2013a; Greenberg, 2013; Kirk et al., 2015; Poland, 2015; Tsou, 2015; Waldram, 2004). Finally, the contribution the DSM-5 could make to the “mounting epidemic of mental disorders in the last 15 years” (Khoury et al., 2014, p. 2) provides a valid concern regarding the influence of this document on the mental health landscape.

Internal Influences

Within the United States alone, the influence of the DSM-5 is staggering. It has been reported that the U.S. government committed to spending over \$100 billion in 2014 on services for individuals that were categorized as having a mental health diagnosis, which were facilitated through the use of the DSM-5 (Kirk et al. 2015; Tsou, 2015). As such, the APA has both the economic and political motivation to ensure that the DSM remains the standard classification document within the United States, if not beyond. With the publication of the DSM-5, the APA finds itself at the centre of several conflicts of interest that speak to the reliability and usability of the DSM-5. Chief amongst these is the fact that the DSM-5 was developed by the APA and was significantly guided by the issues that promote the interests of psychiatrists to ensure that registered members (amongst those using the DSM) would have access to funding (Kirk et al., 2015). Poland (2014) contends that

Since the American Psychiatric Association has vested guild and economic interests in perpetuating the DSM/PPS form of practice of its members, it has an inherent conflict of interest with respect to any proposed changes that would work against those interests. (p. 11)

There is also concern amongst many of the DSM-5's critics as to why the APA released the DSM-5 when it was clear that there were significant concerns surrounding validity and utility, as well as the fact that the ICD-11 – which was one of the original justifications for creating the DSM-5 – had been delayed from its original release date (Khoury et al., 2014). Many saw the

APA treating the DSM-5 as an asset, rather than a resource for the public, from which they hoped to profit handsomely from (Demazeux, 2015; Frances, 2013a). In looking at the numbers associated with the development of the DSM-5, this is not surprising. For the DSM-5, the APA has reportedly invested close to \$25 million, a figure which is almost five times the investment made towards the DSM-IV (APA, 2019b). While revenue figures for the DSM-IV-TR and -5 as of Fall 2019 are still not available, the DSM-IV, with an investment of around \$5 million, has so far netted the APA \$120 million in revenue (Blashfield et al., 2014; Demazeux, 2015).

Considering that sales and merchandising account for approximately 10% of the APA's global revenue (Khoury et al., 2014), and that in the late 2000s, money received from pharmaceutical companies started to dry up (Greenberg, 2013), there is a continued need to fill this gap in the budget by the APA.

Further evidence that demonstrates to critics that the DSM-5 is more of an asset than a publication can be seen in the supposedly transparent nature of the document. While the APA did provide two drafts for the public to comment on in 2010 and 2011, there was very little else that people could see regarding the development of the manual (Blashfield et al. 2014; Frances, 2013a; Greenberg, 2013). Only members of the DSM-5 task force or APA trustees were privy to the actual proceedings and there were strict confidentiality agreements that task force members were required to sign (Frances, 2013a; Greenberg, 2013). Frances (2013a) discusses how

All along, APA has treated DSM-5 more as a private publishing asset than a public trust. First there were confidentiality agreements to protect “intellectual property”, than an inappropriately aggressive protection of trademark and copyright, and finally the unseemly rush to prematurely publish because it was necessary to fill a budgetary hole. (p. 176)

In response, the APA admitted that these agreements were put into place to protect their intellectual property, but also to ensure that nobody on the task force would profit separately

from their findings (Demazeux, 2015; Frances, 2013a). The APA also aggressively went after individuals who were perceived to be infringing on their trademark or material, such as bloggers that were releasing past information connected to the development of the DSM-5 (Frances, 2013a). Finally, since the release of the DSM-5 in 2013, there has been limited material related to its development made available to researchers (Cooper, 2015). While the APA website contains several ‘fact sheets’ that discuss the development process and specific changes made, these are all listed as being created in 2013, with no further information (beyond what is necessary) provided by the APA during the development process, which begs the question: what is being hidden?

External Influences

One of the most significant elements of the development process of the DSM-5, compared to previous editions, was the way that the review process was opened up to the public for comments and feedbacks. According to the APA (2013d),

The draft criteria have been opened for public review and comment three separate times throughout the development process. The first two comment periods elicited nearly 11,000 comments and impacted many of the changes to the proposed criteria. This degree of openness is unprecedented in medicine and will ultimately strengthen the final document. (para. 12)

However, there were no details provided as to how these comments impacted changes or what specific changes were made as a result of this public inquiry. Another external influence during this time was the rise in pressure from public interest groups and members of the psychiatric and mental health profession regarding the links between the APA, DSM-5 and Big Pharma. During the mid-2000s, a Republican Senator from Iowa, Charles Grassley, convened a series of hearings regarding specific doctors and their relationship with particular pharmaceutical companies (Greenberg, 2013). While initially content with identifying individual practitioners, in 2008,

Grassley targeted the association these individuals belonged to, the APA. In a letter to Jay Scully the CEO of the APA at that time, Grassley writes:

I have come to understand that money from the pharmaceutical industry can shape the practices of non-profit organisations which purport to be independent in their viewpoints and actions. Specifically, it is alleged that pharmaceutical companies give money to non-profits in an attempt to garner favor in ways that increase sales of their products. (cited in Greenberg, 2013, p. 88)

In addition, a further report conducted by psychologist, Lisa Cosgrove, identified that

In the DSM-IV Every member of the groups recommending changes for mood disorders and psychotic disorders had received drug money, and as Cosgrove pointed out, "Pharmaceutical companies have a vested interest in what mental disorders are included in the DSM." (Greenberg, 2013, p. 89)

These revelations led to a number of recommendations by the APA Board of Trustees to implement specific rules to cut down on potential conflicts of interest between DSM-5 task force members and outside interests. While these rules may have satisfied some of the more vocal critics (Greenberg, 2013), the reality is that the influence of pharmaceutical companies is so extensive that no one truly knows the scope of the industry's impact on the psychiatric profession, as its influence arises as a result of unconscious biases (Schafer, 2004). An example of this can be seen in the 'Healy Affair' of 2002, in which David Healy had been offered a joint role as Director of the Mood and Anxiety Disorders Clinic at the Centre for Addiction and Mental Health (CAMH) and within the University of Toronto's Department of Psychiatry (Coyne, 2005; Schafer, 2004). Shortly before starting his term with CAMH, Healy gave a talk to the "Looking Back, Looking Ahead" symposium presented by CAMH, which included comments about the drug, Prozac, manufactured by a company called Eli Lilly, and its potential impact on suicide risks among patients (Coyne, 2005; Schafer, 2004). Within a week of this conference, CAMH rescinded its offer to Healy, citing concerns regarding his fit with their clinical and research missions (Coyne, 2005), while also revealing that Eli Lilly had made

significant financial contributions to CAMH (Coyne, 2005; Schafer, 2004). While no reference was made by CAMH or the University of Toronto regarding these financial ties, nor was there any evidence that Eli Lilly had attempted to be involved in the decision not to hire David Healy, the timing of the incident does raise questions about whether those involved were influenced either consciously or subconsciously by their relationship with Eli Lilly (Schafer, 2004).

The influence of Big Pharma does not end with this example. Upon first glance, the incident with Healy may appear to be a case of an academic being railroaded by Big Pharma, however, further digging revealed that Healy himself had a conflict of interest in this matter (Coyne, 2005). The American Journal of Bioethics identified that Healy

had an undisclosed COI, in violation of established journal policies. Healy had been receiving money from at least one pharmaceutical company that had a financial interest in the issues being discussed. The editorial took these breaches as a wake-up call for a tightening of COI policies. (Coyne, 2005, p. W4)

Healy also later revealed that he had received sponsorship from a pharmaceutical company regarding the promotion of a different drug known as Reboxetine (a direct competitor to Prozac), and was also involved as an expert witness in many lawsuits directly against Eli Lilly (Coyne, 2005). This then leads to the question of whether Healy's talk at the CAMH symposium was something that he truly believed in, or was he influenced by other pharmaceutical companies as a result of his sponsorship and the impact losing their support would have had?

As shown in the 'Healy affair' and Frances' involvement as a 'Thought Leader,' the variety of influences wielded by Big Pharma means that professionals will always unconsciously favour these drug companies, especially considering the economics involved. Regarding this financial awareness, Gergen (2007) contends that

In an effort to reduce expenditures managed care has favored drugs over "talking cures" simply because it is more economical to dispense pills than pay for therapist time. By encouraging drug centered treatment, managed care programs also send a message to

therapeutic practitioners more generally: if you wish to sustain a practice supported by insurance programs, it is essentially to shift to drug centered treatments. (p. 162)

It is this desire to focus more on pharmaceutical remedies, rather than person-centred therapeutic based solutions (Frances, 2013a; Walker, 2016), that force psychiatrists and other mental health professionals to ignore the external factors (such as culture and environment) that influence an individual and focus solely on the ‘potential’ internal cause (Gergen, 1985; 2007). While this sounds unfair, it should be noted that at the 2010 APA annual convention, then President, Alan Schatzberg, was reported as responding to the loss of money from pharmaceutical companies to the APA’s Education Program with the statement, “There are a number of new drugs that have been recently released that many of us know little about and that cannot be good for either us or our patients” (Greenberg, 2013, p. 154). To Schatzberg, the concept of learning about new drugs and their impact from anyone other than the companies that make them is foreign, which leads Greenberg (2013) to sarcastically suggest that “Schatzberg couldn’t imagine another way for doctors to learn about new drugs other than from the sales forces of the companies that make them; perhaps he also buys his cars based on what his dealer tells him” (p. 154).

One further external influence that has begun to pressure and shape the DSM system within the United States is the existence of new and pre-existing nosologies. As noted earlier, since the launch of DSM-III, it has influenced the development of the ICD, which began to adopt similar structures and methodological principles (Demazeux, 2015; Gaines, 1992). However, in recent years, the ICD-11, which was published in 2018, began looking to dominate the face of the diagnostic landscape by becoming the global standard for diagnostic health information, with specific sections designated to diagnostic criteria (Blashfield et al., 2014). Not only was the ICD-11 developed in parallel with the DSM-5, many of those that worked on the DSM-5’s development also worked on the newly updated ICD-11 (Blashfield et al., 2014; Frances, 2013a,

Greenberg, 2013). It is important to note, however, that the codes used by the DSM-5 are within both the ICD-10 and -11, which means that clinicians do not need to purchase a copy of the DSM-5 or the ICD10/11, since the ICD is available for anyone to browse for free on their website (Greenberg, 2013). This fact alone threatens the DSM-5 and the APA's revenue, as currently, the DSM-5 retails for approximately \$200 (APA, 2019b).

Another contender against the DSM-5 comes from the National Institute of Mental Health's (NIMH) research division. The NIMH, which aided in several research projects connected to the DSM-5 (Blashfield et al., 2014; Frances, 2013; Greenberg, 2013), came out in 2013 and rejected the DSM-5 based on its lack of validity and stating that it was akin to a dictionary (Demazeux, 2015; Kirk et al., 2015). It then went on to state that it will re-orient its research away from the DSM-5 categories and focus on developing its own Research Domain Criteria (RDoC) (Blashfield et al., 2014; Frances, 2013a; Greenberg, 2013; Kirk et al., 2015). This program aims to move the field away from syndrome definitions towards an understanding of the causes (Blashfield et al., 2014). While there is significant work required for this program to become a reality, including waiting on more sophisticated techniques (Greenberg, 2013), the RDoC has a much stronger claim of being able to redefine how psychopathology is conceptualized compared to the current DSM-5 model (Blashfield et al., 2014). However, the APA claims that their structure is in alignment with the proposed RDoC (APA, 2013b), a claim which may be accurate but has yet to be tested due to its infancy.

Dominant Discourses

The following section provides an overview of the dominant discourses found in my analysis of the DSM-5. These are the discourses that hold prominent places of power within the DSM system and intertextually permeate the previous editions and supplemental literature from

organizations such as the APA and other supporters that surround and embody the DSM-5. The discourses that I have identified from my analysis include: Expertise, Medicalizing Normality, Conceptualization of Culture and Control. Within this section, I seek to identify the constituents of each of these discourses and illustrate their features using examples from the DSM-5 and supporting literature.

Expertise

The Diagnostic and Statistical Manual of Mental Disorders—or “DSM,” as it is generally called—is the authoritative guide to the diagnosis of mental disorders for health care professionals around the world. In the United States alone, it influences the care that millions of people of all ages receive for mental health issues. (APA, 2013c, para. 1)

With this opening paragraph, the APA begins the first of its DSM-5 fact sheets, which were published to promote and inform the public about this new publication. This discourse of expertise is prevalent throughout the field of psychiatric research and clinical practice (Walker, 2016). Foucault (1972) identifies that it is from this position of power that organizations can produce and disseminate significant knowledge as well as to validate or invalidate the work of others. Throughout the history of the DSM there has been a deliberate shift starting with the DSM-III to move the tone of the publication and psychiatric profession from that of the professor-driven model of the DSM-I and –II, to an expert-driven model which relies on the best clinical data available to researchers and to elevate the psychiatric profession (Demazeux, 2015; Gaines, 1992). While this has been the aim, the development of the DSM-5 has demonstrated that the best clinical data is often insufficient and unreliable (Demazeux, 2015; Frances, 2013a; Greenberg, 2013). As such, the DSM development team has had to continue to rely on the clinical judgement of their task force members to make critical decisions regarding what needs to be included in each updated edition (Greenberg, 2013). Despite these challenges, language is used within the DSM-5 to elevate the status of the development process to reflect their expertise.

For example, in looking at the composition of the DSM-5 workgroups, we are informed that "These innovations were designed by the leading authorities on mental disorders in the world and were implemented on the basis of their expert review, public commentary, and independent peer review" (APA, 2013b, p. xliii). This sentiment is also reflected in the DSM-5 Fact Sheet (APA, 2013d), 'The People Behind the DSM-5,' which highlights how "The Work Group members represent more than 90 academic and mental health institutions throughout the world" (para. 4). However, it is only upon reading further that we see that of these 'world-renowned' individuals, only 30% of them were located internationally, and nearly all of the task force chairs and those in leadership positions were American. This analysis is not to take away from the clinical, academic and professional accomplishments and knowledge of these individuals, but rather, highlights the concern that this publication reinforces Western cultural constructions that have been present throughout the development of the DSM system (Gaines, 1992).

In looking at how the DSM-5 reproduces power and knowledge, we can see it quite clearly through both the education system and insurance industry. In the U.S., for example, we have seen that

Psychological and psychiatric 'expertise' has inspired panic in adults about childhood, predicting catastrophe from the slightest parental 'mistake.' It has cultivated a belief in the ability to know, understand, predict the course that 'normal childhood' should take. It is this claim that has been found wanting, understandably leaving lay adults bewildered. (Coppock, 1997, p. 164)

This sets the course to cause parents to believe that any deviation from this societal norm means that something is wrong with their child, who is then in need of fixing. From this point, where the parents seek help defines, in part, what type of help the individual receives, either in terms of clinical/pharmaceutical treatment or through specific educational programs (Frances, 2013a). However, in order for these supports to be provided, a diagnosis needs to be made either from a

psychiatrist/clinician or educational psychologist and the appropriate DSM-5 codes need to be provided either to the insurance company for the clinician's own financial remittance or to the school board for approval to participate within the program (Frances, 2013a; Paris, 2015). As noted earlier, the actual diagnosis does not seem to be all that relevant to the administrative process; it is the codes themselves that hold value (Greenberg, 2013). Gary Greenberg (2103) admits that even as a practicing psychotherapist, he rarely uses the DSM, having already memorized the codes that he needs to provide to his insurance company, and that this practice is widespread, with the DSM becoming an administrative tool for clinicians to use for financial reasons as opposed to treatment (Tsou, 2015). As such, clinicians, looking to ensure their clients receive the treatment that they need, have to follow the rules developed in cooperation between insurance companies, the psychiatric and mental health profession and governments. It also means that, for some clinicians, their hands are tied on what types of treatment protocols can be delivered based on what treatments the insurance companies are willing to pay for. This failure to accept alternative processes has led to an absolutism within the psychiatric and mental health profession that seeks to push a single narrative of what is acceptable and unacceptable, what is normal and abnormal (Coppock, 1997; Gergen, 2007), which does not reflect the majority of those being assessed. This narrative is then utilized and reframed by politicians and governments to draft mental health legislation, initiatives and bureaucracies (Moss & Petrie, 2005) to help the public with their mental wellness through both the provision of care and deprivation of liberty (Kelly, 2015). As noted earlier, the actual diagnosis does not seem to be all that relevant to the process, in terms of the insurance companies, educational institutes, courts and policymakers – it is the codes and language within the DSM that holds the value to the process (Greenberg, 2013, Brown, 2015).

Medicalizing Normality

Throughout the 20th Century, there have been concerns surrounding the threat of mental illness, its impact on the self and others (Gaines, 1992), family dynamics (Hendrick, 1997) and society at large (Kelly, 2015). From a human perspective, it is more natural to think of mental illness in medical terms, as it provides the individual with a reason for what is wrong, such as a genetic or physical issue, as opposed to something fundamentally wrong with the self (Gaines, 1992; Walker, 2016). As such, throughout most of Western history we can see that there has been a need to treat mental illnesses and disorders like how one would treat a broken bone or sprained ankle (Frances, 2013a; Kelly, 2015; Walker, 2016; Young, 2010). The DSM-5 supports this narrative, as it supports the language of medicalizing mental disorders by constructing them as specific illnesses – even though little evidence has been found to support physical causes (Greenberg, 2013; Moss & Petrie, 2005; Walker 2016). For example, the DSM-5’s explanation for development and lifespan considerations highlights how

The organizational structure of the DSM-5...is designed to provide better and more flexible diagnostic concepts for the next epoch of research and to serve as a useful guide to clinicians in explaining to patients why they might have received multiple diagnoses or why they might have received additional or altered diagnoses over their lifespan (APA, 2013b, p. 13).

No consideration is given here to the potential that the patient may have received a misdiagnosis, been over-diagnosed or that they are operating within the realms of their own normality. This lack of consideration is primarily due to, as Kirk et al. (2015) discuss in their chapter on the demise of descriptive diagnosis,

Psychiatry’s inability to define mental disorder coherently continues in the DSM-5, where each disorder is still defined by its “diagnostic criteria,” the checklists of behaviors, emotions and cognitions—devoid of any contextual elements, as if they were objective signs of bodily dysfunctions. (p. 66)

Not only does the language used within the DSM-5 highlight the evidence-based, medical-model nature of the psychiatric and mental health profession and of the document, it is also potent and pervasive (Kirk et al., 2015), and has become a part of public everyday language and collective knowledge. As Kenneth Gergen (2007) discusses in his reflections on the ‘self’,

Terms such as split personality, identity crisis, PMS (premenstrual syndrome), attention deficit disorder and post-traumatic stress also enjoy a high degree of popularity. And, as such terms make their way into the cultural vernacular, they become available for the construction of everyday reality. Veronica is not simply "too fat;" she has "obese eating habits;" Robert doesn't simply "hate gays," but is "homophobic;" and so on. (p. 159)

Despite the pervasiveness of this language within societies collective knowledge, this labelling seeks to only serve the interests of clinicians and their profession (Khoury et al., 2014), and yet has a significant impact on the patient. However, as Psychologist Michael Walker (2016) highlights,

In the medical context, the label or (diagnosis) is the cause of the co-occurring states and behaviours (called symptoms). The problem is that - as the makers of the DSM readily admit – using the most sophisticated equipment available no identifiable and measurable "gene or neurotransmitter or circuitry explanation" for any of the "diagnoses" has ever been identified. (p. xxiii)

In introducing the text through the lens of an ‘evidence-based,’ ‘scientifically-rigorous’ and ‘expert-driven’ development process, the DSM-5 hides both its clinical and scientific limitations from the reader, promoting instead, an absolutist approach to individuals diagnoses which can minimize or deny external factors that impact an individual’s mental including the environment, social factors and culture.

Conceptualization of Culture

According to Attwood Gaines, all medical knowledge, including psychiatry and so-called ethnopsychiatric knowledge, represents culturally constructed systems, characteristically imperfect and contradictory. Culture is something that is ‘constructed through invention, borrowing and recombination’ something that is not necessarily homogenous and integrated. (cited in Waldram, 2004, p.12)

Based on the above passage we would expect that a publication such as the DSM-5, which presents itself as a universal classification system, would display greater openness to the concept of culture within its pages. Indeed, the 'Cultural Concepts in DSM-5' Fact Sheet, produced by the APA in 2013, seemed to demonstrate the efforts of the APA to develop a greater sense of cultural sensitivity. Unfortunately, while it has made some gains compared to its predecessors, it is still very much rooted in cultural biases displayed in most of the Western psychiatric traditions (Waldram, 2004; Murphy, 2015; Walker, 2016). When looking at how the DSM-5 handles cultural diversity, we can see that it focuses most of the text for diagnostics that occur within the West, while the rest of the world is relegated to a special appendix (Murphy, 2015). These Western diagnostics are also the ones that are perceived as universal, appearing across a myriad of cultures (Frances, 2013a; Murphy, 2015). This assumption is a concern, as disorders such as Avoidant / Restrictive Food Intake Disorder are noted within the DSM-5 as occurring solely within the U.S., Canada, Australia and Europe (APA, 2013). While there exists some variation, it would be expected that there would be a much higher appearance of this disorder across multiple countries and cultures before being considered 'universal' (Murphy, 2015). The above information regarding Avoidant / Restrictive Food Intake Disorder can be found within a small section entitled, "culture-related diagnostic issues". This section, which is seen in several diagnosis, seem to focus more on information from other countries as opposed to specific cultures. For example, in discussing Major Depressive Disorder, the DSM-5 devotes eight pages of text to the criteria and features of the disorder. There is only a small section regarding culture, a short paragraph indicating that in other countries (i.e. non-U.S.) that this disorder goes unrecognized (APA, 2013b). In looking at Alcohol Use Disorder, the Culture Related section focuses on specific morbidity rates and alcohol use statistics, as well as details regarding gene

variations (APA, 2013b). Nowhere in either of these examples does it discuss why certain cultures (particularly within the U.S.) are more prone to depressive disorders or alcohol usage.

The issue at hand is that throughout the DSM-5, the material is presented within a specific standard of normality, which is a concern because the standard presented is WEIRD: Western, Educated, Industrialized, Rich and Democratic (Murphy, 2015). As such, the majority of diagnoses provided within the DSM-5 are not presented as a cultural issue because the Western model is not considered a separate culture (Gaines, 1992; Murphy, 2015). Where specific cultural influences exist, the DSM presents them either towards the end of its publication within a section on culture-bound syndromes (APA, 2013b) or relegates them to a secondary symptom. An example of this can be found in the diagnosis of panic attacks. Regarding the cultural changes made to the new DSM-5 model, the Cultural Concepts Fact Sheet highlights how

uncontrollable crying and headaches are symptoms of panic attacks in some cultures, while difficulty breathing may be the primary symptom in other cultures. Understanding such distinctions will help clinicians more accurately diagnose problems as well as more effectively treat them. (APA, 2013a, para. 2)

However, within the updated DSM-5 (APA, 2013b), the following is recorded regarding symptoms connected to panic attacks: "Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms" (p. 208). The issue presented here is that within this section, the cultural expression of uncontrollable crying is relegated to a secondary symptom that has no influence – according to the DSM-5 – on the diagnosis presented, despite being highlighted elsewhere as a primary symptom. A further problem presents itself in that the WEIRD acronym does not even represent the average American seen or treated by a mental health professional `using` the DSM-5 and, as such, can cause more harm to the individual (Khoury et al., 2014). It

also speaks to the fact that while the individual has the best insight as to what kind of life they wish to have and what is genuinely troubling them, the DSM-5 seems to minimize this perspective (Khoury et al., 2014; Gergen, 2007; Poland, 2014).

One of the DSM-5's most prominent critics, Allen Frances (2013a), is surprisingly silent about the issue of culture and the DSM, presumably because he has been practicing in Western psychiatry for over 35 years. According to his texts, mental disorders present pretty much the same way universally and so there is no need for each culture to have their diagnostic system as while surface presentations may vary, humans are similar enough across the board when it comes to mental disorders (Frances, 2013a). He continues to say that

In diagnosing and treating, it is crucial to be sensitive to cultural differences, but they are not so distinct as to require different diagnostic systems for different parts of the world. Across the board, humans are alike enough genetically and culturally that one diagnostic system (either DSM or ICD) is elastic enough to fit all the possibilities. (p. 23)

Nevertheless, the issue at stake here is that if the diagnostic manual being used is not sensitive to these differences, then it presents itself as an implicit standard of normality that classifies all others as deviant (Gaines, 1992, Murphy, 2015). The DSM-5 has expanded on the work of cultural formation from the DSM-IV, to include 'cultural concepts of distress' (APA, 2013b; Murphy, 2015). At this stage, there is little evidence of how this will influence the nature of culture within the field of psychiatry, as culture is still treated as a passing thought to the diagnostic model. This is of concern, as Waldram (2004) in his book, 'Revenge of the Windigo,' cautions,

The windigo's revenge is not its return to eat us in the embodied sense, but rather the persistence and tenacity with which we cling to ill-conceived ideas as truths, the ways in which we are consumed by the very knowledge that we trust to guide us. (p. 320)

The question we must then ask is, does the knowledge within the DSM-5 seek to guide or control individuals?

Control

As noted earlier with Foucauldian notions of power and knowledge, power involves control by members of one group over those within another (Foucault et al., 2001; van Dijk, 1993). One such focus of control by the APA is in their commitment to the process of diagnostic classifications. While in the DSM-5, in the section on ‘Harmonization with ICD-11’, there is support for harmonization of systems due to how

The existence of two major classifications of mental disorders hinders the collection and use of National Health statistics, the design of clinical trials aimed at developing new treatments, and the consideration of global applicability of the results by international regulatory agencies. (APA, 2013b, p. 11)

This new harmonization process is a departure from previous editions that showcased the DSM-IV as an empirically grounded manual (APA, 2000) and, consequently, more beneficial to clinical practice. However, when one considers the financial and professional interests that the APA has in terms of perpetuating the DSM system to its tens of thousands of members, we can see that there is a significant conflict of interest with regard to any changes that could endanger these interests (Poland, 2014). Kirk et al. (2015) highlight how

The “bible” remains an appropriate moniker for the modern DSMs, suggesting beliefs that need no roots in rationality or science. Bio-psychiatry grips its bible tightly, “on faith alone” more so in times of trouble, inspiring renewed resolve among the psychiatric priesthood and acquiescence among the public. (p. 76)

Within the DSM-5, we can also see that any issues connected to “principled disagreements” with the ICD-11 were “settled with the preponderance of evidence (most notably validators *approved* by the DSM-5 Task Force” (p. 11, *emphasis mine*). While not influenced by the APA, when we also consider the delayed launch of the ICD-11 from mid-2012 to late 2018, this has also provided the DSM-5 and the APA with the time and opportunity to cement their position as the experts of this updated classification system, a title they aim to maintain.

The average person sitting in a clinician's office is not aware of any of this. All they know is that they and their family members are relying on an expert to translate the terms being talked about with regard to their diagnosis. This reliance on the expert is due to the vocabulary used within the DSM-5, along with other medical texts, which creates a barrier that forces the patient to rely on an expert to bridge (Khoury et al., 2014; Coppock, 1997). This expert-driven model is also one that seeks to (covertly) control not just the narrative of the diagnosis, but also the individual through defined power dynamics, which place the `expert` mental health professional above the patient (Khoury et al., 2014; Mitchell, 2003; Moss & Petrie, 2005). This power relation was observed by Michel Foucault, who noted how it occurs within specific institutions and marginalizes individuals not out of malice, but out of ease of use and tradition (Moss & Petrie, 2005). Further to this, Mitchell (2003) identifies that children are expressly marginalized by this particular approach as there is a long tradition of children's voices not being heard within the field of mental health treatment. He goes on to argue "that the pervasive stance in children's mental health is based upon expert-driven, top-down theoretical views" (p. 288), which he identifies as a constant in his practical experience in the field. A key driver of this appears to be what Kluft (2015) identifies as the 'desire to do good', a desire that promotes the voice of the `expert` and insulates the parents from blame. The British Sociologist Vicki Coppock (1997), who is an expert in the field of childhood notes how this

'Expert' control distances parents and children through the use of technical jargon, a vocabulary which confuses and often predetermines outcomes through a subscription to categories or disease models. For parents the model has attractions in that they can feel relief at receiving an explanation for their child's behaviour which absolves them of the charge of 'bad parent'. For professionals the model allows them to be 'caring' while also repressing deviance, through the provision of help or treatment. (p. 155)

Not only does the professional in this model demonstrate 'caring', but the expert-driven language throughout this process also helps to promote the health/disease binary of mental health as well

as the establishment of the professional as the one who `knows best` (LeFrancois & Coppock, 2014). Walker (2016), in looking at this relationship, connects this to the DSM-5 and shares how by “Divesting the Diagnostic and Statistical Manual (DSM) of its truth status, we can see more clearly how the psychiatric vocabulary defines and marginalizes people as well as asserting role and power relations between them” (p. 87). In this situation, the patient, already made to feel inferior because of the process and labelled with something that they potentially have difficulty understanding, now must wait on the decision of others to determine whether they will receive the help that they need moving forward (Frances, 2013a). Such a situation does little to recognize or respect the dignity of the individual sitting across from the professional and, instead, can increase the marginalization they feel based on the diagnosis received (Walker, 2016).

DSM-5 vs Human Dignity

These feeling surrounding marginalization comes from how the “true impact in the diagnostic system is not in the words as written, it's in the way words come to be used” (Frances, 2013a, p. 139). As soon as the diagnosis is made, especially when no effort is made to understand the individual's situation or culture (Murphy, 2015), significant harm can be inflicted on the individual through both the marginalization of themselves and their situation as well as through the stigmatization they will experience throughout their life as a result of the diagnosis (Frances, 2013a; Waldram, 2004). The use of the DSM-5's one-size-fits-all vocabulary (Walker, 2016) can cause people to be placed within a box, defined by the diagnosis that they receive, that they now must live their lives within. This restrictive diagnosis fundamentally impacts how they and others see themselves, their experiences and, ultimately, their potential recovery (Demazeux, 2015; Frances, 2013a; Walker, 2016).

Despite the statements included within the DSM-5 regarding its aim to help reduce stigma (APA, 2013b), the DSM-5, with its use of absolutes, does surprisingly little to achieve this (Khoury et al., 2014). In fairness, as a guide to clinicians and researchers, the reduction of stigma is not one of its primary goals, but considering that many medical and psychological organizations stress the importance of the individual/patient within their mission and values, including the APA (2019a), an opportunity has been missed within the DSM-5 to address this area. Unfortunately, the fact that this was not addressed is not unsurprising. Both Kelly (2015) and Walker (2016) have identified that the issues of patient dignity and stigma have only been superficially discussed by governments and the psychiatric profession as a whole. Meanwhile, in fields where dignity has never really been a concern, such as business and leadership development, it is steadily gaining traction (Hicks, 2011). It has been demonstrated that if the patient is seen as an active participant in their treatment, a greater sense of agency is attached to that individual, which strengthens the rights that they possess along with their dignity (Kelly, 2015; Levine, 2015b; Prout & James, 1997). Within the U.S., this rights-based model has not flourished (LeFrancois & Coppock, 2014; Mitchell, 2003) primarily because of the power dynamics at play within the psychiatric profession. While the patient should be respected as an individual, they are still the patient, and as such, are beneath that of the `expert` and so have their role to fill (Kelly, 2015; Levine, 2015b). It has, in part, become the role of the DSM-5 to help assert this role of the patient by including language that can minimize their experiences, trivialize the lack of support they face, and focus primarily on what is wrong (Khoury et al., 2014; Walker, 2016). Basically, the individual is reduced from a person to an object (Frances, 2013a; Mitchell, 2003; Moss & Petrie, 2005) and is placed in a position of submission to the professional who

can, in theory, cause them to lose their original identity and begin to identify solely with their disorder (Walker, 2016). Mitchell (2003), in his critique of the DSM-IV, highlights that

The whole notion that young people's most distressing behaviours may only be interpreted only as 'disordered' seems untenable when examined critically. In fact, the DSM-IV-R's 'common language' has been translated through use of deterministic theories that view young people as objects and not subjects, as non-competent rather than competent, and as adults-in-miniature rather than citizens in their own right. (p. 284)

While a number of critics and governments have called for changes to this style of 'common language' and treatment, which also aligns with those developed by the World Health Organization (Kelly, 2015), there are also a considerable number of mental health and psychiatric professionals who call for a more comprehensive rights-based approach to clinical treatment and language (LeFrancois & Coppock, 2014; Levine, 2015a; Mitchell 2003; Walker, 2016). The APA has yet to implement such changes, and for now, the DSM-5 continues to perpetuate the creation and subjectification of the patient.

In addition to the harm that can be inflicted to an individual's personal dignity, it is worth noting that, on a systemic level, the DSM system propagates discrimination against a variety of social and cultural groups, with its strict normative discourse that has both a gendered and age bias (Gaines, 1992). In 1968, when the DSM-II was launched, homosexuality was considered to be a mental disorder. In 1973, this classification had been removed and replaced with the category, 'Ego-dystonic sexuality,' as a result of pressure from activist groups (Brown, 2015; Cooper, 2015; Frances, 2013a; Greenburg, 2013; Spitzer, 1981). This category split LGBTQ2+ people as dealing with either ego-syntonic or ego-alien homosexuality, with those being classified as ego-alien requiring treatment (Spitzer, 1981). This compromise left both sides with bad feelings, but Robert Spitzer, who negotiated it, knew that, at the time, psychiatry was still regarded as bogus in many areas and needed public support (Frances, 2013a). In 1980, when the

DSM-III was launched, the homosexuality debate continued (Spitzer, 1981) and it wasn't until the first revision to the DSM-III in 1987 that this concept of Ego-dystonic sexuality was removed entirely and those who were left conflicted about their sexuality could receive treatment under the category of Sexual Disorder Not Otherwise Specified (Greenberg, 2013). More recently, the classification of Asperger's syndrome within the DSM-IV to the subsequent and reclassification within the DSM-5 has prompted similar pressure from activist groups, although no changes have yet to be made to this classification (Bagatell, 2007). These are but two areas where the line between what is considered to be normal and abnormal in terms of mental health has shifted over the years, causing harm, humiliation and the loss of identity and dignity to thousands of individuals.

Further to this, the DSM-5 focuses mostly on the limitations of the patient without considering their abilities or resilience (Khoury et al., 2014). Women, in particular, are amongst those most likely to be dismissed when presenting symptoms – especially women of colour and from other cultures – and are more likely to be inappropriately prescribed a variety of medication (Frances, 2013a; LeFrancois & Coppock, 2014). It is this piece where children, especially girls, are considerably overlooked and where culture can play a large part in understanding exactly where their strengths lie (Prout & James, 1997; Hendrick, 1997). Waldram (2004), in looking at the field of psychiatry within North America, discusses how

Textbooks are filled with conclusions about human behaviour that have been based on assumptions, methods, and subject samples that are culturally biased and do not reflect the spectrum of existing human variations, especially within a culturally pluralistic society such as North America. (p. 3)

In taking a singular intrapersonal definition of mental health, framed within a medical context, the DSM minimizes the role of external factors on the individual, such as their culture, environment, and place within society (Khoury et al., 2014). In looking at how children are

treated, it should be recognized that the patient, but especially the child, must be active in the determination of their lives (Prout & James, 1997; Mitchell, 2003) and that the current model within the DSM, including the DSM-5, as an export-driven model does nothing but reduce children to objects that need to be fixed by the system (Mitchell, 2003; Moss & Petrie, 2005; Frances, 2013a).

Chapter 6: Discussion

The findings of this analysis, guided by social constructionist and Foucauldian approaches, have located four discourses that continue to be perpetuated in the DSM system and, most notably, the focus of this inquiry, the DSM-5. These discourses are, firstly, used by the publishers of the DSM-5, the APA, to continue to establish their expertise within the mental health field within the United States and, indeed, globally and be seen as the 'go-to' manual for clinicians and researchers (Frances, 2013a). Secondly, the DSM continues to increase the number of diagnoses that exist within the DSM system over past editions, causing a narrative that can lead to the medicalization of ordinary life and behaviours. Next, the DSM system promotes a narrative that denigrates and minimizes the impact of culture on a person's journey or diagnosis. Finally, the DSM-5 and the DSM system as a whole enforces a rigid set of controls across the psychiatric profession and emboldens the power relations that exist between patients and clinicians. The purpose of nosology and other classification systems within the psychiatric and mental health field has always been to help clinicians and researchers develop a reference system that can aid them in their practices. American Mental Health Counsellor, Jason King (2013b), further builds on this description in his article, 'The DSM-5 does not make Diagnoses,' from quoting the following from the DSM-IV:

“The specific diagnostic criteria included in the DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion”

(emphasis added). Furthermore, “a common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. (p. 21)

However, while this may be the intent, as noted above, in practice, the opposite takes place where individuals do not see the classification as a disorder that they *have*, but that they *are*, for example, schizophrenia (Frances, 2013a; Walker, 2016). Each of these discourses has an impact on those that they seek to serve and help. From the clinician’s perspective, the DSM system pigeon-holes them into providing a set code for a set treatment, depending on what is available through the insurance companies, so that they can a) provide treatment and b) be paid (Frances, 2013b; Gergen, 2007; Greenberg, 2013; Tsou, 2015). From the patient’s perspective, while they have much easier access to the DSM-5 through legal and illegal means, the language is still above many of them and requires the use of an ‘expert’ to decode it for them and to help them understand what impact this will have on their lives (Walker, 2016).

Looking to the Future: The DSM-6?

Since its launch in 2013, the DSM-5 has already received two supplemental updates, the first in 2016 and the second in 2017. Currently, these updates fall into two distinct categories, with the first being focused on the co-listing of DSM-5 diagnosis against the new ICD-10-CM codes that have to be implemented within the United States for coding purposes. These codes were initially cross-listed in the original version of the DSM-5, however, at the time, they were operating on the best information at hand and knew that updates were to take place. The second focus of these updates is to reflect changes to the diagnostic criteria. While these updates are an established part of any significant publication, what we see here is different from previous editions, which provided a full update of the text (i.e. DSM-III-R). Instead, the APA is rolling out specific ‘supplemental updates’ with these minor changes in an attempt to incorporate new

knowledge as it emerges. What this means for the next version of the DSM, the DSM-6, is unclear. On its website, the APA (2019b) shares the following information:

Since the research base of mental disorders is evolving at different rates for different disorders, diagnostic guidelines will not be tied to static publication dates but rather to scientific advances. These incremental updates will be identified with decimals, i.e. *DSM-5.1*, *DSM-5.2* until a new edition is required. (para. 8)

This is the same phrasing that has been used in several previous APA publications, including the version of the DSM-5 that was published in 2013. Based on this and the fact that the APA website is currently seeking proposals for changes to the DSM-5, it leads clinicians and researchers to believe that the current 'continuous improvement' model, utilizing digital supplements, seems to be the favoured approach. While from a technical perspective, this will help to provide quicker updates, based on any margining scientific knowledge, it does little to address the discourses currently made by the DSM-5, which can only be tackled by a complete revision of the text as a whole. The idea of a new revision of the DSM system comes across as an outdated approach, as far as the APA is concerned, with regards to keeping current with new scientific updates. It is an approach which many critics argue will help to facilitate significant change within the field of nosology.

Limitations & Next Steps

While this Foucauldian-informed discourse perspective of the DSM-5 provides those within the mental health field an understanding of how specific discourses have an impact on both the psychiatric and mental health profession and the clients that it purports to serve, it is by no means a complete study of the impact of how these different systems of discourse are produced through language and semantics. What this research does achieve, is to draw attention to some of the nuanced critiques surrounding this publication, challenging its place of power within the field and the public consciousness. This work also establishes a framework for future

analyses of the impact of the DSM system within the field. In terms of the limitations of this study, I did not include a specific breakdown of words and phrases within the DSM-5, compared to previous editions. As such, this study is unable to inform, beyond general terms, how specific discourses have evolved semantically within the text itself. Additionally, although this study contributes to a theoretically informed, discourse-based analysis of the DSM system in general, it was not grounded within the current local/Canadian social climate and the issues of marginalized social groups that connect with and rely on psychologists/psychiatrists or other mental health professionals. However, for future research prospects, these would make for excellent additions to the literature surrounding the DSM-5.

Conclusion

A central premise of Foucauldian theory is its understanding that discourses are socially situated structures of knowledge that are organized around the functions of control and exclusion (Foucault, 1972; Mills, 2004). Within the DSM-5, we have seen an attempt to make this particular text out to be a scientifically reliable resource that clinicians and researchers can use to optimize their practices. However, not only does the existing literature and data from multiple sources demonstrate severe concerns regarding the reliability and validity of the diagnostic categories, even those involved in the funding and research of these criteria question these issues (Greenberg, 2013; Poland, 2015). More telling is how, despite undergoing two supposed paradigm shifts in its history, the DSM-5 continues to propagate social, cultural, political and disciplinary frameworks and stereotypes within its pages, calling into question its so-called authoritative stance. These frameworks, despite their intended use, to aid clinicians and researchers with their work, instead, continue to disrupt the dignity of the patients they seek to serve. Ultimately, when looking at whom the DSM-5 serves the most, it is not the patient, but the

psychiatric profession and, in particular, the APA, that, time and again, continues to have its best interests at the forefront in the creation, publication and dissemination of the DSM. Despite this, due to its current popularity within the U.S. and the mental health profession, this publication will continue to shape how mental health is approached, until the APA, in a hope to discover the truth, once again reconstructs and redefines what mental illness and disorders look like from person to person.

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