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Stalling or Oiling the Engines of Diagnosis? Shifting Perspectives on the DSM and Categorical Diagnosis in Psychiatry

Abstract

Diagnosis in psychiatry and its precursors has long attracted debate and dissent. Attempts to discipline professional praxis are associated especially with the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM). In this article, I explore how social actors with the institutional power to contribute in important ways to shaping psychiatric contexts construct the problems with and purposes of the DSM and of diagnosis in psychiatry. I suggest that despite common assumptions that influential psychiatrists and related stakeholders uncritically adopt the DSM and other tools of categorical diagnosis, their relationship with these is rather more nuanced, ambivalent, and even fraught. However, I will also show that critiques can themselves be folded into styles of psychiatric thought in ways that do little to impact wider concerns about biomedicalisation and pharmaceuticalisation - and might even further accelerate these processes. Moreover, since professional critiques of the DSM often underscore its ubiquity and entrenchment, when positioned against implicit or explicit justifications of the ongoing use of this text they might inadvertently contribute to a 'discourse of inevitability' - acting to 'oil' rather than 'stall' what Annemarie Jutel terms the 'engines of diagnosis'.

Introduction

Diagnosis in psychiatry has long attracted debate, dissent, and sometimes derision. What diagnostic categories might properly refer to, and what are deemed to 'cause' purported psychopathologies vary greatly over time and across space (Berrios, 1996; Halpin, 2022; Pickersgill, 2014). This heterogeneity is commonly regarded as problematic, with successive attempts at diagnostic calibration and unification made using what Timmermans and Berg (2003) call terminological standards.

The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) is one such standard. Traditionally, this has focused on enhancing the 'reliability' of diagnosis (Kutchins and Kirk, 1992). Still, considerable variation remains regarding how the nature, prognosis, and interventional strategies for codified disorders are conceived,

with clinicians at times creatively reworking diagnostic categories (Whooley, 2010). This variance both reflects and contributes to longstanding professional eclecticism within psychiatry (Baruch and Treacher, 1978; Sadowsky, 2005).

Today, concerns reverberate widely that the DSM – indeed, the wider project of categorical diagnosis itself – might no longer be fit for purpose. These manifest, for example, in encouragements to focus on symptoms rather than disorders in research (Insel, 2013; Kotov et al, 2021), and to move therapeutic orientations towards narrative and milieu and away from labels and categories (Johnstone et al, 2018). Some participants in these debates are firm in their position that the reign of the DSM is over.

In this article, I explore how social actors with the institutional power to contribute in important ways to shaping psychiatric contexts construct the problems with and purposes of the DSM and of diagnosis in psychiatry. I show how, despite common assumptions that influential psychiatrists and related stakeholders uncritically adopt the DSM and other tools of categorical diagnosis, relationships with these are rather more nuanced, ambivalent, and even fraught. However, critiques can themselves be folded into styles of psychiatric thought in ways that do little to impact wider concerns about biomedicalisation and pharmaceuticalisation - and might even further accelerate them. Moreover, since professional critiques of the DSM often underscore its ubiquity and entrenchment, when positioned against implicit or explicit justifications of the ongoing use of this text they might contribute to a ‘discourse of inevitability’ (Leonardi, 2008; Pickersgill, 2019), and so act to ‘oil’ rather than ‘stall’ the “engines of diagnosis” (Jutel, 2009: 21).

Diagnosis and its Engines

Diagnosis is central to much of biomedical praxis (Blaxter, 1978; Brown, 1995; Jutel, 2011). Instantiated often as a ‘dance’ between patient and clinician (Hobson-West and Jutel, 2020), it relies both on terminological standards - such as the DSM and the ICD (the World Health Organization’s International Classification of Diseases) – and on more informal idioms and practices. In the realm of mental health, for instance, a range of ‘sub-types’ of depression can exist, that escape formal recognition and standardisation, but which nevertheless play a role in choreographies of care (McPherson and Armstrong, 2006).

Diagnosis plays a communicative and stabilising role in constituting assemblages of global and local epistemic practices, therapeutic regimes, and professional and personal experiences of bodies and subjectivities. Power operates diversely through such assemblages, mediating and moderating what diagnoses are and what ends they are leveraged. Often deeply political constructs (Pickersgill, 2012; Scott, 1990), diagnostic categories can be assembled through gendered and other norms which inform their applications (Figert, 1996; Lane, 2007). Accordingly, diagnoses can also contribute to processes of racialisation (Kapadia, in press) and criminalisation (McBride, 2017).

Given the normative dimensions of diagnosis (Lane, 2020), critical attention to their endurance and proliferation is vital. Following Conrad's (2005) work on the 'engines of medicalization', Jutel (2009: 21) introduced the phrase 'engines of diagnosis' to characterise that which powers "the creation or maintenance of specific diagnoses" (ibid). Jutel (2009, 2011) has underscored the role of the pharmaceutical industry as such an engine, alongside other industries; for instance, those concerned with weight-loss. These function in some countries, like the US, against the backdrop of private insurance which can act to 'fuel' (cf. Bell, 2017) engines of diagnosis by encouraging the administration of certain diagnostic categories and associated treatments over others (Ebeling, 2014).

Jutel (2011: 101) further underscores the linkages between epistemological and ontological agendas in promoting diagnoses: "Research teams, normally with – but sometimes without – commercial funding, are built around both legitimate and contested diseases". We can see, then, that some elements of psychiatric science itself represent one kind of engine of diagnosis. This characterisation recognises that some within psychiatry have professional interests in the continuance, and sometimes even expansion, of categorical diagnoses, even while – as we will see – others propel criticism of the DSM. Engines, I suggest, are not necessarily clearcut, and can be regarded as acting synecdochally. For instance, normative conventions for reporting studies in psychiatry through the terminology of the DSM might serve as engine of diagnosis within mental health research, while - to return to Jutel's (2011) point - the expansion of research could collectively be regarded as an engine in other contexts (e.g., social policy).

The DSM

The DSM is surely the most famous of terminological standards in mental health. First published

1952, a second edition, DSM-II, was released in 1968. The arrival of DSM-III in 1980, however, profoundly recast how the manual was regarded within US psychiatry (Mayes and Horwitz, 2005). Many aspects of its development were hotly contested (Decker, 2013; Schnittker, 2017); for instance, in relation to homosexuality (Bayer, 1981; Kutchins and Kirk, 1997). Such contestation helped to fix professional attention upon the DSM-III. Containing many more categories than its predecessor, and a reworked apparatus for ontologising these via specific criteria rather than a more narrative format, the DSM-III was big news. It also represented, as an expensive professional manual, big business for the APA (Kirk and Kutchins, 1992, Lee, 1999).

Even within countries that relied principally on the World Health Organization's (WHO) International Classification of Disease (ICD), such as the UK, the contents and logics of the DSM have shaped debate about the principals and trajectories of psychiatric research and practice (Halpin, 2016; Pickersgill, 2014). As the DSM was further revised as DSM-III-R (1987), and then DSM-IV (1994) and DSM-IV-TR (2000), both its length and influence grew. The attention garnered by the publication of the 2013 DSM-5, and its subsequent 2022 text amendments (DSM-5-TR), implied that for the APA, the DSM - and the broader project of categorical diagnosis - was not going anywhere.

Yet, as noted, the DSM attracts considerable controversy. It is critiqued, for instance, for encouraging conceptions of subjectivity, pathology, and care that focus on individuals over populations, and medicine over psychological or social interventions - underscoring the imbrication of the DSM in processes of (bio)medicalisation and pharmaceuticalisation (Conrad and Schneider, 1992; Crespo Suárez and Machin Suárez, 2021; Healy, 2004; Jutel, 2010; Lee, 1999; Lurhmann, 2000). The DSM is commonly seen as shaping a form of practice that reduces complex experience to a checklist which in turn determines particular modes of intervention, often resulting in the application of drugs.

While criticisms of the DSM are often associated with so-called 'anti-psychiatry', many psychiatrists themselves are also critics - as they are of their profession more widely (Callard, 2014). Clinicians can, for instance, operate with considerable 'diagnostic ambivalence' (Whooley, 2010) about whether and how to employ DSM categorisations and the treatments with which they are associated (Smith, 2014; Rafalovich, 2005). Over the last decade or so, internal critique in psychiatry has often targeted the problems of the DSM in relation to innovation and drug discovery (Pickersgill, 2019). Questions circulate about whether the categories contained within

the DSM remain appropriate frameworks for research – which as described above has itself been an engine of diagnosis. A common refrain in this regard is that the deficit of new psychopharmaceuticals being brought to market is a direct result of an over-reliance on the DSM.

Such views align with those expressed by officials in the US National Institute of Mental Health (NIMH), as well as many other researchers. In 2013 the then Director of the NIMH, Thomas Insel (2013), argued forcefully the DSM was no longer fit for purpose in research. Instead, the NIMH ‘Research Domain Criteria’ (RDoC) should be used as a framework for interrogating the biological and psychological dimensions of specific symptoms of mental ill-health. A “research classification system” (Cuthbert and Insel, 2013: 2), RDoC refuses to “take as a starting point the traditional view of disorders as symptom complexes based largely on clinical descriptions” (ibid, 4). Rather, it is concerned with “psychopathology in terms of dysfunction of various kinds and degrees in particular [biological and 5psychological] systems” (ibid).

An additional “dimensional framework” – the Hierarchical Taxonomy of Psychopathology (HiTOP) – has been developed by, largely, psychologists based in the US (Kotov et al, 83). More explicitly psychological than RDoC, though still engaged with genetic and neurobiological concepts and findings, the HiTOP Consortium considers that existing diagnostic systems “do not depict psychopathology accurately”, and placing limits on “their validity in research and utility in clinical practice” (ibid). Both RDoC and HiTOP seek to stimulate research that is less reliant on categorical diagnosis, potentially stalling the engines of diagnosis. While the DSM continues to be used extensively in research and practice around the world, their very existence invites renewed attention to the shifting significance of categorical diagnosis within psychiatry and beyond.

Methods

In this paper, I draw on semi-structured interviews with 17 elite professional actors in the US (n=10) and UK (n=7), including 12 psychiatrists, who are able to exert different kinds of influences on psychiatry. These include key scientists and clinicians (e.g., heads of key programmes, highly visible commentators, and so on), journal editors, and members of funding agencies. They were recruited specifically on the basis of their prominent institutional role or personal influence. A focus on such relatively elite respondents adds to renewed interest in the

sociology of psychiatry which has focussed on, for instance, researcher-clinicians (Halpin, 2016, 2022) and psychiatrists in private practice in the US (Smith, 2014; Whooley, 2010)

To an extent, my interviewee's capacity to help shape discourse, research, and training in psychiatry could allow their characterisation as 'drivers' of the engines of diagnosis. Yet, I am hesitant to fully or singularly embrace that metaphor; they might also, for instance, be considered 'mechanics' or even 'saboteurs'. While my respondents' power within the wider terrain of psychiatry is marked in sometimes clear ways, their agencies and normative orientations in relation to the semiotic engines of diagnosis are more ambiguous (and even ambivalent). This is due to the ambiguities of such engines themselves, their aforementioned synecdochical nature, and their interpolation across different institutional and discursive contexts. It is also related to exactly the complexity in response to diagnosis that I outline below.

The interviews were conducted in late 2015/early 2016 as part of the first work-package of a continuing study into shifting understandings of psychiatric diagnosis, and the data were contextualised against this ongoing research. While an important impetus behind the interviews which form the basis for this paper was RDoC and its implications (see Pickersgill, 2019), these ranged far more widely. I asked questions around, for instance, important developments in psychiatry to-date, expectations and concerns about its future, the reception of the DSM-5, and the aims and function of diagnosis more generally.

I approached my data in a broadly abductive fashion (Tavory and Timmermans, 2014; e.g., Halpin, 2022), engaging for instance with wider the wider literature on categorisation, medicalisation, and pharmaceuticalisation noted above, and coding for content that I was specifically interested in examining further alongside broader themes which accounted for substantial elements of the data. The extent and tenor of concerns around categorical diagnosis surprised me at times, despite my assumption that individual accounts of diagnosis might not be straightforward (Pickersgill, 2014; Whooley, 2010). Accordingly, I delved more deeply into these, as well as attempts to substantiate the ongoing use of diagnosis despite concerns. These data form the bedrock for this article. My analysis is informed too by my professional and personal interactions with both research-orientated psychiatrists and other clinicians. This includes dialogue with friends and colleagues working in psychiatry and psychology, including through collaborative research. Likewise, my interpretations are shaped by my close engagements – again including direct collaboration - with (former) patients, users, and survivors of psychiatry, whose

politics and positionality vis-à-vis mental health research and practice are as diverse as these self-ascribed ascriptions of identity might imply.

Categorical Diagnosis and its Discontents

My respondents, like many mental health specialists around the world, emphasised that the DSM as a significant text for psychiatry (Halpin, 2016). This significance is commonly situated as predominantly relating to the advent of the DSM-III, with subsequent editions representing less epistemological and ontological innovation. As senior psychiatrist R9 put it: “DSM-III was a major revolution, DSM-IV was a very *minor* modification and 5 was almost nothing”.ⁱ Regardless of the decreasing ‘revolutionary’ potential of DSM, its ubiquity was clear; R16, a UK-based journal editor, pointed out with ironic humour: “everywhere you bloody go, people are using the DSM! [laughter]” They provided some intriguing reflections on debates around the DSM when asked about the reception of DSM-5:

DSM[-5] wasn't very different [...], it was just more of the same. But of course it gave a good focus for everybody who's against biolog-so there was a great, particularly people who disliked the drug companies I think it sort of merged DSM very much with the, the, they saying it was pharmaceutically driven. Well I think American psychiatry is to some extent pharmaceutically driven. But the irony of this is that I don't know if you know this, the drug companies have all given up and they've all gone to China. And er those of us who had been a little critical, they wish they could come back! 'Cause there are no new drugs for psychosis. Nothing. And no new, none of the big companies are working on them. They've had their fingers burned. So, I didn't...pay, play much of a role in relation to DSM-5 because basically I don't like defending American psychiatry. And I didn't see why, what it had to do with us. It's, we don't use DSM-5. And, so why bother attacking it?

R16 signalled the kinds of critiques operating around the DSM in terms of its proximity to the pharmaceutical industry that I noted earlier, as well as the disinterest in some of the larger pharmaceutical companies away from investment in mental ill-health that, in part, drove forward the RDoC initiative. The extract places the respondent in an ambivalent position: an insider who is aware of the normative and economic stakes in US psychiatry, and yet also as an outsider who presents the DSM as having little “to do with us” – despite finding it “everywhere you bloody go”. In my wider fieldwork, such ambivalence has played out in varying ways, with clinicians, for instance, having sometimes strong opinions on research while accounting for this as far from

their zone of attention, and research-orientated psychiatrists casting the DSM as deeply problematic while nevertheless relying on its categories. Such ambivalence foreshadows much of what follows.

Critiquing the DSM

Some in psychiatry can be sceptical of some of the charges levelled against it in relation to the DSM and the wider project of categorical diagnosis having a deterministic relationship to clinical practice. As R7, a journal editor, told me, “I think [practitioners] are looking for the diagnosis as a sort of clue to what might help, not as the answer”. Diagnosis in this respect forms part of an iterative and dynamic process of ascertaining how best to comprehend and respond to subjective distress, rather than a precise characterisation of a pathological reality that must be responded to in specific and pre-ordained ways. R14, speaking about ICD diagnostic categories, described this as follows:

ICD-10 should be seen as [...] an algorithm. There should be judgment applied and careful consideration about what an individual's *likely* diagnosis is and-and what the weight of evidence suggests they appear to have with a view that that *helps* you with er planning their care [...] The diagnostic categories are not going to *remove* the need for careful clinical judgment and er considering all the data.

Concerns nevertheless exist that the DSM *does* in fact encourage the kind of approach that some respondents refused to recognise within psychiatry (e.g., Frances, 2013), acting as an engine of diagnosis rather than simply container of diagnostic entities. R9 told me that they “absolutely *loathe* the checklist approach” taken within DSM-III and -IV, which they saw as

creating a whole host of psychiatrists who think that all you do is have somebody come into your office and say so ‘what kind of problems have you been having’ and if they get the right probe then they’ll follow up on it, if they don’t they’ll start saying, well, have you been having any trouble sleeping, how is your appetite, et cetera et cetera et cetera. Just going through a longer list of symptoms until they get a bingo [...] [T]he notion that you can, do a good diagnostic evaluation spending one hour talking to a patient, well, 45 minutes talking to a patient, 15 minutes writing it up, and a 15 minute medication check for a follow-up. That’s not - where you again go through the same checklist of symptoms - that’s not the way psychiatry should be practised. No.

As indicated above, then, psychiatrists are fully able to critique the DSM, and actively do so. Importantly, these critiques can also be expressed in registers that accord with some of the vernaculars of critical historians and sociologists of biomedical knowledge – underscoring the entwinements of psychiatry and sociology (Millard, 2017). Ultimately, many of the concerns I encountered related to the reality that the DSM was purported to represent. In the words of R4, a senior member of the NIMH:

I was trained a long time ago, it was actually an advantage for me, I was trained before the DSM-III came out so I didn't grow up believing that these are real disorders. It was sort of an odd foreign thing, that was implanted when it came out.

As we will see, these concerns frequently foreground the purported reification of DSM categories.

The dangers of reification

The language of reification is hard to escape within critical writings on diagnosis, and pervades psychiatric discourse itself. As R10, a prominent scientist, described:

DSM criteria are just a set of criteria that have [...] the best reliability and face validity that we've been able to get thus far. They're not [...] tablets coming down from Mount Sinai, and they *shouldn't* be reified.

Nevertheless, this was the reality for many psychiatrists:

The problem with DSM is that, you know, it has led to you know a sense that these are really [...] actual reified entities that underline these conditions. And that's a real problem, too.

For R3, a journal editor who was generally an advocate of RDoC, a move away from the DSM was necessary for treatment development (discussed in Pickersgill, 2019) but also because of the dangers of reification – highlighting in the process some key engines of diagnosis:

[P]rofessions tend to [...] reify any socially agreed upon structure and to make it into something that it isn't. In other words we have an idea, this idea of something we call schizophrenia which

comes from careful clinical observations, recognising the diverse heterogeneity of things, but at least it helps drive a discussion. The courts take that diagnosis and use it for a different purpose. The insurance companies take those diagnosis and use it for a different purpose around billing, and er and erm families use it for a different purpose to get benefits and to get services, access to services, and so everybody's got a stake in reifying more or less these provisional constructs. And because they get [...] turned into *things* at time to time they need to be deconstructed and looked at in different ways.

R16 also indicated similar concerns to the sociologically-inflected comments of R3, noting that part of the benefit of the advent of RDoC is that "it's been good to puncture the reification of diseases in DSM." To their mind, "a lot of American psychiatrists really believe these diseases existed"; consequently, "it's good to have someone point out that they don't." Likewise, when asked about the utility of diagnostic tools, R14 reflected:

I think we've forgotten something and I think for the sake er of becoming more scientific and er objectified and more medical which is important because it's an avenue to anti-stigma but also an avenue to connect up the mind and the body really [...] I think we've forgotten that diagnosis has been a theory and it's a working hypothesis and much more important than a diagnosis is the formulation [i.e. a broader understanding of aetiology and functioning than diagnosis per se]. And that's really where psychiatry's been at for a long time, that there's a diagnosis but the formulation is far more important about that person, and what helps them and what their causes and difficulties are and what might be contributing to their particular problems. So certainly in my training, and now the formulation is the most important thing we do, not the diagnosis. The diagnosis er is a working hypothesis based on the best data available at the time, often er phenomenologically based. And I know our diagnostic decision making is as good as other medical disorders and to some extent psychiatry's gone over the top with structured instruments and measures and algorithms and criteria. Er but I think it's being reified to a greater level than it should sometimes

Mirroring nature?

A critique resonant with that of reification was that the DSM was simply not a good mirror of nature. In the words of R12, a prominent US psychiatrist:

You know when I was [in a prior senior role], I already saw that the evil that the DSM was doing to the research establishment by erm fulfilling its goal of creating a common language. The

trouble was it was a common language that was not a very good mirror of nature, at least in many situations.

Notably, such critiques of the DSM often hold on to a notion of the existence of the disorder the manual seeks to describe (as in the examples above) and so can be interpreted perhaps a more of stalling, or even repositioning, rather than dismantling of the engines of diagnosis. Sometimes, though, clear criticisms of the nature of a disorder itself are advanced:

[S]cientists waste their time studying, you know, DSM panic disorder. Well, people have panic attacks, but the idea that there's a discrete disorder characterised by something that spontaneously attacks, so many attacks per week, this is just folly.

As R10 described:

I'm not sitting here as a *fan boy* for DSM-5. I mean, I think DSM-5 is a useful *tool*, it's not, you know, [...] the old Buddhist saying, [...] well, there's one version that can't be an old Buddhist saying, because they didn't have hamburgers! But it was, you shouldn't mistake a picture of a hamburger for a hamburger. But basically, you know, that, *that* something is a finger, a finger pointing at the moon is different than the moon itself

R9 had similar reflections around the problematic relationship between signification and the signified:

[P]sychiatric diagnoses are complicated constructs, particularly things like schizophrenia which is [...] obviously not a single illness. You know I'd like to quote Wittgenstein, we sometimes think that because there's one word to refer to something that it's only one thing.

Despite such criticisms, the notion that the experiences characterised by terms like panic disorder and schizophrenia are pathological are not subject to critique. In a similar fashion, R16 noted how “you don't know” if the diagnostic categories contained within the DSM and ICD “have a biological reality at [...] their centre” – they were, for him, “sort of artificial constructs.” However, “one day we'll get beyond this”. In arguing against some diagnostic terms, or even a categorical approach (as currently practised), more generally, it is, then, perfectly possible to engage in processes of medicalisation – or, at least, refrain from participating in the praxis of de-medicalisation. Accordingly, and as the next section will more clearly show, a move away from

the DSM and categorical diagnosis - what we might call re-or even in some cases de-categorisation - does not need to be coupled with de-medicalisation per se.

Diagnosis and Biological Imaginaries of Mental Ill-Health

The fact that the DSM apparently lacked congruence with nature was not accounted for solely as a philosophical problem, but also one with practical implications for treatment development. Since “people couldn’t get a grant or couldn’t write a paper and get it published in a leading journal without using, specifying a DSM disorder” (R12), the entire research ecosystem was impacted by the DSM (Halpin, 2016). R13, who worked for a smaller mental health funder, remarked as follows:

[I]t’s hard to, not to see the evidence that shows that clinical trials are failing because we [...] imagine that patients enrolled in clinical trials are homogenous when they’re not, and we keep making that assumption over and over and over again, and the trials keep failing over and over and over again. So, why are we repeating the same mistakes, erm, instead of looking for other things to do? The pressure to drop the DSM diagnosis is a logical place to start, because it’s clear that recruiting people for rigorous hypothesis-driven studies by diagnostics isn’t working. The populations are very very different. And then, and then the practical aspects of that are that academic research doesn’t, findings don’t seem to apply to the real world in a reliable way. So, what’s the problem in translation there? Undoubtedly part of it has to do with the buckets that diagnosis are.

Such criticisms of the DSM and the role of categorical diagnosis in research seem to take for granted the importance of pharmaceutical – rather than for, instance, psychological – therapies. They consequently implicitly reinscribe an at least partly biological imaginary of mental ill-health. Accordingly, re-/de-categorisation need not be aligned with processes of de-pharmaceuticalisation or de-biologisation.

Accounts of depression and drug discovery is a case in point. Depression is a frequent example of a disorder that can be characterised in multiple ways, with R3 indicating some of the challenges:

[O]ne of the strange things about the categorical system is it’s so broad that it sometimes seems almost laughably meaningless. In other words, so er depression. You can have depression if you

sleep too much, or too little, if you have too much emotion or too little emotion, if you've got too much energy or too little energy, if you know too anxious and pacing all around or if you were to sit in all day. You know, you can have the opposites, right, and you can still have the same thing.

One senior psychiatrist, R11, described the implications of this for research: “If you take people with major depression who meet criteria for the diagnosis, you have an *extraordinarily* heterogeneous population” – including “people who have the same diagnosis but have not a single *symptom* even in common”. This meant that if a scientist wished to undertake research on mental health that “depended on the homogeneity of the sample, you were defeated at the outset”. As R12 went on to say:

[If] you go to something like depression, which affects 15 to 20 per cent of the population, very very heterogeneous, and the heritability is much less [then for schizophrenia], maybe 35 per cent, not 65 to 80 per cent, then the DSM just kills you, you know? Five of nine [criteria must be met for a diagnosis], so some people are positive on one through five, and others on five through nine [...] one simple example of how damaging it is, is that people were looking for a biomarker for depression, better to do clinical trials, make diagnosis, but the gold standard for the biomarker was DSM-III-R or DSM-IV, DSM-5 depression, which is a chimera, you know, so if that's the gold standard you've got a fool's errand.

It is in part due to these challenges of heterogeneity that drug companies are understood to have “given up” – to recall R16's opening comments – on psychopharmaceutical innovation (Pickersgill, 2019), despite their previously very significant role as an engine of diagnosis (Jutel, 2009, 2011).

Some respondents also underscored the issue of polydiagnosis, another issue regularly flagged as problematic within psychiatry as well as in activist and survivor discourses. For R3, “psychiatric diagnoses are really *rarely* distinct”, but psychiatrists were encouraged to think of patients in terms of sometimes multiple diagnoses by the DSM. R12 described this challenge as follows:

[T]here are kids who have, you know, some high functioning autism plus ADHD plus OCD, you know, plus some mood problems, and they get four diagnoses. But that's insane, right? There's probably just one kind of thing wrong in their brains, and this is really a phenomenon on the spectrum of clustering of too much loading on several axes, you know, some of that loading

undoubtedly being genetic, but not all of it being genetic, right? Or there are lots of people who have three anxiety disorders and major depression.

They continued:

[W]hat we haven't done, because everybody's relied on the DSM, on the *fictive* categories, we haven't studied, we really don't have a set of dimensions, we don't have our [analogue of the] blood pressure cuff [for psychiatry], partly of course again, partly we don't have objective tests, but we're never going to have objective tests if the gold standard is the DSM and we're measuring against chimeras. So genetics is a nice anchor because you can go into it, you know, with broad diagnostic categories.

R3 also reflected that “genetics are a good place to start” if one wanted to really understand psychiatric disorders, and R14 - who was hardly enthralled by diagnosis per se - likewise produced a biological imaginary within the interview (and in his wider work):

[T]he idea that we can underpin diagnosis with more neuroscientific objective data is a good one, it's an important one wherever possible. And I think the move towards that is desirable but we have to be cautious about not overreaching.

R14's cautions in the above are important; as he later noted, neurological data will not “be the only source of data” relevant to clinical practice – after all, “most jobbing psychiatrists and researchers still take very much a broad biopsychosocial approach”. Still, that neurological data is deemed relevant at all – and is singled out for particular discussion – underscores the centrality of at least partly biological imaginaries of mental ill-health within this psychiatrist's praxis. He is not, of course, unusual in that respect: few, if any, psychiatrists I have engaged with completely excise biology from the heterogenous ontologies operant within clinical practice, even as totalising biological reductionism is likewise uncommon. In R14's words:

We have diagnostic criteria, we have to limit who we see, but the reality is that a lot of the people we see don't have a pure diagnosis, they have multiple disorders, and so the trials we have aren't particularly pragmatic. The studies we have are the special cases when you try and transfer into the real situation doesn't really work. So I think we need much more of that. And of course saying this neuroscientific basis for disorder cuts through all of that, ‘well, this is the disorder, this is how you treat it’. And I think for some disorders, schizophrenia and maybe bipolar disorder we will have a better understanding of that in the future. Depression, some types of depression,

severe depression, but I think the majority of depression, will continue to be very socially culturally influenced and determined by environment as well as personal disposition and coping styles.

In this extract, R14 develops resonant claims to those of R12; i.e., that diagnosis is not “pure”, and that people can meet the criteria for “multiple disorders”. However, while R12 seemed to imply that there was “probably just one kind of thing wrong” within the “brains” of some people who might attract different diagnoses, and so demonstrated commitment to the potentiality of neuroscientific research to reveal new truths about the nature of mental ill-health, R14 was more tentative. Nevertheless, the value of neurobiological research was underscored in part through the discourse of severity with which he associated his comments. While depression – apart from “severe depression” – was accounted for in terms of a psychosocial ontology, “schizophrenia and maybe bipolar disorder” were presented as conditions that might have their complexities more brightly illuminated through neurobiological investigation.

To recap: a refusal to commit fully to the DSM and to posit the value of re/de-categorisation within mental health can still be complicit in neurobiologisation or geneticisation – which themselves might act as engines of diagnosis. A devaluation of the DSM does not necessarily mean a devaluing of or move away from the biological imaginary with which it is associated; for instance, a highly neurogeneticised understanding of mental ill-health could further elide its social dimensions (Whooley, 2014).

The Value of Diagnosis

Why, if there are so many issues with the DSM – and categorical diagnosis more generally – do psychiatrists continue to make use of it? For R11:

I think there, at least in our world, the DSM erm was understood as a erm convenience and not as science. Not as *valid* er indications of erm clear, er, clearly demarcated disease entities. I mean, the, incredible comorbidity of these conditions already made it erm made it er evident that there weren't particular boundaries, that nature wasn't defined this way. You know that people could meet criteria for many different diagnoses [...] DSM-5 was a *best effort* to take er, er complex information and try to er, erm make it more erm, *useful*. So, and useful in what ways? Well, in communicating to patients, destigmatising illness, in selecting among categories of therapeutics

One reason for using the DSM is because its use is deemed to be expected, with such expectations themselves consequently representing an engine of diagnosis. As R1, a key psychiatrist within the APA, put it:

I think that the DSM is a very *pragmatic* instrument. That is, its role is to help physicians identify what ails the patient and institute a treatment based on that determination. Importantly, so far, all the data we have on medications is based on their testing in diagnoses. So all of our evidence base right now is designed that way, so that the DSM is going to have to be very important.

The notion that “all of our evidence” is assembled through the DSM was also more widely evident – both within my interviews, as well as collaborative and informal engagements with psychiatrists (Halpin, 2016).

Diagnosis in research

We saw earlier in R12’s comments that couching grant applications in the language of the DSM is necessary, and this was echoed too in my interview with R4. For him, US mental health research and practice were “so dependent on DSM”. There was, for instance, a pervasive sense that DSM disorders were essential to frame studies around:

[T]here was no rule about it but it had in fact become the de facto standard to get a research grant in clinical research, that you had to study a DSM disorder. Er usually one disorder, almost always versus healthy controls. And it was a sort of infectious disease model, you know, you either have this disease or you don’t, you either have cholera or Ebola virus, influenza or whatever, and we want to understand what characterises that *disease*, implying that it is a real disease, and of course, to compare that we look at healthy control subjects because they don’t have ‘the disease’. Then you would run this experiment.

This epistemic norm, in turn, was regarded as catalysing processes of ontological reification, of the kind reflected upon by other respondents:

Often, especially for clinical trials, but in other studies as well, the idea that it was a real disease carried over so far that people would say ‘well, I don’t want to confound the understanding of this pure disease of depression by having comorbid disorders like anxiety disorders or personality disorders, I have to just understand the real depression’. So anybody with a comorbid disorder is ruled out, and now we understand that ‘pure depression’ is characterised by x, whatever you’re

measuring, cortisol levels or serotonin levels or cognitive deficits or whatever, compared to healthy controls.

In the UK context, R17 - a senior member of the Royal College of Psychiatrists - also flagged the imperative to employ the DSM for research; in his case, to secure a desirable home for study outputs: “you have to use DSM, if you’re going to have any chance of publishing [in] the Archives [of General Psychiatry] or JAMA”. In effect, the articulation of knowledge claims through the diagnostic formalisms of US psychiatry was framed as an obligatory rhetorical passage point (Broer and Pickersgill, 2015; cf. Callon, 1986) for publication, and so epistemic circulation, within prestigious US journals - underscoring how research can act as an engine of diagnosis (Jutel, 2011).

Diagnosis in clinical practice

Diagnosis is also argued at times to be helpful clinically. Some - like R11 - say, for instance, that it has value to those psychiatrists work with: “So I think erm diagnosis is er like, is er, it helps patients, you know, participate in their own care in some way and family members to be participant in-in er in the care process as well”. For R6, a journal editor:

the value of a diagnosis in psychiatry, while we *hope* it will be leading to biological mechanisms, the value of that diagnosis is much more in the ability to predict future outcomes. And that is really at the core of what a psychiatrist needs to do. We don’t get paid, really, to show to a person that whatever happens in their behaviour is due to some [neurobiological] circuitry. Most people are not that interested. It might be nice to know, but they really want to know, if I have a condition, a diagnosis, that is reliably diagnosable, what does this actually mean for future events? Will this change my life expectancy? Will this change my ability to function in society? Will I need treatment? And if so, will the treatment work for me? So those are the questions. That’s the simple *clinical* utility of a diagnosis, which will *always* be there. That’s really why we have the field of psychiatry in the first place. That *society* wants us to make diagnoses to predict future outcomes, so that society can then intervene and say, ‘oh, now we have to do something because this is too risky’, or ‘the person might hurt themselves’, or whatever it might be.

Such accounts present society per se as an engine of diagnosis, through underscoring the interpolation of diagnosis language and psychiatric ontologies within institutional and everyday life.

For their part, R16 discussed the clinical utility of diagnosis explicitly in contrast with a dimensional approach to mental ill-health. Debates about whether diagnosis in psychiatry should be dimensional or categorical have been revitalised through the publication of the DSM-5 (Hollin, 2017); for R16, dimensionality was preferable – but there were caveats:

I've been quite interested in dimensions and actually with [colleague], we were quite keen to try and replace diagnoses. But in fact if you, in practice you do a study where you try and predict the future with dimensions or predict the future with categories, dimensions do slightly better. But of course, a diagnosis you just get one: schizophrenia, bipolar. Dimensions, you get five different pieces of information. And in order to tear up all the textbooks and everything and have a new classification system, it's got to be dramatically better. You know, it wasn't really much better, it was a little bit better.

In effect the embeddedness of the DSM within psychiatry was accounted for as delimiting the potential for reform, and the advantages of dimensional approaches were framed as insufficient to propel this. R16, then, offered up a pragmatic defence of the DSM, rather than an solely epistemic one. Other respondents also flagged the challenge that changes to diagnostic criteria would have for the US healthcare system, since “diagnostic criteria are often used to say whether certain people get certain kinds of medical services or not” (R10). In a similar way, R3 spoke of how insurance companies “know how to reimburse diagnoses. They don't know how to reimburse dimensions”. R13, mirroring critics like Kutchins and Kirk (1997), described how “the whole trail in the US from diagnostic codes to money [for reimbursement], corrupts people's allegiance to things.” R9 likewise took a systemic view:

[T]he daily activities of the thousands of psychiatrists who are seeing patients to make initial diagnosis, and everybody has to bear in mind that the *whole* clinical system is linked to DSM diagnoses. And, you know, psychiatrists who see patients have to put in a DSM category. And [...] the reimbursement is linked to that specific diagnosis. That's the whole system and it's not going to change any time soon

Diagnosis and professional identity

Common too in my encounters with mental health researchers and practitioners, especially but not only psychiatrists, is a sense that categorisation through diagnosis is essential to medicine as a

profession itself. R1, for instance, asserted (somewhat surprisingly) that it was essential since “most medical thinking is categorical – the person is ill or they’re not ill”. Put less strongly, one senior psychological researcher, R5, told me: “humans are categorisers. Clinicians *have* to categorise. You can’t live without these processes.” For R10, despite limitations to current approaches to diagnosis, “you still need to take care of people in front of you, and you need some kind of rubric to organise your thinking, irrespective of whether it’s the perfect rubric or not”. In the words of R17:

All of us, well, not all of us, there are some people who just simply don’t believe in it, but all of us believe in better and more accurate diagnosis, it’s just the way forward, it’s the only way you can do research, if you, if you-if you, it’s the only way you can treat patients. If you don’t have some concept of diagnosis, you cannot practise any form of medicine, you can’t, and there’s no point in training.

Such purported beliefs can be regarded as oil or fuel (Bell, 2017) for the engines of diagnosis.

For R17, dimensional approaches to mental ill-health might cohere more closely to pathological reality, yet they failed to align with the realities built through epistemic and clinical institutions:

[H]ealth services can only run categorically, and epidemiology, you know, most of my research runs categorically, simply because finally the *world* has to. You’re either sick or you’re not, you’re either off sick or you’re not, you’re either getting insurance or you’re not. You can’t have a, you can’t have a dimensional approach to that, you know, it has to be categorical. And even though life and most diseases are not categorical, *nevertheless* we treat them as if they are. And I just don’t see how you could organise healthcare unless you did do that. I think, I don’t know what it would look like, it would be really strange.

Again, then, a partly pragmatic as well as epistemic defence (cf. Jutel, 2021: 2) of diagnosis was offered – one which cast this as essential to medicine and so to the professional identity of psychiatrists. At the same time, R17 reported a somewhat idiosyncratic use of diagnosis in practice: “we also make diagnoses that don’t exist, like we will say someone’s stressed, because that’s not a *diagnosis*, but it’s a useful shorthand to deal with patients, GPs”. In effect, diagnosis was presented as useful and even necessary, but diagnostic categories – and as codified within texts such as the ICD and DSM – were not the final arbiter of what a patient was in fact taken to be experiencing. Pathological reality in this rendering, then, was ambiguous and not necessarily

tightly coupled to terminological standards - but it was nevertheless still somehow comprehensible (Halpin, 2022; Pickersgill, 2014).

Discussion

Understandings of and opinions about categorical diagnosis in general and the DSM in particular – as a key engine of diagnosis – range widely within the mental health professions, with notable attempts to move away from this approach in research and clinical practice. Such re- or even de-categorisation acts as an ontoepistemological process that has the potential to stimulate a broader reimagining of what diagnosis is and what – and whose – purposes it serves. Overlapping with sociological and other critiques of diagnosis, mental health elites in the UK and US – including my interviewees – are often cutting about the DSM in particular – evoking, for instance, key concerns about diagnostic reification. The US NIMH RdoC initiative is itself an example of this critique. While today's NIMH Director, Joshua A. Gordon, has moved away the kinds of strong statements about the DSM made by his predecessor (Gordon, 2020), RdoC continues to be promoted (Cuthbert, 2022). The NIMH supports research that employs the DSM, and researchers themselves can draw on both this and RdoC, but the categorical approach of the DSM is not as epistemically disciplining as it once was.

Importantly, concerns about the DSM cannot be presumed to translate into a rejection of the orientation of psychiatry towards 'pathology' per se. Some psychiatrists remain committed to the notion that neurobiological research might reveal new truths about the nature of mental ill-health. These might cut across or redefine existing diagnostic systems, without resulting in a wholesale rejection of the diagnostic enterprise itself. Despite resonances with psychological or even sociological imaginaries of distress, moves away from discrete diagnostic entities hardly preclude the advancement of a biologized ontology of mental ill-health. Indeed, they might even act as a vanguard for it (Whooley, 2014).

This is not to say that psychiatrists writ large can be reduced to biological determinists, eagerly medicalising everyday experience simply to accumulate cultural and economic capital. There is more at stake here than professional interests, even as these participate in constituting praxis. Many in psychiatry, though, are just as able to discuss the limits of biological approaches and the strengths of psychosocial epistemic and clinical perspectives as they are the potentiality of the neuro (even if the glitter of the latter often proves more compelling). Rather than implying a

straightforward biomedical imperialism, my data demonstrate psychiatrists' willingness to contribute reflexively to discussions about one of the most significant engines turning the wheels within their profession (Callard, 2014; see relatedly Strong, 1979), as well as the fact that the braiding of diagnostic approaches, biological understandings, and pharmaceutical interventions within psychiatric discourse is not necessarily as tight as might be assumed.

Yet, the picture is complicated still further when we consider the role of these reflexive appraisals themselves, as articulated against the backdrop of constructions of psychiatry that emphasise the inescapability – and indeed the utility – of categorical diagnosis in general and the DSM in particular. It is rare to see expectations around the effects of RdoC, for instance, imply a complete dissolution of the salience of diagnosis. In effect, critique comes often to re-inscribe the significance of diagnosis in general and the DSM in particular, and so – when uttered in particular contexts – might construct it as inevitable. Within this discourse of inevitability (Leonardi, 2008; Pickersgill, 2019), one which sociological research itself might inadvertently contribute, diagnostic categories are implicitly presented as an ongoing feature of the future via only ever murky visions of any alternatives. Accordingly, psychiatric critique of the DSM can become domesticated and might paradoxically act itself as a technique of deflection through underscoring the systemic role diagnosis plays – not least in professional understandings of their own medical identities.

Reflexive commentary around the DSM - a key element at once powering and resulting from the sociotechnical engines of psychiatric diagnosis (Jutel, 2009) – might, then, not be stalling such engines, but in some circumstances act as a kind of oil for them. We might consider other mechanisms for strategic engagement with the DSM in a similar way; the 'psychiatric workarounds' charted by Whooley (2010), for instance, might also act to oil the engines of diagnosis in mental health through hailing the primacy of diagnosis even while some specific formal diagnostic categories are rejected.ⁱⁱ As sociological scholarship on the engines of diagnosis expands, additional attention to what fuels (Bell, 2017), oils, or even stalls these might help to enhance understandings of how diagnostic categories proliferate, circulate, and are driven to embed within everyday experience.

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Data Availability Statement

Data summaries that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy and ethical restrictions.

ⁱ Italicised text represents interviewees' own emphasis.

ⁱⁱ I thank one of the anonymous reviewers for prompting me on this point.