

Some introductory notes on Mental Health and Society: Week 3

This week we'll be dealing with some information on the history and classification of abnormal behaviour, and indicate the types of professional working in the area. The history of abnormal psychology and psychiatry is very diverse. Most abnormal textbooks will give you an idea somewhere in their early chapters.

Theological or spiritual views – have been popular in many civilisations throughout history. People acting in a disturbing way are thought to be possessed by demons or evil spirits or subject to some supernatural influence. The problem is thus a spiritual one, and tends in such societies to be dealt with by priests, shamen etc. Some authors believe that mentally ill people were in the Middle Ages accused of witchcraft and burned (according to Zilboorg, 1941). Maybe 'witches' were not 'genuinely' mentally ill but scapegoats for community's problems. Other versions suggest that madness itself was likely to be thought of as the work of the devil or of witches (Porter, 1988)

There are two trends in the history of modern psychiatry whose contest has shaped what we have today

1) Organic version – In this view mental illness is 'one of the ills that flesh is heir to'. From this perspective it is emphasised that mental illness results from disturbed organic brain function. Organic and organismic views can be traced back to the Ancient Greeks - Hippocrates developed theories about the brain's role in abnormal behaviour, and Plato believed that abnormal behaviour emerges from the conflict between reason and emotion.

In some societies trepanning (trephination) was practised, whereby holes were cut in the skull. Sometimes the people who did this were under the impression that the evil spirits would be let out in this way. However, as most trepanned skulls come from cultures which have disappeared, we don't know what the people believed they were doing

In Europe and North America in the 18th century, with the enlightenment and the 'age of reason', a belief in the rational, physical, material, causal nature of the universe became more widespread among the intellectuals of the day and it became increasingly common to regard psychological and organic factors as the causes of what became known in the 19th century as 'mental illness'. Though some theories such as Mesmerism didn't correspond to modern scientific accounts of these processes, we can see them as attempts to explain madness in terms of new physical discoveries such as electricity. As the 19th century progressed there were reforms in the treatment of the 'mentally ill' Philippe Pinel is credited with unchaining the lunatics in La Salpetriere and La Bicetre hospitals; Dorothea Dix (1802-1887) in the US was in charge of the Civil War nurses for the Union side, and also campaigned for better treatment for patients in asylums. There were advances in therapy and theory. Jean-Martin Charcot (1825-1893) pioneered the treatment of hysteria with hypnosis. Richard von Krafft-Ebing (1840-1902) discovered that GPI (general paralysis of the insane or general paresis) was to do with the long term effects of syphilis on the nervous system.

The conceptualisation and treatment of mental disorders tends to reflect the assumptions and stereotypes to which societies subscribe. E.g. 'Masturbatory

insanity' in the 19th century perhaps reflected Victorian concerns with sexuality. Masturbation was a sign of moral degeneracy, gave you spinal inflammation, made you blind & hairs grow on the palms of your hands, and was believed to be practiced by deceitful, selfish and cunning people. Also, theories that there were sex differences in susceptibility to mental illness tended to reflect the status quo - women were believed to be more susceptible to mental disorders because of their 'weaker' nervous systems, and the presence of their reproductive organs – the very word 'hysteria' implies that the womb was thought to be responsible. Moreover, many key figures in 19th century psychiatry (such as Henry Maudsley) believed that education for women would damage their reproductive health. Freud believed that strong sexual repression in women was the cause of their 'intellectual inferiority'. Freud also promoted what he called the 'infantile seduction theory' of hysteria. Here, he originally believed the stories told to him by women that they'd received unwanted sexual attention from older men when they were girls. However this would have been unacceptable because it would suggest that child abuse was going on on a massive scale in middle class Viennese society, so he replaced it by an idea that patients had fantasised sex ('seduction') with older male friend or relative.

Griesinger (1817-1868) claimed that 'mental diseases are brain diseases'. Kraepelin (1856-1926) believed abnormal behaviour resulted from organic abnormalities. Kraepelin is credited with laying down the foundations of modern classification systems, for example distinguishing dementia praecox (now a defunct category largely replaced by schizophrenia) from manic depression (alternating psychosis).

2) Psychological and social approaches. These can also be traced to the Ancient Greeks. Aristotle analysed the emotions and consciousness, Socrates believed that reason is the cornerstone of the good life. Later in the middle ages, as well as encouraging beliefs in devils, demons and witches (e.g. in the inquisitors' manual, the 'Malleus Maleficarum', published by Sprenger and Kramer in 1484) the Catholic Church produced some thinkers who meditated on the nature of human mental life. For example St Augustine (354-430) who valued introspection, self-analysis, and examination of one's conscience. Later, in the Renaissance Oxford theologian Robert Burton (1577-1640) published the 'Anatomy of melancholy' whose causes he believed included jealousy, love, superstition, solitude, hypochondriasis & mania.

As the European enlightenment developed, it was increasingly believed that psychological conflicts were the source of personal unhappiness and failure to adapt socially. E.g. Heinroth (1773-1843) believed that 'mental illness' resulted from unacceptable impulses and guilt generated by those impulses, and was one of the first to suggest that the individual is sometimes not aware of these conflicts. Later Freud (1856-1939) developed similar theories which emphasised conflict between the id, ego & superego. The 19th century saw many theorists developing ideas about the links between mind and body. E.g. Jean-Martin Charcot (1825-1893) and hysteria where physical symptoms were believed to arise as a result of psychological causes. These might involve pain, loss of sensation, blindness, tics, seizures, paralysis or motor impairment. Charcot noted 'la belle indifference' - that hysterics were generally not concerned about their condition and that symptoms followed patient's often inaccurate theories about how the body worked. Charcot used hypnosis and effected sometimes miraculous cures. He also induced symptoms in healthy people with hypnosis. Pierre Janet (1859-1947) believed that hysteria

involved splitting unpleasant ideas which originated with an unpleasant experience, and shutting them off from conscious awareness so that they manifested themselves in a different way. It was believed that if the patient were able to express the strong feelings that occurred when the event originally took place then the symptoms would lessen. Freud was originally influenced by Charcot, but soon lost interest in hypnosis, and instead relied upon techniques such as dream analyses and free association. However, he retained an interest in hysteria and phobias, and we'll see him again in a few weeks in connection with anxiety disorders.

The 'medical model'. Much 20th century thinking about problems of the kind we'll be dealing with in abnormal psychology is informed by the medical model which proposes that problems of the mind are most usefully conceptualised in terms of a disease or organic malfunction. This is reflected in the terminology, like 'mental illness', mental disorder, psychological disorder, and psychopathology.

This conviction that madness was a medical matter also informed the development of mental hospitals throughout the 19th century and Britain led the world in lunacy. Most of our classifications of mental problems derive from similar classification schemes for physical illness. In the next document we'll deal with the details of two well known schemes, DSM (American) and ICD10 (European). In the meantime let us note some problems with the medical model.

1. Is illness a useful or logically correct way to understand problems in living? Szasz (1974: 267) says 'Strictly speaking disease or illness can affect only the body; hence there can be no mental illness...Minds can be 'sick' only in the sense that jokes are 'sick' or economies are 'sick'. Also he says that going to a psychiatrist is like taking your TV to a repair shop because you don't like the programmes. The medical model converts moral and social questions into medical questions.

2. The stigma of labels (Becker, 1973; Rothblum et al 1986). With a mental health diagnosis one may experience difficulty finding work, or somewhere to live (Page, 1977), or in making friends. A diagnosis may create a role or self-fulfilling prophecy (Scheff, 1975), for example the 'alcoholic role' or 'neurotic role' which people then live up to.

3. Pseudo-explanations. Making diagnoses gives the illusion that we understand more than we do. 'Why does he do this?' - 'Because he's schizophrenic' - 'How do we know he's schizophrenic?' - 'Because of what he does'. Consequently there is an element of tautological or circular reasoning. Diagnoses may only be descriptive labels rather than explanations.

4. Patient role. The medical model encourages people to adopt the role of the patient (Korchin, 1976). This may encourage people passive and likely to wait for someone else to cure them. It may also affect the way that practitioners see them and interpret their actions – everything they do is seen as part of their 'illness'. For example, a famous study by Rosenhan (1973) examined the self fulfilling role of symptoms and labels by getting eight people admitted to hospital who complained of voices saying 'empty', hollow' and 'thud'. After being admitted the people then acted normally, but were not discharged immediately. Their stays ranged from 7 to 52 days with an average of 19 days. Whilst in hospital they made notes on what was going on in the wards. When their medical and nursing notes were obtained afterwards, they contained statements which reframed their activity as if it were a symptom of something, for example 'patient engages in writing behaviour'. Once discharged, several of their case records read 'schizophrenia in remission'.

Types of professional involved in dealing with abnormal behaviour.

Clinical psychologist. Clinical psychologists' careers begin with a degree in psychology. This is usually followed by relevant work experience and then a postgraduate course in clinical psychology. In the 1990s the UK followed the US in making these into doctoral courses. Clinical psychologists may use behaviour therapies, cognitive behaviour therapies or insight (talk & self exploration) therapies.

Psychiatrist. Medical doctor who has specialised in psychiatry. Can prescribe drugs. In this country the role is often oriented towards drug therapy, but there seems to be more influence of psychoanalysis in the US.

Psychoanalyst. Usually medical doctor who has undergone psychoanalytic training. Sometimes has also undergone psychiatric training. Traditionally, this was largely based on self-analysis, which involved submitting to psychoanalysis oneself. As well as Freud, British psychoanalysis often involves the so-called 'object relations' school (Klein, Winnicott).

Mental Health Nurse. Usually about 3 years training to RMN, but may be general nurse who has specialised. They may also have a degree in nursing or some other discipline. They often work in hospital settings but may work with patients or ex patients settling in the 'community' in the role of a CPN (community psychiatric nurse). Or as they tend to get called now Community Mental Health Nurses (CMHNs)

Social workers, psychiatric social workers. Typically have degree and CQSW, or more recently Dip S.W.) They often work with patients and their families and ease transition to non-hospital care. Approved social workers are also involved in admitting people to hospital under Mental Health Acts.

Counsellors. Often have degree; usually have diploma or master's qualification in counselling.

Mental Health Support Workers Work with people with severe and enduring mental health problems who live in the community. Their focus is on the whole person, including their social circumstances, and they base their support on maintaining a close relationship with the person.

Many health authorities and hospitals working with a team based approach to therapy and treatment, so depending on the personnel available patients may be dealt with by a number of staff working together.

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Mental health and society: Lecture on classification and diagnosis week 3

What do we mean by abnormal? Culture and society change and values about what constitutes acceptable behaviour may be different. Killing, self mutilation, screaming, starving, bingeing etc may be legitimate under some circumstances. On the other hand some behaviour has sometimes been outlawed e.g. masturbating, drinking, being gay or lesbian etc. and regarded as pathological which might now be officially accepted. The medical model inherited from physical medicine tempts us to think in terms of categories of disease and health as if they were mutually exclusive, and of disease categories as if they were like physical diseases.

In most modern Abnormal Psychology books however a more subtle definition and model of abnormality is used where several aspects of the situation are considered. Various criteria used to determine what situations are suitable for therapeutic intervention. E.g. most abnormal psychology books list some or all of the following criteria.

- i) Personal unhappiness*, dissatisfactions and concerns. However, some people whose behaviour is problematic do not acknowledge a problem.
- ii) Concerns of other people*. Parents, friends, work colleagues might think there are problems. Often the case with e.g. drinking - other people become concerned before the drinker him/herself.
- iii) Dysfunction*, An inability to carry out one's functions in an effective, self enhancing manner. However, sometimes people undergo a great deal of unhappiness or deprivation to serve some higher goal.
- iv) Legal and community problems*. People come into conflict with the law, all the way from minor nuisance to murder. Or there may be conflict with other people e.g. neighbours.
- v) Danger, to oneself or others*. Relatively rare amongst distressed people but nevertheless a potent issue for practitioners. Predicting dangerousness arose out of a 19th century concern to know the criminal mind, and with the problem of 'moral insanity'. More recently there have been a number of cases where people have been discharged from institutional care to create problems for themselves or the community later.

Dangerousness, Psychopathy and the Law

There is a complex intersection of diagnostic schemes and legislation at work to determine the placement of problematic people. For example when we consider the category of 'psychopathy' this has been the subject of a great deal of research and legislation. It does not formally appear in DSM or ICD but it appears under 'antisocial' personality disorder in DSM and 'dissocial personality disorder' in ICD. In the 1983 Mental Health Act it is defined as follows

Psychopathic disorder means a persistent disorder or disability of mind (whether or not including a significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.' (HMSO, 1983, p 2).

To try to identify 'psychopaths' a number of people have come up with diagnostic criteria (e.g. Cleckley, 1964; Hare, 1980). Hare, 1980 identifies the following features:

1) Glibness and superficial charm. 2) Grandiose sense of self worth. 3) Need for stimulation and proneness to boredom. 4) Pathological lying. 5) Cunning and manipulative. 6) Lack of remorse or guilt. 7) Shallow affect. 8) Callous and lacking in empathy. 9) Parasitic lifestyle. 10) Poor behavioural controls. 11) Promiscuous sexual behaviour, 12) Early behavioural problems. 13) Lack of realistic long-term plans. 14) Impulsivity. 15) Irresponsibility. 16) Failure to accept responsibility for own actions. 18) Juvenile delinquency. 19) Revocation of conditional release. 20) Criminal versatility.

There are other attempts to identify distinctive features of psychopathy too. Hancock et al (2011) attempted to distinguish the language use patterns of psychopaths from other criminals and discovered that those who met the criteria for psychopathy on the Hare Checklist were more likely to include more rational cause and-effect descriptors (e.g., 'because', 'since'), focused on material needs (food, drink, money), and contained fewer references to social needs (family, religion/spirituality). Psychopaths' speech also contained a higher frequency of disfluencies ('uh', 'um').

Despite all these features which clinicians can look for, there are problems. For example Blackburn (1990, p 57) points out that 'Psychopathic disorder or anti-social personality are simply umbrella terms which cover a mixed group of people who have in common only a history of socially deviant behaviour.'

As Levenson (1992) adds, social deviance in psychopathy is defined by reference to prevailing social norms. So 'opponents of Nazi rule in Nazi Germany, opponents of segregation in the American South and apartheid in South Africa and, currently, Americans who are not devoted to increasing consumption display a 'psychopathic trend'' (Levenson, 1992, p 54) Moreover the DSM-IV criteria for Anti-social personality disorder make no reference to 'such practices as "despoiling the environment and destroying other species for personal profit", "manipulating others to their detriment on the conduct of management", "destroying the long term productive capacity of an economy in the interest of short term profit" or "using deceptive practices to obtain public office" (Levenson, 1992, p 55).

In discussions for DSM 5 there was some consideration of a new 'dyssocial personality disorder' category. However, the existing 6 categories of personality disorder were retained.

Management of identity and stigma

People may manage the impression others get of them so as to appear favourably, as described in Erving Goffman's 'Presentation of self in everyday life' and 'Relations in public'. 'Abnormal' behaviour can be the subject of stigma & prejudice. Ex 'mental patients' may have problems with housing, jobs etc. more so than patients who've had physical medical problems.

Maladaptive behaviour can be distinguished from deviant behaviour. Deviant behaviour may be unusual but doesn't necessarily interfere with people's lives, and can even be productive, whilst maladaptive behaviour is detrimental to one's wellbeing.

Prevalence, incidence and classification. It is difficult to obtain accurate information about the extent of 'maladaptive' behaviour, because many cases may not come to the attention of professionals, and people may not reveal the extent and nature of their problems. Violent offenders may mostly get caught but e.g. people with e.g. anxiety conditions, phobias may not. Kessler et al (2005) in a survey of nearly 10,000 people – the National Co-Morbidity Survey in the US suggest a lifetime rate for all DSM disorders of 46.4%, with the more commonly reported difficulties being mood disorder (20.8%), anxiety disorders (28.8%), substance use disorders (14.6%) and 'impulse control disorders' (24.8%). These latter include conduct disorder, oppositional-defiant disorder, intermittent explosive disorder and ADHD.

Wittchen et al (2011) reviewed a large number of surveys and epidemiological studies from European countries and surmised that mental health problems (or as they say 'disorders of the brain') affect 38.2% of the EU population in any given year. E.g. depression 6.9%, anxiety disorders 14%.

The classification of problems is very widespread in psychiatry, possibly as a result of the influence of the medical model and by analogy with physical medicine. In books and articles you'll see a lot of reference to DSM III, DSM III R, or DSMIV, the diagnostic and statistical manual of the American Psychiatric Association. There are advantages and disadvantages to having a standardised classification for people and their problems.

Advantages are i) A classification system facilitates rapid and accurate communication between clinicians ii) Can help relate individuals' problems to general principles. E.g. what therapies have worked with cases like this in the past? iii) Use in record keeping and studies of incidence, prevalence, causes and therapies of particular kinds of problem.

Disadvantages are i) putting labels on people which is said to somehow increase the likelihood that they'll persist with the maladaptive behaviour that got them diagnosed in the first place. ii) May invite prejudice and discrimination, jobs, friends, housing, insurance etc. may all be more difficult to get if you've got a psychiatric record. iii) Uniqueness of individuals' problems mean that widely applied blanket categories may mask the essential unique features of the problem. iii) Categorising on the basis of symptoms may mask the possibility that the same symptom may occur as a result of different causes. iv) Ambiguities, inconsistencies, reliability problems with applying classification schemes. Even with explicit criteria, different clinicians apply the criteria differently. Patients may display different symptoms as their problem evolves and may describe it differently. There may be interactional effects between clients/patients and therapists/psychiatrists.

In addition to DSM, there is the *ICD 10* by the World Health Organisation (WHO 1992) This is a list of categories to describe a person's condition. The mental disorders chapter is based on psychiatric conventions in WHO member states e.g. it maintains the neurosis psychosis distinction because it is widely used whereas this is no longer a feature of DSM.

DSM IV is a more 'programmatic' document in that the authors were trying to influence the diagnostic activity of clinicians. *DSM IV* involved a revision of the previous schemes and appeared in 1994. A good scheme should attempt to classify i) the nature of the problem e.g. a person believes they are being spied on ii) the context - a) recent experiences which may have aroused stress and initiated or

worsened the condition. b) the client/patient's vulnerabilities and weaknesses c) assets and strengths.

Application of DSM IV/DSMIV-TR involves rating the client/patient on a number of dimensions or 'axes', so that the diagnosis results in a characterisation of the problem in terms of a number of clinically important factors.

The first three axes have now been collapsed into a single classification scheme in DSM5. As we go through the module I'll be highlighting some of the differences in individual disorders from the old to the new version. However, most books will be based on DSM IV because it's been around for nearly 20 years.

AXIS 1 contains the primary classification of the problem that requires attention. It does not include personality and specific developmental disorders.

Thus, it contains:

- i) Disorders of infancy childhood or adolescence. e.g. disruptive behaviour, gender identity disorders and certain eating disorders.
- ii) Organic mental disorders. Transient or permanent brain dysfunction due to e.g. ageing, psychotropic drugs, including psychotic states brought about by e.g. alcohol consumption.
- iii) Psychoactive substance use disorders, Personal and social problems brought about by the use of e.g. heroin, 'crack', cannabis (?), alcohol, tobacco.
- iv) Sleep disorders. Insomnia and sleep difficulties, achieving sleep or staying asleep. Daytime sleepiness, impairment of respiration during sleep, sleep walking, sleep terrors, disturbance of the sleep wake schedule.
- v) Schizophrenia. Disorganised behaviour and thought which is chronic and severe enough to be considered psychotic (delusions, hallucinations) incoherence and social isolation.
- vi) Delusional (paranoid disorder) system of delusions, often of being persecuted, without the incoherence bizarreness seen in schizophrenia.
- vii) Psychotic disorders not classified elsewhere. Includes schizophreniform disorders which look like schizophrenia, but are of less than six months duration. Brief psychosis in reaction to a stressor, schizoaffective disorders (a combination of delusion and disorganisation accompanied by elation and/or depression).
- viii) Mood (affective) disorders. Mania (elation) or depression or bipolar affective disorder (manic-depression).
- ix) Anxiety disorders. Anxiety, tension and worry without the delusional aspects of schizophrenia. Also includes stress related anxieties e.g. post traumatic stress disorder PTSD. May be brief or chronic.
- x) Somatoform disorders. Somatic symptoms for which no medical cause can be found, and which may be related to psychological factors and conflicts.
- xi) Dissociative disorders. Sudden temporary change in normal functioning e.g. sleepwalking, amnesia.
- xii) Sexual disorders. Sexual thoughts and behaviour which are troubling to self and others. Includes paraphilias, impotence, premature ejaculation etc.
- xiii) Factitious disorders. Producing symptoms deliberately to play the role of the patient. This seems to be under voluntary control and more like lying than delusions.
- xiv) Impulse control disorders not classified elsewhere. Failure to resist impulses, e.g. chronic gambling, arson, stealing.
- xv) Adjustment disorder. Reactions to life events which are expected to ease when the stressor lessens or the circumstances change.
- xvi) Psychological factors affecting physical condition. Psychosomatic or psychophysiological disorders. Migraine, dysmenorrhoea, asthma, ulcers.

AXIS II Developmental and personality disorders. These are characterised as beginning in childhood or adolescence and usually persist in stable form in adult life.

i) Developmental disorders. 'Mental retardation' (as the Americans called it up to 2013; now intellectual disability) where a person is severely subaverage. Pervasive developmental disorder involves impairment in interaction and communication and stereotyped behaviour. Specific developmental disorders include problems with particular things like speech, literacy, numeracy, or physical co-ordination.

ii) Personality disorders. These are enduring inflexible maladaptive patterns of perceiving, thinking about and relating to the environment and oneself. Problematic because many people may exhibit these characteristics, does not distinguish clearly between maladaptive traits that cause personal unhappiness and ineffectiveness which is of clinical significance and the traits that non clinical samples might have. In addition there are:

AXIS III Physical disorders that seem relevant to the case, e.g. history of heart attacks.

AXIS IV severity of psychosocial stressors in the client's recent past. Usually rated on scale of 1 to 6. 1 = none, 2 = mild e.g. job problems, 3 = moderate, e.g. retirement, relationship problems, 4 = severe e.g. divorce, unemployment, 5 = extreme e.g. victim of rape, serious crime of violence, serious illness, 6 = catastrophic e.g. death of child, being taken hostage.

Now called 'significant psychosocial and contextual features' in DSM5.

AXIS V contains a global assessment of psychological functioning, social relationships, and occupational functioning both now and at the highest point in the past year. Now dropped in DSM5.

Evaluating DSM: Criticisms and difficulties

American Psychiatric Association president Carol Bernstein (2011) says:

"a large number of patients receiving any *DSM-IV* diagnosis also meet criteria for multiple diagnoses. Some studies have identified clusters of disorders that co-occur at very high frequencies. For example, many of the *DSM-IV* anxiety disorders co-occur, often with a mood disorder (often described as an "internalizing cluster"); antisocial personality disorder, attention-deficit/hyperactivity disorder, multiple substance use disorders, and other disruptive disorders co-occur with each other at high frequency (often described as an "externalizing cluster"); and patients with personality disorders (PDs) rarely receive a single PD diagnosis".

In compiling DSM the authors sought to be specific about the kinds of behaviour and experience which would lead to diagnosis and less emphasis than previous schemes than theories about the causes of mental problems. Some evaluation studies which went into its development suggest that inter-clinician agreement is good for axes I and V but less satisfactory for axis II and IV. (Spitzer et al, 1979; Spitzer & Forman, 1979). Some believe that including e.g. literacy & numeracy difficulties is inappropriate. Seems to be easier to achieve agreement between clinicians on broad categories than fine grained distinctions (Rutter & Shaffer, 1980). Some argue that we need a classification scheme which involves inferences about causes and inner psychodynamics (e.g. Vaillant, 1984). Some argue the opposite, that DSM relies too heavily on theory ('schizophrenia' 'anxiety' 'paranoia' are after all hypothetical constructs). R.B. Cattell (1983) suggested that

instead of relying on the classifications described in DSM, we should break the problems down into a large number of symptoms which can be reliably rated and then apply this to a large group of people and factor analyse to see which symptoms tend to occur together. He claimed that this should form the basis of our diagnostic and classificatory scheme. He says of DSM: 'The categories are not even objectively statistically discovered but are apparently the work of a committee.' (1983, p. 771). Some studies already had done this and the results were not supportive of the existing category schemes (reviewed by Mirowsky, 1990). In 'real life' there's overlap between the categories and different patients behave differently in different situations.

Additional problems with the process of categorisation are highlighted by Acton (1998) who identifies i) lack of coverage, ii) co-morbidity – there may be people who display problems with symptoms falling into two or more categories and iii) within category heterogeneity – there may be a great deal of diversity amongst, say, 'schizophrenics'. Some clinicians feel that categories are an artificial barrier to understanding. As Kendell says (1991, p. 13):

"For the last 20 years I have been dismayed by the widespread assumption that schizophrenia and manic depressive illness are distinct diseases because we have given them different names . . . I have therefore tried again and again to convince my students and colleagues that these assumptions are unjustified and that we must be prepared to consider other possibilities, and to think in dimensional terms." Or, like Mirowsky (1990) some argue that the boundaries are arbitrary.

Some controversial diagnoses and objections to DSM

Some object to DSM on the grounds that it embodies 'masculine-biased assumptions about what behaviours are healthy and what behaviours are crazy' (Kaplan, 1983: 786) which are codified in diagnostic criteria. Kaplan (1983) says DSM makes "the assumption that women should act more dependently than men - by which DSM guides clinicians to label women. That is, DSM singles out for scrutiny and therefore diagnosis the ways in which women express dependency, but not the ways in which men express dependency. For instance, DSM does not mention the dependency of individuals - usually men - who rely on others to maintain their houses and take care of their children." (1983: 789).

Or to take another example **Pre-menstrual Tension, or 'pre-menstrual dysphoric disorder' (PMDD)**. This has long history and concerns about the effects of hormones on mood can be traced to the 1920s. There was some suggestion from a DSM study group that DSMIV should contain this category, which could be diagnosed when a women regularly experiences at least 5 of 11 symptoms during the week prior to menses, which include sad or hopeless feelings, tense or anxious feelings, marked mood changes, frequent irritability or anger and increased interpersonal conflicts, decreased interest in usual activities, lack of concentration, lack of energy, changes in appetite, insomnia or sleepiness, subjective feelings of being overwhelmed or out of control, physical symptoms such as swollen breasts, headaches, muscle pain, bloating sensations or weight gain. The proposal of this category was extremely controversial. Although the study group intended that it should only apply to about 5% of women, there were concerns from the National Organisation of Women that as many as 42% of women would qualify for a diagnosis. (Chase, 1993, DeAngelis, 1993). There were concerns that this category

would encourage people to see women's behaviour as a function of their hormones and might promote discrimination. It is also difficult to demonstrate differences between those who suffer and those who don't. Moreover, researchers don't tend to promote links between 'male hormones' and mental health.

It is now a discretionary category under the heading of 'depressive disorder not otherwise specified'. The debate has been revived as it has appeared as a 'proper' disorder in DSM 5 (Epperson et al, 2012).

A further example of a category which is problematic is **ADD/ADHD - Attention deficit hyperactivity disorder**. To what extent is this category being developed in order to aid the management of troublesome children? (Laurence and McCallum, 1998). Incidence is rising, especially in the US. The symptoms are vague and often expansively applied (Isaacs, 2008; Timimi and Leo, 2009). To what extent then is psychiatry engaged in an attempt at 'the production and maintenance of social normality and competence' (Rose, 1996). As Laurence and McCallum (1998, p. 199) 'The possibility of thinking and acting on modern categories of child arose from governmental attempts to know and understand the disruptive individual by means of techniques of calculability which carved out a new space - the space 'inside the child's head' – for the operation of power'

The DSM system is coming under criticism from the US National Institute of Mental Health as well.

<http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>

DSM, it says, is like a dictionary or checklist and has been constructed to achieve reliability. Director of NIMH Tom Insel claims that the categories have poor validity because they fail to correspond in any meaningful way to underlying pathology or biomarkers. The NIMH proposes instead RDoC – Research Domain Criteria – where categories are based on more physiological markers derived from neuroscience and molecular genetics rather than merely by listing symptoms. Of course, because such features are often hard to detect reliably or decisively, it's still pretty much in its infancy.

Opposing classification

Many more radical critics of the idea of mental illness and psychiatry oppose the process of classification because it is dehumanising or because the idea of 'mental illness' is based on a logical or psychological fallacy. Szasz (1967) believed that 'the mind was not an organ of the body therefore it cannot be diseased' and furthermore argued that any benefits from diagnosis were offset by the dehumanising aspects of disease classification and treatment (Szasz, 1970). Laing (e.g. 1960) Cooper (1970) believed that i) the symptoms of 'mental illness' could be understood in terms of the life history, sets of experiences, family circumstances of the person who ended up diagnosed as in 'Sanity Madness and the Family' (Laing 1970). ii) The symptoms were a way of trying to cope with and transcend the circumstances which gave rise to them - a 'breaking through' rather than a 'breaking down'.

For more on the contemporary manifestations of antipsychiatry see Hopton (2006) or Whiteley (2012) in the Brown library or via the list of material on diagnosis I've provided on my website.

More modern critiques tend to focus on the question of how we conceptualise and apply categories, such as depression (Pilgrim and Rogers, 1999; McPherson and

Armstrong, 2009), female sexual desire disorders (Angel, 2012), or ADHD (Wheeler, 2010).

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