ABSTRACT: This paper examines and offers a critique of the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR), underlying principles and assumptions, and the nature and consequences of its nosological framework. The reason for this critique is to look at the rationale for some of the diagnostic categories and also why some categories are retained, including some of the long-standing diagnostic groups, such as schizophrenia. It is not the intention here to rehearse the problems of biological psychiatric thinking, nor argue the strengths and weaknesses of the DSM-IV-TR in its definitions and descriptions of particular syndromes and illnesses. The ideas presented here derive from a range of previous research that argued that the DSM-IV-TR colludes in a system of psychiatric care in which all people, by virtue of characteristically human foibles and idiosyncrasies, are potentially classifiable into a variety of diagnostic mental health categories. In the present study, it was argued that because of resource constraints, professional dispute, and public concern, the major criterion for attracting a formal diagnosis is not classifiability according to the DSM-IV-TR, but rather, that of ‘social risk’, defined in terms of risk to oneself and/or others and embodying obvious social control functions. Here, we expand and develop some of these ideas, and relate them more specifically to insights offered by critical or deconstructive psychology and the development of the forthcoming the DSM-V.

KEY WORDS: catch all, diagnosis, Diagnostic and Statistical Manual of Mental Disorders-IV text revision, psychiatry, risk.

INTRODUCTION

This paper examines and offers an initial critique of some of the underlying principles and assumptions of the Diagnostic and Statistical Manual of Mental Disorders 4th Edition, Text Revision (DSM-IV-TR), and the nature and consequences of its nosological framework, rather than being critical of the construction and substance of its categories. We start with the premise that most areas of health care use a medical model underpinning, and this promotes scientific investigation as the unrivalled way to eventually understand clinical phenomena. We argue here that clinical work is not a laboratory, and that in mental health, scientifically-proven evidence might not often exist in terms of diagnostic categories, and that the DSM-IV-TR, with its range of ‘catch-all’ criteria, is too often used to create an illusion of understanding. Highlighting this point, we argue that obedience to a set of rules deemed proper treatment or fulfilling the modus operandi of the clinical area concerned really does not base diagnostic evidence on a clear scientific rationale (Sobo 2001). The dilemma between what is understood and proven through scientific methods and what is in essence opinion is problematical, as according to Sobo (2001) science should command absolute loyalty. We argue here that just by using a scientific format or waving...
its banner does not really add validity to those who speak as scientists. In fact, its virtues can often act as a smoke-screen. The language, the prestige, the trappings of science can often be so distracting that science’s core values are often overshadowed, along with absolute clarity about what is known and not known. The DSM IV-TR diagnoses on this are often based on operational definitions, rather than pathogenesis or aetiology (Sobo 2001).

With these thoughts in mind, the rationale for retaining some of the most long-standing diagnostic categories in psychiatry, including schizophrenia, are sometimes called into question and should be revisited so that clients are correctly and more accurately diagnosed. It is not our intention in this paper to rehearse the problems of biological psychiatric thinking, nor point out the strengths and weaknesses of the DSM-IV-TR in its definitions and descriptions of particular syndromes and illnesses, but more to further examine and add to claims made by Holmes & Warelow (1999), who argued that the DSM-IV-colludes in a system of psychiatric care in which all people, by virtue of characteristically human foibles and idiosyncrasies, are potentially classifiable into a variety of diagnostic mental health categories. This paper argues that because of resource constraints, professional dispute, and public concern, the major criterion for attracting a formal diagnosis is not their classifiability according to the DSM-IV-TR, but rather increasingly, that of ‘social risk’, defined in terms of risk to oneself and/or others and embodying obvious social control functions.

WEAK POINTS OF THE DSM-IV-TR

As a preliminary, we want to briefly set out that what we see as the problems with the DSM-IV-TR, to which critique and insights from a critical psychiatry could be directed.

DSM-IV-TR potentially legitimizes the psychiatrization of everyday life

The DSM-IV-TR deconstructs the distinction between the sane and insane, and because of this, it not only has the potential to destigmatize people presently labelled ‘mentally ill’ (which is a good thing), but it also moves towards legitimizing the psychiatrization of everyday life. No aspect of human behaviour, thinking, and feeling under these arrangements are exempt from its all-encompassing grasp.

In practice, psychiatry does not expand at the rate that the DSM-IV-TR would allow. The ‘extra-scientific’ considerations that inhibit expansion include the existence of dissenting or ‘radical’ professionals, including psychiatrists, the competing interests of other professional groups and their discursive systems, the moderating voice of the public at large, and limitations within the medico-psychiatric profession itself. Nevertheless, Sedgwick (1982) observation that ‘it is not the need of the people which propels the juggernaut of the public health establishment, but the subjective need of the (psychiatric) juggernaut to persuade itself and identify new objects for its concern’ (Sedgwick 1982, p. 171) nicely captures the trend in contemporary psychiatry and the catch-all criteria of the DSM-IV-TR.

In an earlier paper, Holmes and Warelow (1999) argued that the key determining factor in the classification of a person as having a mental illness is that of ‘risk’: risk to self or others. Both can be seen as arenas that potentially undermine the stability of the social order. It has to be acknowledged that this is an empirical claim, which could be refuted by empirical investigation, and that the evidence would suggest that although the DSM-IV-TR provides a taxonomic classification of what are called mental illnesses, that no available definition adequately specifies precise boundaries or offers consistent operational definitions that covers all situations. It also should be noted that framing a model of mental health in terms of order or risk tends to betray psychiatry’s covert social control function and its aspirations to eliminate behaviours that disrupt or contest the social norms. Adding, say, suicidal risk to the operational definitions of health-care admission criteria will ensure almost guaranteed admission to health-care facilities, rather than judging each admission on the mental status examination and the contextual circumstances of the client’s situation.

Rolfe and Cutcliffe (2006) extend this point further by saying that virtually no area of human activity or experience has avoided the dead hand of psychiatry, and that psychiatric, psychological, and managerial tongues tend to offer jargon definitions ‘that make obscurity more opaque’ (Howard 1978, p. 619). Howard describes ‘weasel words’ and states these as being evasive and ambiguous, which tends to manipulate understandings (and therefore diagnosis) that misinform readers/listeners when the opposite is required, so that the meaning of the words are clear rather than being twisted and misinterpreted in this process. This misinterpretation colludes with the all-encompassing diagnostic categories of the DSM-IV-TR, whereby convoluted and camouflaged terms and their meanings encapature potential sufferers and the general public who are persuaded by the allocated label. Therefore, with these subtexts in place, the boundaries of what is normal and what is pathological become problematical, because everybody potentially falls somewhere within these operational definitions, which is reflective of our
historically evolving concepts of disease. This view is in keeping with the deconstructive work of Derrida (1987), who talked of pretentious rhetoric to obscure the simplicity of ideas. Frances and Pincus (2004) suggest this makes it difficult to know where psychopathology ends and the wear and tear of everyday life begins. Holmes and Warelow (1999) argued this point, calling this 'catch all', and reminding those who construct future diagnostic manuals to be more vigilant with what are rather elastic nosological categories/boundaries. This point is highlighted by Lane (2009), who makes the point that the American Psychiatric Association (APA) still continues to debate whether what we call day-to-day activity, such as avid shopping, should be considered a sign of mental illness. APA's DSM-V, expected in 2012, is not just deciding the fate of (what they call) shopaholics, it is also debating whether overuse of the Internet, 'excessive' sexual activity, apathy, and even prolonged bitterness should be viewed quite seriously as brain disorders and placed under the purview of the new manual. If you spend hours online, have sex more frequently than aging psychiatrists, and complain incessantly that the government can't account for all its financial commitments, take heed, as you might soon be classed among the 48 million Americans the APA already classifies to have a mental illness (Lane 2009).

Clearly the draft paper/discussions indicate that the DSM-V has added in a range of nosography, which continues to expand and embellish psychiatry and its seemingly all-encompassing grasp. The evidence that has been accumulating, and a formal assessment of that evidence, probably lie outside the scope of this paper, but suffice to say, we argue here that it is not the severity of the problem that is at issue, rather the risk posed by the person to themselves or others that determines their classification under the DSM-IV-TR. This suggests that professionals have control over both diagnoses and/or the decision to treat based on the diagnosis; for example, a person with obsessive/compulsive traits who needs to have the dinner cutlery arranged in a certain way, however distressing to the person concerned, would not get the same professional intervention/attention that a person expressing either suicidal/homicidal ideation would receive, and these decisions are based on risk rather than pathology.

Many DSM-IV-TR diagnostic groups overlap, are of questionable utility, and some refer to 'conditions' that do not appear to have clinical equivalents in practice

The fact that many DSM-IV-TR diagnostic groups overlap means that a person can legitimately attract a variety of possible diagnostic labels for the same set of symptoms, as would/could be the case for delirium, dementia, and amnestic disorders, and similarly, the range of schizophrenia disorders: schizoaffective disorder, bipolar conditions, and other psychotic disorders, including drug-induced conditions, impulse control disorders, and across the full spectrum of personality disorders. Similarly, there are categories that include V codes that encompass a range of relational problems, which become a focus for clinical attention and which one could argue are all within whatever we might describe as a 'normal range' of day-to-day functioning, such as sibling relational problem (V61.8), partner relational problem (V61.10), parent–child relational problem (V61.20), and encompassing all of these, harnessing the catch-all category relational problem that is not otherwise specified (V62.81). In a dysfunctional family, all of the above would be significant, with none being exclusive to any/all of the others. In fact, in any family, all of these categories could be said to be day-to-day phenomena that would not or should not attract attention, let alone a formal diagnosis. These problem areas, when they come to the clinical attention of practitioners, are usually listed under axis 1, otherwise, if not the principal focus of attention, then is/are listed under axis IV. This issue aside, these categories under relational problems are applied to all members of a relational unit who are being treated for the problem. This captures the whole family under the DSM IV-TR and its psychiatrization of everyday life, and encompasses the view put forward by Sedgwick (1973) and (Frances and Pincus 2004), whereby diseases are invented rather than discovered, and at times empirical evidence is at odds with the data available. V codes under the DSM-IV-TR multi-axial system add to the rich phenomenological description of a condition, but in this process, widen the diagnostic parameters.

The DSM now contains three times as many disorders as it did in 1952, and it is more than seven times longer than the first edition. The jury is still out on whether the dozens of new additions hold up to scientific scrutiny. Robert Spitzer, editor of two previous editions, including the one that formally approved post-traumatic stress disorder (PTSD), recently conceded that his colleagues must now 'save PTSD from itself' (Lane 2009). To its members and to the public, the APA boasts that the manual is rigorous and evidence based, drawing meticulously on data and field trials, but the very fact that the APA has produced a taskforce to decide whether bitterness, apathy, extreme shopping, and overuse of the Internet belong in the manual indicates, as Allen Frances (2009) who chaired the DSM-IV taskforce suggested, that the DSM-V is headed in a very wrong direction, arguing that
he did not think they realized the problems they are about to create, nor are they flexible enough to change course (Lane 2009).

**DSM-IV-TR avoids any explanatory referents**

We have argued here that risk and other issues can be used as a major determinant in psychiatric diagnosis and make the point in this section that the DSM-IV-TR makes no attempt to explain why a person who is regarded as having a mental illness continues to attract the diagnostic label, even when they have ceased to exhibit symptoms and the risk factors have diminished. In fact, this point is only given cursory detail in the guidebook, which suggests that indicating the severity of a specific disorder is a failure by many users of the manual, because failure to note ‘routinely the severity of a disorder is unfortunate because differences in severity account for a major proportion of the heterogeneity of symptomatic presentation, prognosis and treatment response’ (First et al. 2004, p. 55). The manual uses generic definitions to refer to specific conditions, and these are used as explanatory guidelines about symptomatology and whether disorders are in partial or full remission. The disclaimer to this is a notation under ‘prior history’ that suggests that because a person has had a diagnosis under the DSM-IV-TR previously, then although fully recovered, this potentially alerts both the individual and clinician to the possible treatment and prognostic implications of ever having had the disorder, and exploring lifetime comorbidity and risk factors encompassing the idea that once diagnosed, the person retains this diagnosis, despite the fact that they are symptom free (First et al. 2004, pp. 55–56). Anecdotal evidence adds a dimension to this argument, where in clinical situations, often an adolescent patient can be labelled with a diagnosis, such as an adjustment disorder with mixed disturbance of emotions and conduct (309.4). The treatment package is then tailored around the diagnosis, rather than the person and the set of circumstances concerned. All adolescents could be said to have a range of issues dealing with mixed emotions and subsequent conduct. Further to this and extending this point, Spitzer and Frances (in Lane 2009) also strongly disagree with a proposal to include ‘subthreshold’ and ‘premorbid’ diagnoses in the new DSM-V. Both terms give cover to what Lane (2009) calls the kindling theory of mental illness in children and infants, saying some psychiatrists believe that it is possible to stamp out ailments before they burgeon into full-blown disorders. In practice, psychiatrists in Florida alone gave antipsychotic drugs off-label (without formal Food and Drug Administration (FDA) approval) in 2007 to 23 infants who were less than 1 year old at the time. They extended the practice to 39 toddlers aged 1, 103 aged 2, 315 aged 3, 886 aged 4, and 1801 aged 5 (Lane 2009). The kindling theory of infant mental illnesses reminds us, as Darrel Regier (then the APA’s deputy medical director) told the FDA’s Psychopharmacologic Drugs Advisory Committee in 2005, that the APA already considers 48 million Americans as meeting the criteria for a mental illness. ‘Subthreshold’ and ‘premorbid’ diagnoses, warn Spitzer and Frances, could add tens of millions of newly-diagnosed ‘patients’ to that number, the majority of whom would likely be false positives, subjected to the needless side-effects and expense of treatment. Conceivably, we might by 2012 reach a point where the APA is defining more than half the country as meeting the criteria for a mental illness. ‘In its effort to increase diagnostic sensitivity’, Spitzer and Frances conclude that the DSM-V taskforce ‘has been insensitive to the great risks of false positives, and of medicalizing normality . . .’ (Lane 2009), and of trivializing the whole concept of psychiatric diagnosis. These are remarkable accusations from two men who, between them, oversaw the formal approval of more than 150 mental illnesses in 24 years (Lane 2009).

**Guideline rather than a precise tool**

The formal criteria of the DSM-IV-TR are open-ended, and its use allows a substantial degree of clinical judgement and latitude in determining diagnoses in particular cases. As the DSM-IV study guide, which is widely taken as authoritative across the USA, advises, when the psychiatrist encounters ‘patients who do not quite fit the criteria . . . DSM-IV leaves room for the clinician’s judgement . . . there are few absolute rules . . . the criteria are provided as guidelines . . . with the art of diagnosis dependent on the clinician’s ability to find and fit the patient into the appropriate diagnostic category even if s/he has atypical signs and symptoms’ (Fauman 1994, pp. 1–8). Adding this degree of freedom to the already open-ended formal criteria of the DSM-IV-TR makes it almost impossible, in principle, to escape the pathologization of some aspect of anybody’s total psychological and behavioural repertoire. The DSM-IV-TR (p17) suggests that psychiatric disorders are neither homogenous nor divided by clear boundaries, conceding that there is ‘. . . considerable heterogeneity of the presentations encountered even within each disorder and . . . the boundaries between disorders are often fuzzy . . . with many presentations falling between the cracks and . . . which cannot be comfortably forced into (note the wording here) any of the DSM-IV-TR categories’. These factors make proclaiming a diagnosis a very elastic exercise, whereby nearly every issue/
behaviour/idiosyncrasy would come under the watchful
criteria of the DSM-IV-TR. Surely, these flexible arrange-
ments would include every diagnosis listed in the manual,
as these taxonomies are descriptions and not explanations,
and this paradox would be further compounded by the
polythetic, rather than monothetic, criteria outlined in the
DSM-IV-TR. Also, the multiple diagnosis or comorbidity
arguments where patients meet the criteria for more than
one diagnosis and comorbidities put forward the chicken-
and-egg proposition, where one diagnosis would/could be
causative to the other. Sobo (2001) suggests that the
overly frequent need to diagnose patients with multiple
diagnoses should raise a red flag, arguing that while
finding comorbidities is consistent with guidelines, it
might also indicate basic deficiencies in our understand-
ing. In physical medicine, more than one diagnosis is not
uncommon, but psychiatric patients are so regularly diag-
osed with more than one DSM IV-TR disorder that we
must consider the possibility that many current diagnoses
are failing to broadly enough capture and define particu-
lar psychopathology.

In June 2009, Allen Frances, head of the DSM-IV
taskforce, issued strongly-worded criticisms of the pro-
cesses leading to the development of the DSM-V and the
risk of serious, subtle, ubiquitous, and dangerous, uninten-
tended consequences, such as new false epidemics. Allen’s
work indicates that the DSM-V has displayed the unhappy
combination of soaring ambition and weak methodology,
and is concerned about the taskforce’s inexplicably closed
and secretive process. An overview of the online literature
indicates this concern by those who believe illnesses are
invented (Moynihan et al. 2002; Summerfield 2001)
and/or promoted at the hands of pharmaceutical compa-

DSM-IV-TR is a catch all from which no one
escapes, deconstructing the distinction between
insanity and sanity

The DSM-IV-TR views all people as a complex of factors
that, to some extent or another, locates them within a
variety of diagnostic categories.

How are the boundaries to be maintained that restrain
medicine from applying this procedure to people on the
basis of, for example, their racial identity, physical fitness,
intelligence, skin colour, weight, language spoken, or sex,
particularly as some of these can become susceptible to
generic ‘explanations’? The caveat that the DSM-IV-TR
only defines as mental illness those conditions that ‘cause
clinically significant distress or impairment in social, occu-
pational, or other important areas of functioning’
(Fauman 1994, p. 8) ultimately provides no safeguard,
since any characteristic can easily come to be negatively
valued through cultural reconstruction, and thereby
become a source of distress to the individual and/or those
with whom they associate (arguably the case with Cornelia
Rau in Australia). For instance, we argue that the
condition described and listed under 313.82, described as
an ‘identity problem’, which portrays potential problem-
atical areas and a range of issues that people might have
that might come under clinical attention, such as career
choice, uncertainty about long-term goals, friendship pat-
terns, sexual orientation and behaviour, moral values, and
group loyalties. We argue here that most adolescent chil-
dren would have issues along identity lines post-puberty
and upon entering adulthood. We should be clear and add
that the prime movers in the identification of mental
illness and the desire for professional interventions are
not the people with mental illness themselves, but more
often, those with whom they associate: family, friends,
colleagues, physicians, government, social workers,
church, police, and the media.

In their guidebook, First et al. (2004, p. 409) described
as future contenders a range of conditions being consid-
ered for the next DSM edition. These conditions range
from caffeine withdrawal and other conditions to a range
of circumstances that appear directly linked to hospital
admission and/or treatment prescribed by the mental
health service juggernaut to often unsuspecting clients.
Conditions, such as neuroleptic malignant syndrome,
neuroleptic-induced acute dystonia, neuroleptic-induced
acute akathisia, neuroleptic-induced tardive dyskinesia,
neuroleptic-induced parkinsonism, and medication-
induced postural tremor, are all contenders and are symp-
tomatic of treatment-based strategies, and could be said
to be emblematic of psychiatric expansionism, whereby
both everyday behaviours and the seeking of treatment
for conditions listed under the DSM-IV-TR might place
people under the expanding purview of mental health. It
would seem that all of the categories listed above are
conditions that the hospital has been instrumental in
causing by virtue of treatments offered for other illnesses.

Mad/bad distinction

In keeping with the breakdown of discursive boundaries
and dichotomized categories, the DSM-IV-TR creates a
situation in which the collapsing of the mad/bad distinc-
tion can proceed with some authority, since all socially-
unacceptable behaviour can be located within its catch-all

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criteria. It effectively dissolves the boundaries between ‘bad’ and ‘mad’. Such a view appears/tends to be authorized by the DSM-IV-TR.

Human foibles, personality, and diagnosis
The fact is that nobody can truly claim that their behaviour is completely free of the symptomatology listed in the DSM-IV-TR criteria. The signs and symptoms described in the DSM-IV-TR are so all-encompassing that they can be considered inherent aspects of the human condition, because they often include the range of human foibles, intricacies, the unboundless differences of personality, and the peculiarities associated with diagnosis. Thus, the DSM-IV-TR, because of these individual idiosyncrasies, does not really face up to and allow for the permeability, fickleness, and inconsistency of the narrow range of boundaries between mental health and mental illness. These are traditionally acknowledged aspects of psychiatric nosology and are acknowledged and recognized in previous versions of the manual. The distinctive strategy of the DSM-IV-TR, with these narrow boundaries, is that it effectively eliminates them by treating human life as inherently a series of ‘boundary conditions’, in which exhibition of signs and symptoms of mental illness are perfectly normal, and individuals move in and out of symptomatology throughout their lives, as might be the case with a potential inclusion in the DSM-V of a condition named ‘temper dysregulation with dysphoria’. It would be reasonable to assume that dysphoria might attract some attention as a diagnosis, yet temper dysregulation would not appear to separate this condition from others by virtue of the fact that temper dysregulation is probably common to everyone. In response to Szasz’s (1974) warning that according to modern psychiatry, we are all in danger of being regarded as ill until proven otherwise, the DSM-IV-TR declares such ‘proof’ to be quite real, whereby, according to the catch-all descriptors, we move in and out of mental health and mental illness dependent on a range of contextual life circumstances. In this respect, we might view the DSM-IV-TR as the forerunner of a truly post-modern psychiatric nosology, in which all categories are possible, and all human beings can be situated with varying degrees of certainty. The number of possible categories expands to equal the number of individuals to whom the DSM-IV-TR applies. The categories of the DSM-IV-TR are infinitely elastic, and thus, ultimately self-dissolving whenever it suits.

Stigma: now you see it, now you don’t!
Decisions to resort to the DSM-IV-TR are laden with diagnostic risk for both the person being diagnosed and the person using this taxonomy, as arguably, decisions derived from this ‘bible of practice’ might not always be consistent with the contextual facts and could be seen as artificial, self-constructed, and designed to enable the practitioner to afford the issue of a label. The consignment of a label allows clinicians to provide a treatment package to be applied, and criteria for this treatment are then justified. The one labelled can then almost self-fulfil the assigned diagnostic categorization. Usage of the DSM-IV-TR encourages the concoction of this label, based on risk for the presenting individual and their family, who might become destructive or violent; second, for the psychiatric professionals who might find themselves the target of recriminations or legal proceedings should this happen; and third, for the community at large that might have to bear the brunt of those destructive or violent strategies that the literature appears to suggest is happening right now, as the large institutions close and care is delivered in community settings (Elder 2009). From this standpoint, the DSM-IV-TR has become a tool for the management of risk, and risk has become, or is likely to become, the yardstick for psychiatric diagnosis and treatment. Under these arrangements the status quo tends to remain, and psychiatry maintains its place as the gatekeeper to social norms. Anyone falling outside of these parameters is then deemed ‘bad’; therefore, incarceration in other institutions becomes an option. As Rose (1996) observes, some forms of what were, until now, regarded as madness now pass for normality, and the management of populations in terms of risk blurs the division that was once symbolized by the walls of the asylum.

Szasz’s (1973, p. 23) description of mental illness being a ‘myth’ is also instructive, whereby he insists that diagnosis and categorization of illnesses and diseases are done at the clinicians’ ‘own peril’. Similarly, the DSM-IV-TR does not say that mental illnesses do not exist; it simply provides a diagnostic umbrella under which clinicians might place any individual, or not, as they see fit, according to personally interpreted non-psychiatric riders relating to harm, impairment, dangerousness and so forth (Holmes & Warelow 1999). We argue here that the DSM-IV-TR contains such a flexible and unlimited range of diagnostic parameters that, in fact, all behaviour has the potential to be categorized under this taxonomy, and the risks plus the social control functions this poses to oneself and/or others would be almost infinite. These arrangements also offer clinicians the opportunity to gauge the ‘peril’ of which Szasz spoke, to assess the risk, and to manufacture a mental illness when the risk is undesirable.
Psychiatry as risk management
This notion of psychiatry as risk management is consistent with the suggestion that the DSM-IV-TR is a postmodern taxonomy (Holmes & Warelow 1999). Clearly, everyday life has become risky, and this view is articulated in a range of post-modern literature (e.g. Beck 1992; Beck et al. 1994; Giddens 1991; 1994; Lash & Urry 1994; Luhmann 1993). Post-modernism is a theoretical movement, but has also developed in response to what might be called tangible, significant changes in the world. These factors contribute to the emergence of ‘risk’ in post-modern literature. The world is viewed by some commentators as increasingly risky in relation to a wide variety of social phenomena, and these are as significant today as they were at the end of the 20th century. These issues are factors that have placed risk at the centre of a substantial post-modern literature, and with this, it is not surprising that the discreditation of traditional boundaries, and the problem of risk management, should be reflected in the intellectual products of our time, including the DSM-IV-TR.

The issue of risk in relation to the DSM-IV-TR is instructive here, and Giddens (1991) makes the point that the concept of risk is closely related with that of security. He argues that the nature of risk has changed and that there is a ‘globalization of risk in the sense of intensity’ (e.g. nuclear war) and in terms of ‘the expanding number of contingent events which affect everyone or at least very large numbers of people on the planet’. New risks arise from the nature of modern social organization. There is risk stemming from the created environment, or socialized nature: the infusion of human knowledge into the material environment, and the development of institutionalized risk environments affecting the life chances of millions (e.g. investment markets). In addition, and very importantly, there is greater awareness of risk as risk, which is well distributed throughout society.

The security threat that individuals face is, at base, the threat to their very identity from the ways in which abstract systems tend to operate. The challenge to individuals is to construct and reconstruct their own identity, which is no longer safe and given, being often constructed by traditional institutions, arrangements, and cultures, but are constantly at risk. This construction and reconstruction of identity plays into the expansionist framework offered by the DSM-IV-TR.

Giddens (1991; 1992; 1994) argues further that there is a ‘globalization of risk in the sense of intensity’ (e.g. nuclear war) and in terms of ‘the expanding number of contingent events which affect everyone or at least very large numbers of people on the planet’. New risks arise from the nature of modern social organization. There is risk stemming from the created environment, or socialized nature: the infusion of human knowledge into the material environment, and the development of institutionalized risk environments affecting the life chances of millions (e.g. investment markets). In addition, and very importantly, there is greater awareness of risk as risk, which is well distributed throughout society.

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According to Fauman (1994, p. 1), in the CONCLUSION sustained. health movement, which is now based on risk, could/is needed. The DSM-IV-TR is that it deconstructs the modernist notion, and isolated modern self. Rather, our interpretation of the DSM-IV-TR is an ‘inappropriate (tool) to obtain an understanding of the post-modern self’ (p. 21). That is, as a diagnostic manual, it leaves much to be desired, but as a tool of risk management, it needs no alternative. We reject Gottschalk’s assertion that DSM-type diagnoses rest on and reproduce the idea of a stable, self-contained, and isolated modern self. Therefore, the DSM-IV-TR is an ‘inappropriate (tool) to obtain an understanding of the post-modern self’ (p. 21). That is, as a diagnostic manual, it leaves much to be desired, but as a tool of risk management, it needs no alternative. We reject Gottschalk’s assertion that DSM-type diagnoses rest on and reproduce the idea of a stable, self-contained, and isolated modern self. Rather, our interpretation of the DSM-IV-TR is that it deconstructs the modernist notion, and formalizes a dynamic, multidimensional alternative that nonetheless enables more or less useful differentiations to be made, upon which a socially-validated mental health movement, which is now based on risk, could be/is sustained.

CONCLUSION

According to Fauman (1994, p. 1), in the Study Guide to DSM-IV, any diagnosis in the DSM-IV-TR is like a ready-made suit that comes in a variety of standard styles and sizes. They fit many patients well, others adequately, and some barely at all. The clinician’s task, like the clothier’s, is to fit individuals with specific characteristics into standard, predefined categories. In this fitting, the clinician, like the clothier, is required by the model to find and fit the patient into the appropriate diagnostic category, even if he or she has atypical signs and symptoms. This is not or should not be the intent of the manual, which appears to be conducted under what is called ‘practitioner discretion’ and is often driven by risk factors. These risk factors are factors for both clients with and without mental health issues, as we have alluded in this paper. Also, risk to the agency or the clinician providing the service, where potential litigation can be part of the admission criteria.

We have suggested, however, that rather than ready-made suits, the DSM-IV-TR offers made-to-measure garments, such that all comers might be suitably attired. In other words, all people can be diagnosed as having a mental illness. We have argued that a diagnosis under the DSM-IV-TR is in many ways socially, contextually, and culturally determined, and we do not believe that the decision as to what are appropriate criteria for human phenomena should be assigned to a category of mental illness and should not be one that is open for individuals to make. However, the promotion of pathologizing interpretations of human phenomena by the psychiatric system and pharmaceutical companies, which we have argued is facilitated by the DSM-IV-TR, often seems to be at odds with the wishes and preferences of society at large. Further, society at large tends by inaction to allow the psychiatric system to expand at an alarming rate, as it continues to include everyday idiosyncrasies under its growing diagnostic juggernaut. The DSM-IV-TR is a liberal instrument that breaks down conceptual and diagnostic barriers, and provides a broad, non-stigmatizing approach to identifying and responding to a very wide range of human behaviour. Less positively, however, because it depicts us all as neither ‘sane’ nor ‘insane’, but more or less ‘mentally disordered’ at different times, the DSM-IV-TR has the potential to exert increased social control not only over those who were once identified as unequivocally ‘mentally ill’, but over everyone. It enables the psychiatric establishment to extend its legitimate authority to everyone. No individual can be excused from its social control function, since we all come under the unbounded diagnostic umbrella of the DSM-IV-TR. Traditionally, psychiatrists have been the gatekeepers to the ghetto for social misfits, but the DSM-IV-TR taxonomizes sanity and insanity in and out of existence, as the system, and those who work in, it deem fit. The floodgates are as wide or as narrow as those gatekeepers wish to make them. For these reasons, the development of the DSM-IV-TR might turn out to be as significant for the progress of psychiatry internationally as was the work of Tuke and Pinel in Europe, likewise appearing to liberate those with mental illness from their chains, but in fact, serving the ends of social control exercised through the mental health system, affirming and legitimating the expansion of the authority of psychiatry over everyday life.

We would suggest that the views and educational understandings offered in this paper contain a reasonable response that users and the public at large would now begin to find much more acceptable as they start to see the need for society to adopt protective strategies, which might involve radical intervention and recourse to compulsory measures. The DSM-IV-TR seems ideally suited to being used in this way, despite its authors’ disclaimer
that it has limited relevance in legal contexts. That is, as a diagnostic manual, it leaves much to be desired, but as a tool of risk management, it needs no alternative.

REFERENCES