Theoretical Alternatives to the Psychiatric Model of Mental Disorder Labeling

Contemporary Frameworks, Taxonomies, and Models

Edited by

Arnoldo Cantú, Eric Maisel and Chuck Ruby

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To my parents, Maria and Pedro,
whose unconditional and immeasurable love
have made me the person I am today.
-AC

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Editor's Introduction

Arnoldo Cantú

We live in a divisive and polarizing time in which it is becoming increasingly important for people to be able to speak their minds and contribute to our "epistemic commons" (i.e., the "stock of evidence, ideas, and perspectives that are alive for a given community"[1]) lest we fall prey to the *spiral of silence*—that is, how comfortable and willing an individual feels in voicing (or, more concerningly, not) a particular view or opinion may be associated with how popular or unacceptable that thought is perceived to be.[2]

Now more than ever—especially in the field of mental health with its predominant and controversial biomedical model used for labeling and "treating" human suffering—we need to embody and exert a sort of "cognitive liberty"[3] to satiate our collective hunger for wanting to voice (and hear) differing views, opinions, and perspectives about addressing complex social problems.

The World Health Organization (WHO) recently produced a reported in October of 2023 entitled "Mental health, human rights and legislation: guidance and practice"[4] that some are suggesting is *more* than advocacy for a paradigm shift in the field of mental health.[5] Relatedly, just a few years ago in 2017, United Nations Special Rapporteur, Dainius Pūras, pointedly stated that "there is unequivocal evidence that the dominance of and the overreliance upon the biomedical paradigm, including the front-line

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[1] Joshi, H. (2021). *Why it's OK to speak your mind*. Routledge. p. xvi

[2] Noelle-Neumann, E. (1974). The spiral of silence a theory of public opinion. *Journal of Communication*, *24*(2), 43–51. https://doi.org/10.1111/j.1460-2466.1974.tb00367.x

[3] https://www.madinamerica.com/2019/07/cognitive-liberty-principle-rally-behind/

[4] https://www.who.int/publications/i/item/9789240080737

[5] https://www.madinamerica.com/2023/11/the-who-and-the-united-nations-let-freedom-ring-for-the-mad/

and excessive use of psychotropic medicines, is a failure."[6] He added that the biomedical model is an "obstacle" that neglects "the importance of context, relationships and other important social and underlying determinants of mental health."[7]

This volume is an attempt at that—at contributing to our epistemic commons as it pertains to the field of mental health and considering how associated disciplines (e.g., psychiatry, clinical psychology, social work, counseling) play a role in contributing to a paradigm shift. As the title suggests, this book consists of differing philosophical views, models, taxonomies, frameworks, and perspectives across the globe for viewing and supporting those experiencing suffering and distress.

It is my hope that these alternatives can, hopefully, further help the reader move away from viewing "mental health problems" through the traditional biomedical model lens, and consider more humanistic, non-medicalized, and non-pathological ways for helping people. We are *all* weary travelers roaming this earth—trying to make sense and meaning of it all—with our common humanity binding us together. It is only fair for us to help bring one another up—not disempower each other through questionable labels and models—when we are already suffering.

Disclaimer: *If you or anyone you know is taking a prescriptive psychiatric medication for any reason deemed appropriate by the prescribing physician, alteration or discontinuation of the drug(s) is not recommended by any of the information provided by the reading material found in this volume, Similarly, the content in this book should not be interpreted, directly or indirectly, as suggestions for any other current support (e.g., psychotherapy, counseling) to be abruptly discontinued without discussion with your healthcare provider.*

[6] https://www.ohchr.org/en/statements/2017/09/statement-mr-dainius-puras-special-rapporteur-right-everyone-enjoyment-highest
[7] Ibid.

Setting the Stage

The Foundational Flaw of the DSM

Chuck Ruby

Abstract: *The DSM is seriously flawed and, therefore, isn't a legitimate professional tool. It is a collection of moral pronouncements about appropriate ways of living and not a diagnostic guide that identifies and classifies illnesses. As such, it has been used over the years under the pretext of advancing mental health to oppress people who do not conform to certain desired behaviors and experiences. In essence, it extends the reach of the criminal justice system to enforce desired conduct, but it does so without the protections of due process of law. Furthermore, it provides no basis for helping people who are in the throes of emotional distress. We would be far better off abandoning the attempt of squeezing the square peg of human suffering into the round hole of medical nosology.*

Moral Disorders

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) is a compendium of human experiences and behaviors that have been deemed abnormal by psychiatric fiat. They are called mental *dis*orders because they deviate from sanctioned mental orders, but they are presented as illnesses or diseases of the mind. Such a capricious distinction between mental normality and abnormality, and the illogical leap from deviation to illness and disease, places in doubt the legitimacy of the manual and the categories within it, especially when using it under the guise of the assessment and care of one's health.

It is important to emphasize that all attempts to distinguish between mental normality and abnormality (order vs. disorder) are necessarily based on everchanging moral value judgments about the appropriateness of human thoughts, emotions, and conduct.[1] Classifying these purported forms of abnormality into different categories is not a clinical or medical task, but an

[1] Unfortunately for a large portion of the population subjected to the *DSM*, these moral value judgments grew from a European, White, male, Judeo-Christian perspective.

administrative one primarily for the purpose of communicating about them with others. This can occur in the larger interest of coercing people into more convenient (i.e., "normal/ordered") ways of being. It is not a process of identifying and classifying illnesses, diseases, or "dysfunction[s] in the individual"[2] as is claimed by the *DSM* and commonly believed within psychiatry, clinical psychology, and other allied clinical professions.

Physical and chemical processes of the body do, in fact, have abnormal ways of functioning from a *biological viability standpoint*. Those dysfunctions directly threaten ongoing biological capacity and life, and that is why they are assessed and treated with medical science. As with all fields of science, this is independent of moral values of those who identify and classify the abnormalities. Most importantly, the choice to remedy or ignore these physical and chemical dysfunctions is a decision made by the affected individual, not the physician. This is in line with the humanistic principles of informed consent and self-determination.

On the other hand, the only way to judge dysfunction (i.e., "abnormality/ disorder") of human experiences and behaviors is from a *moral standpoint* – that which an observer considers good or bad, right or wrong, too much or too little, appropriate or inappropriate. The etymological origin of the term supports this assertion as the prefix in *dys*function means "…destroying the *good* sense of a word or increasing its *bad* sense…."[3] [italics added for emphasis]. So, a mental dysfunction would be claimed based on a lack of good thoughts, feelings, and actions and a surplus of bad ones. But how do we determine if those things are good or bad? This moral foundation is also revealed in the fact that, contrary to when physical and chemical dysfunctions occur, people who are labeled mentally disordered are often forced or cajoled into treatment "for their own good." They are not afforded the right of informed consent and self-determination or to seek out help at their own choosing and for their own reasons. In short, they are not permitted to determine what they desire or what is good or bad for themselves.

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[2] American Psychiatric Association. (2013). *The Diagnostic and Statistical Manual of Mental Disorders* (*5th Edition*). Washington, DC: American Psychiatric Association, p. 20.
[3] https://www.etymonline.com.

This moral quagmire is accentuated by the failure of the psychiatric community to provide robust evidence for the claim that mental disorders are the result of "dysfunction in the individual." In fact, if physical and chemical dysfunctions were ever discovered as the cause of what had been deemed a mental disorder, the problem would no longer fall within that domain. As examples, the lethargy of low thyroid functioning, the delirium of urinary tract infections, and the mood changes of Lyme disease are not symptoms of mental disorders; they are symptoms of *physical and chemical process dysfunctions*. These bodily defects are the critical targets of treatment. Ignoring the defect and merely treating the symptoms can be lethal. The point is that mental disorders *cannot* have a bodily dysfunction as the cause because if they did, it would be oxymoronic – they wouldn't be mental disorders. Instead, they would be physical disorders and the target of medical specialties like neurology, endocrinology, and oncology—not psychiatry.

With mental disorders, only the so-called symptoms can be treated. This means disrupting the central nervous system with chemicals, electricity, or surgery with the intention of interfering with *normal* brain functioning for the sole purpose of preventing the unwanted experiences and behaviors from happening, or to wheedle a person to stop behaving and thinking as they do. Thus, psychiatric treatment doesn't correct, cure, or medicate a defect that is responsible for symptoms since no such defect exists. It merely dampens or eliminates the so-called symptoms. This is especially problematic since the above forms of psychiatric treatment obscure personal meaning—meaning that sprouts forth from our experiences. Remove or numb the experiences and you remove or numb the meaning, potentially resulting in a pointless life.

There are nagging questions that result from the foregoing discussion. How do we identify bad or inappropriate thinking? Does it have to be very different from what other people think? Different from which people? How much different? Must thoughts cause social and interpersonal problems? Or is it sufficient that they only result in an internal sense of distress that no one else would notice? What about the reverse? What if others deem the thoughts bad and troublesome but the thinker does not? How attentive

should a child be during boring classroom instruction? Which beliefs are good, and which are delusions?

This predicament applies to behaviors as well. Is it bad to take drugs? Does it depend on whether the substance is illegal or prescribed? How much of a quantity would it take to reach the appropriate-inappropriate threshold? How about other problematic behaviors? Is it bad when a person exhibits road rage? Is violent crime a sign of dysfunction in the individual or just a criminal choice and failure to inhibit urges? When someone is in despair, how long can they stay in bed and isolate from others before it is considered inappropriate?

This also applies to emotions. What are bad emotions? Are despair and fear bad? Or is it only inappropriate when no one else is feeling those things? What level of emotional distress is inappropriate? Is it bad to hold a grudge against a spouse for something they said that was hurtful? Does it matter how long the resentment lasts? What are valid reasons for feeling shame? How much excitement or pride is too much? Are emotions inappropriate only when they lead to problematic actions?

We have no authoritative basis for answering these questions, and this means we have no authoritative basis for using the *DSM*. They are not medical questions or matters of literal health and illness that can be studied through laboratory analysis of human functioning. Instead, when it comes to the orthodox assessment and treatment of people struggling with life problems, clinicians use their own personal moral values or the mental health industry's ambiguous conventional wisdom contained in *DSM* diagnostic guidelines. It comes down to how *should* a person think, how *should* a person act, and how *should* a person feel.

Historical Examples

Despite the fundamental moral basis of determining mental and behavioral abnormality, psychiatry has identified numerous types over the years, passing them off as bona fide illnesses and subjecting them to medical forms of treatment. The following are just a few illuminating examples.

In the early 19th century, slaves who had the urge to run away from their masters were said to be suffering from the mental disorder *drapetomania*. Those who resisted working for their masters were said to suffer from *dysaesthesia aethiopica*.[4] Whereas these were considered legitimate psychiatric diagnoses then, it is now obvious to us they were wholly based in the morality of the times when ideas of racial inferiority were commonplace, and resisting the institution of slavery was considered a bad thing.

Another example is autism. In her book, *Asperger's Children: The Origins of Autism in Nazi Vienna,*[5] historian Edith Sheffer explained that scientists in 1930s Germany wanted to identify children who were socially reticent—in particular, those who were disinterested in joining the Hitler Youth. They enlisted the help of pediatrician Hans Asperger to study the problem. Building on earlier 20th century concepts of autism[6] as something akin to schizophrenia, where inner life dominates over the outer world, Asperger eventually came up with a category for these children called *autistic psycho-pathology*. This culminated in dozens of them being euthanized because they were not interested in joining social groups, which was considered a mental abnormality. But this was nothing more than a moral judgment about the appropriateness of their interests and disinterests.

Further examples live on in more modern times. Homosexuality was classified as a mental disorder until 1973 when the American Psychiatric Association (APA) polled its members during the annual convention and found a majority of them *believed* it shouldn't be considered a mental disorder anymore. Out of nearly 10,000 members in attendance, 61% voted to remove it from the *DSM*.[7] Alarmingly, almost 40% were still committed

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[4] Cartwright, S. (1851). Diseases and Peculiarities of the Negro Race. *DeBow's Review, 11*.

[5] Sheffer, E. (2018). *Asperger's Children: The Origins of Autism in Nazi Vienna*. New York: W. W. Norton & Company.

[6] The term autism was coined in 1911 by the German psychiatrist Eugene Bleuler as explained in Evans, B. (2013). How autism became autism: The radical transformation of a central concept of child development in Britain. *History of the Human Sciences, 26(3)*, 3-31. http://doi: 10.1177/0952695113484320. The ideas of autism at this pre-Nazi time were still, nonetheless, based on moral judgments about how much inner life should dominate over the outer world.

[7] Burton, N. (2015, September). When homosexuality stopped being a mental disorder: Not until 1987 did homosexuality completely fall out of the DSM. *Psychology Today*.

to the idea that it was a mental/behavioral abnormality. In contrast to other medical specialties, voting on the reality of mental disorders is not uncommon in psychiatry—it just isn't as blatant as this example. More typically, mental disorders are discussed and negotiated in committee meetings behind closed doors where committee members use their moral values (and financial interests) in determining what is and what isn't a mental abnormality.

In her book, *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*, psychologist Paula Caplan, Ph.D. reviewed the case of masochistic personality disorder, which was eventually abandoned in the 1980s after activists argued it was discriminatory against women – it was.[8] The category was intended to describe people who appear to allow themselves to be abused in relationships. To quell the activists' protests, the name was changed to self-defeating personality disorder to remove the negative connotation of the term masochistic. An incident during the negotiations over this proposed category further demonstrates its moral, not scientific or medical, foundation. During a committee meeting about the proposed symptoms, a committee member noted that one of them applied to her, and so the chair removed it from the list.[9] The committee was trying to decide how much mistreatment a person should tolerate in a relationship—and how much was too much.

As another example, Asperger's disorder (named after the pediatrician from Nazi Germany above) was eliminated as a diagnostic category during the 2013 revision of the *DSM*. It was removed because a large study demonstrated "there was great variation in how BEC [best-estimate clinical] diagnoses within the autism spectrum (i.e., autistic disorder, PDD-

Retrieved from: https://www.psychologytoday.com/us/blog/hide-and-seek/201509/when-homosexuality-stopped-being-mental-disorder.

[8] Caplan, P. (1995). *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Boston, MA: Addison-Wesley. This same information was also reported later in Kutchins, H. & Kirk, S. (1997). *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*. New York: Free Press.

[9] Ibid, p. 91.

NOS, and Asperger syndrome) were assigned to individual children."[10] In other words, well-trained clinicians couldn't agree on what it was, even when using specific diagnostic criteria in the *DSM*. This suggests that diagnostic decisions about Asperger's disorder were substantially based on clinicians' individual ideas of the inappropriateness of certain behaviors and experiences. But it wasn't just Asperger's disorder that was eliminated. All three diagnoses above (autistic disorder, PDD-NOS, and Asperger syndrome) were eliminated and combined into a new category label – autism spectrum disorder (ASD). This is nothing more than a semantic sleight of hand and, more problematically, there is still only minimal agreement about what the new category ASD is, suggesting a continuation of personal moral criteria used in diagnosing it.[11]

One last illustrative example of morality at play in determining mental abnormality was in May 2019 when the World Health Organization's (WHO) legislative body ratified a proposal to reclassify gender incongruence (also called gender dysphoria and commonly known as transgender) in the *International Classification of Diseases* (*ICD*) so it would no longer be considered a mental disorder.[12] Like the issue earlier with homosexuality, this is a clear example of how political pressure and changes in moral views—not science—dictate whether or not something is considered inappropriate and, thus, a mental abnormality. The advocates of this change claimed it "...was taken out from the mental health disorders because we had a better understanding that this wasn't actually a mental

[10] Lord, C., Petkova, E., Hus V., Gan, W., Lu, F., Martin, D., Ousley, O., Guy, L., Bernier, R., Gerdts, J., Algermissen, M., Whitaker, A., Sutcliffe, J., Warren, Z., Klin, A., Saulnier, C., Hanson, E., Hundley, R., Piggot, J., Fombonne, E., Steiman, M.…Risi, S. (2012). A Multisite Study of the Clinical Diagnosis of Different Autism Spectrum Disorders. *Archives of General Psychiatry, 69(3)*, 306–313. doi:10.1001/archgenpsychiatry.2011.148.

[11] Rice, C., Carpenter, L., Morrier, M., Lord, C., DiRienzo, M., Boan, A., Skowyra, C., Fusco, A., Baio, J. Esler, A., Zahorodny, W., Hobson, N., Mars, A., Thurm, A., Bishop, S., & Wiggins, L. (2022). Defining in detail and evaluating reliability of *DSM-5* criteria for autism spectrum disorder (ASD) among children. *Journal of Autism and Developmental Disorders, 52(12),* 5308–5320. doi:10.1007/s10803-021-05377-y.

[12] Human Rights Watch. (2019, May). New health guidelines propel transgender rights: World Health Organization removes 'Gender Identity Disorder" diagnosis. Retrieved from: https://www.hrw.org/news/2019/05/27/new-health-guidelines-propel-transgender-rights.

health condition and leaving it there was causing stigma."[13] What this translates to is they removed it as a mental disorder because they no longer thought it was a deviation from normal experiences and behavior; in other words, it was no longer inappropriate.

These are noteworthy illustrations of the moral basis of mental disorder diagnoses. The same criticism applies to all other mental disorder categories in the *DSM*.[14] They are descriptive category labels for different kinds of human experiences and behaviors that are considered inappropriate by those in power, yet they are camouflaged as internal dysfunction to be addressed with a medically-minded approach. This evolution of mental disorder diagnoses has been an ongoing process of medicalizing moral injunctions.

The Psychiatric Bible

The orthodox mental health industry ignores the moral basis of mental disorder and insists on creating an ever-increasing array of categories in the *DSM*. The *DSM* is mockingly by some, yet reverently by others, called the "psychiatric bible." Whereas I think this nickname is appropriate as the manual is a collection of moral pronouncements, the name also, unfortunately, implies some kind of legitimacy. In its opening pages, it starts with this puzzling disclaimer: "Although DSM-5 remains a categorical classification of separate disorders, we recognize that mental disorders do not always fit completely within the boundaries of a single disorder."[15] It is alarming that the manual admits at the outset that its guidelines do not define separate disorders. The categories have such

[13] Ravitz, J. (2019, May). Transgender people are not mentally ill, the WHO decrees. CNN. Retrieved from: https://www.cnn.com/2019/05/28/health/who-transgender-reclassified-not-mental-disorder/index.html.

[14] This excludes diagnoses in the *DSM* that describe real biological pathology and associated mental symptoms (e.g., major and mild neurocognitive disorder due to diseases such as Alzheimer's disease and HIV infection, substance withdrawal, and substance/medication induced mental disorders).

[15] American Psychiatric Association. (2013). *The Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*. Washington, DC: American Psychiatric Association, p. xli.

blurred boundary lines that they substantially overlap with each other, and they are so inclusive as to define almost any human problem.

But, arguably, the most confusing thing about the *DSM* is the official definition it gives for mental disorder, at last count numbering in the hundreds:

> A mental disorder is a syndrome characterized by *clinically significant* disturbance in an individual's cognition, emotion regulation, or behavior that reflects a *dysfunction in* the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with *significant distress* in social, occupational, or other important activities. An *expectable or culturally approved* response to a *common* stressor or loss, such as the death of a loved one, is not a mental disorder. *Socially deviant behavior* (e.g., political, religious, or sexual) *and conflicts* that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a *dysfunction in* the individual, as described above.[16] [italics added for emphasis].

I remember the first time I read this definition. I felt like I was watching a shell game, desperately trying to keep my eye on the pea. Consider how the italicized terms above make it impossible to settle on a firm operational definition of the construct, and, thus, to decide whether something is a mental disorder. The only way to interpret these terms is to use moral value judgments about what constitutes clinical significance and distress, dysfunction, expectations, cultural norms, commonness, social deviance, and conflicts. These morality-laden terms and phrases also show up in each diagnostic category's criteria as well.

The last sentence in the definition is particularly troublesome. It claims, "socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society" are not mental disorders. But since everything in the *DSM* is based on moral judgments about what behaviors and experiences are inappropriate enough to be

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[16] American Psychiatric Association. (2013). *The Diagnostic and Statistical Manual of Mental Disorders (5th Edition)*. Washington, DC: American Psychiatric Association, p. 20.

considered disordered, they are necessarily some kind of deviant behavior or conflict with societal (moral) norms. So, this caveat would dictate nothing in the manual is a mental disorder. However, immediately after this proviso, it claims these deviant behaviors and conflicts are mental disorders if they arise from a dysfunction in the individual. But this is exactly what the definition says they are in the first place, making the absurd argument that a mental disorder is not a mental disorder unless it is a mental disorder!

Research on the *DSM* exposes this poor foundation. In scientific terms, the *DSM* is neither reliable nor valid. First, it has poor *reliability*.[17] Reliability is when an assessment tool provides the same results regardless of who uses it or how many times it is used to assess one person for the same problem. Ideally, we want an assessment tool to be consistent in its conclusions and not be biased by the evaluator's personal values. The *DSM* fails in this regard, as reflected in the previously noted lack of expert consensus regarding autism and in the manual's own admission that it doesn't identify distinct problems. They are not different kinds of discrete dysfunctions in the individual.[18] Second, the *DSM* has poor *validity*. Validity is when an instrument identifies the thing it says it is identifying. As has been mentioned already, the thing it says it is identifying is not really a dysfunction in the individual.

Because of these reliability and validity problems, the *DSM* has received severe criticism, even from top mainstream authorities in the field. The Task Force Chair of one of the editions, Allen Frances, M.D., exclaimed: "There is no definition of mental disorder. It's bullshit. I mean you just can't

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[17] Cooper, R. (2014). How reliable is the DSM-5? Blog entry at Mad in America. Retrieved from: https://www.madinamerica.com/2014/09/how-reliable-is-the-dsm-5/; Kirk, S. & Kutchins, H. (1992). *The Selling of DSM: The Rhetoric of Science in Psychiatry*. New Brunswick, NJ: Aldine Transaction.; Regier D. A., Narrow W.; Clarks D.; Kraemer H.; Kuramoto S.; Kuhl E.; & Kupfer D. (2013). DSM-5 field trials in the United States and Canada, Part II: Test-retest reliability of selected categorical diagnoses. *American Journal of Psychiatry, 170*, 59-70. https://doi:10.1176/appi.ajp.2012.12070999.

[18] Allsop, K.; Read, J.; Corcoran, R.; & Kinderman, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatric Research, 279*, 15-22. https://doi.org/10.1016/j.psychres.2019.07.005.

define it."[19] He later discouraged professionals from buying and using the *DSM*. He said the *DSM* was so "dangerous in its product that many mental health professionals may choose not to use it…. My advice - don't buy DSM 5, don't use it, don't teach it."[20] Two Directors of the National Institute of Mental Health (NIMH) have also denounced the *DSM*. Steven Hyman, M.D. (1996-2001), said the *DSM* was "totally wrong," "an absolute scientific nightmare," "a fool's errand," that it had "wasted human capital and industry funds,"[21] and contained "widely accepted but fictive diagnostic categories…."[22] Hyman's successor, Thomas Insel, M.D. (2002-2015), said the *DSM*'s "weakness is its lack of validity" and its categories are "based on a consensus…not any objective laboratory measure."[23] Because of these serious problems, the NIMH has abandoned the *DSM* for research purposes, yet bizarrely suggested that it continue to be used by practitioners.[24]

Some mental health member organizations also registered their complaints about the *DSM*. The British Psychological Society (BPS), representing over 70,000 members, declared that the diagnoses were based on social norms, subjective value judgments, and had no confirmatory evidence of biological causation (dysfunction in the individual).[25] The Society for

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[19] Frances, A. (2010, December). Inside the battle to define mental illness. *Wired*. Retrieved from https://www.wired.com/2010/12/ff_dsmv/.

[20] Frances, A. (2013, July). Should social workers use the DSM-5. *SWHELPER*. Retrieved from: https://www.socialworkhelper.com/2013/06/07/should-social-workers-use-dsm-5/.

[21] Hyman, S. (2013, May). Psychiatry Framework Seeks to Reform Diagnostic Doctrine. *Nature*. Retrieved at https://www.nature.com/news/psychiatry-framework-seeks-to-reform-diagnostic-doctrine-1.12972.

[22] Casey, B.; Craddock, N.; Cuthbert, B.; Hyman, S.; Lee, F.; & Ressler, K. (2013). DSM-5 and RDoC: progress in psychiatry research? *Nature Reviews Neuroscience, 14(11)*, 810-814. https://doi:10.1038/nrn3621.

[23] Insel, T. (2013, April). Post by Former NIMH Director Thomas Insel: Transforming Diagnosis. Retrieved at https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/transforming-diagnosis.shtml.

[24] American Psychological Association. (2013). NIMH funding to shift away from DSM categories. Retrieved from: https://www.apa.org/monitor/2013/07-08/nimh#:~:text=Instead%2C%20the%20institute%20is%20developing,%22abandonment%22%20of%20the%20DSM.

[25] British Psychological Society. (2011). Response to the American Psychiatric Association: DSM-5 Development. Retrieved from: http://whatcausesmentalillness.com/images/110630britishpsychologicalassnresponse2dsm-5.pdf.

Humanistic Psychology (SHP) (Division 32 of the American Psychological Association) drafted an open letter in opposition to the *DSM* because of these problems. The petition eventually received over 15,000 endorsements from individuals and more than 50 organizations, including 16 other divisions of the American Psychological Association. Members from the American Counseling Association (ACA) also submitted a petition to address these very same problems.[26]

Despite this uproar from within professional circles, the American Psychiatric Association, who publishes the *DSM*, refuses to address this serious problem with the foundation of the orthodox psychiatric belief system. Other major mental health member organizations in the United States have likewise ignored it.[27] As a prime example of this intransigence, it was only after two years of repeated urging that the Chief of Professional Practice of the American Psychological Association finally responded in 2019 to a request for ethical guidance about the *DSM*, saying "I can appreciate that this is an important issue to you, and I hope that I can be of service by offering clarity and a conclusion. The APA will not be making a comment on this issue now, nor in the foreseeable future."[28] This is an unacceptable response from an organization that has the responsibility to address ethical issues facing its members.

This is not just an academic question. On the contrary, the *DSM* can be harmful to the people who are labeled with its dubious diagnoses. First, it can damage one's sense of identity, worth, and power. This is especially true if the person believes the diagnosis reflects an innate personal defect

[26] Robbins, B.; Kamens, S.; & Elkins, D. (2017). DSM reform efforts by the Society for Humanistic Psychology. *Journal of Humanistic Psychology*, 1-23. https://doi.org/10.1177/0022167817698617.

[27] International Society for Ethical Psychology and Psychiatry. (2017). ISEPP Demands Ethical Guidance on the DSM: In the Face of an Ethical Double Bind, ISEPP Petitions Leading Professional Mental Health Member Organizations. *PRNewswire*. Retrieved from: https://www.prnewswire.com/news-releases/english-releases/isepp-demands-ethical-guidance-on-the-dsm-300504497.html.

[28] Personal email communication with Dr. Jaren L. Skillings, Ph.D., ABPP, Chief of Professional Practice, American Psychological Association, September 26, 2019.

in functioning, just like how the *DSM* says it is a "dysfunction in the individual."

Second, having a diagnosis can affect how other people interact with the person. Not only do laypeople tend to keep their distance from someone who has been diagnosed mentally disordered, many professionals' perceptions are negatively affected as well. In other words, many professionals view and treat people based on the *DSM* label they've been assigned, not necessarily based on their actions or stated desires. A classic study showed just how powerful this effect can be.[29]

Third, *DSM* diagnoses (even the relatively "minor" ones) in a person's record can also jeopardize many rights and privileges. These include employment suitability, security clearances, military service, health and life insurance eligibility, parenting and adoption rights, and parole and probation actions. As our private lives are increasingly subjected to the prying eyes of government and industry, will we see a *DSM* label being the basis for denying other things like housing and financial eligibility and acceptance at colleges and universities? It seems they are as harmful as criminal conviction records. Given the moral basis for how people are branded with them, this is not surprising. They are little more than derogatory moral judgments of people who face very common and understandable human struggles.

Moral Categories Run Amuck

Despite having this overabundance of mental disorder diagnoses in the *DSM*, just three categories would be sufficient: *Up*, *Down*, and *All-Around*.

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[29] Rosenhan, D. (1973). On being sane in insane places. *Science, 179 (4070)*, 250-258. This study was critiqued in Cahalan, S. (2019). *The Great Pretender: The Undercover Mission that Changed Our Understanding of Madness*. New York, NY: Grand Central Publishing. In it, Cahalan expresses great concern about some of the study's results possibly being fabricated. However, in a recent interview with *Psychiatric Times*, she said: "I still think that the idea of seeing a patient, not just a diagnostic label, is an extremely valuable lesson. I also believe that his [Rosenhan's] statements about being primed to see certain behaviors as pathological in certain contexts and perfectly normal in others is something that all doctors should be aware of. Those parts of the paper, I believe, still have value." Aftab, A. (2020, February). 50 shades of misdiagnosis. *Psychiatric Times*. Retrieved from: https://www.psychiatrictimes.com/qas/50-shades-misdiagnosis.

People who are very excitable or obsessed are Up; those who are in the depths of despair are Down; and those who are very confused, disoriented, and disconnected are All-Around.[30] Although these are somewhat lighthearted categories, they do accurately describe the most basic forms of human distress and subcategorizing them any further has little value. But how did the number of mental disorder categories grow so much?

In 1812, Benjamin Rush, who was considered the father of American psychiatry, classified only two types of mental and behavioral problems: "They have been divided, 1, into such as act, *directly* upon the body; and, 2, such as act *indirectly* upon the body, through the medium of the mind" [italics in the original].[31] Examples of the first category were brain lesions, tumors, epilepsy, exposure to toxic substances, and excessive consumption of alcohol. Some examples of the second category were intense study, rapid shifting of attention from one topic to another, extensive and constant imagination, excessive memorization, and intense emotions. It seems clear from our vantage point that Rush's first category consisted of physical (neurological) diseases, not mental disorders. On the other hand, the second category formed the forerunner of the present-day mental disorder construct.

Twenty-eight years later, in line with Rush's second category, there was only one category officially tracked by the U.S. census.[32] This was idiocy/insanity. Forty years after that, the census differentiated among seven different categories that could be grouped into the Up, Down, and All-Around distinctions. These were mania, monomania, dipsomania, melancholia, paresis, dementia, and epilepsy. Mania, monomania, and dipsomania would correspond to the Up category. The latter two of them are obsessions with something: a fixed idea and alcohol, respectively.

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[30] Even these three categories suffer from reliability problems. This is because human experiences are multifactorial. It is far too simplistic to claim a person only suffers from one of these. In reality, we are all suffering from all three of these, with the intensity on a continuum, at any point in our lives.

[31] Rush, B. (1812). *Medical Inquiries and Observations Upon the Diseases of the Mind.* Philadelphia: Kimber & Richardson. Retrieved from: https://archive.org/details/2569037R.nlm.nih.gov, p. 30.

[32] American Psychiatric Association. (2018). DSM History. Retrieved from: https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm.

Melancholia corresponds to Down. Paresis, dementia, and epilepsy belong to the medical specialty of neurology (as did Rush's first category above), and it doesn't make sense to include them as mental disorders. Still, the symptoms of these last three would be classified as psychosis, and so would fall within the All-Around category.

Later in the 19th century, psychiatrist Emil Kraepelin (1856-1926) presented two categories, again aligned with Up, Down, and All-Around. He differentiated between *dementia praecox* (All-Around) and *manic-depression* (Up and Down).[33] Over the subsequent decades after Rush, Kraepelin, and others, there were efforts to subdivide these basic mental disorder categories into a multitude of more specific types of inappropriateness, but they were disguised as matters for medical assessment and care.

In *Cultures of Healing: Correcting the Image of American Mental Health Care*,[34] philosopher and psychotherapist Robert Fancher described how in the late 19th and early 20th centuries, in addition to expanding the categories of mental disorder, there was also a significant transition in psychiatry's focus. It shifted from remotely located rural asylums to urban-based hospitals that were centers of general medical care, the latter whose various medical specialties had far better scientific reputations than asylum psychiatrists who relied mostly on confinement, isolation, chains, and straitjackets to treat (subdue) people.

Psychiatry also expanded its influence at this time by targeting additional forms of mental abnormalities. These were mild to moderate forms of distress that were not as devastating as the more severe situations common in the asylums, and they could be handled in outpatient as well as short-term inpatient settings. These developments allowed psychiatry to join the ranks of other, more respected, medical specialties, thus setting the stage for diagnostic expansion. However, this apparent elevation of the profession to the level of other medical specialties, such as neurology and

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[33] Hoff, P. (2015). The Kraepelinian tradition. *Dialogues in Clinical Neuroscience, 17(1)*, 31- 41.

[34] Fancher, R. (1995). *Cultures of Healing: Correcting the Image of American Mental Health Care*.
New York: W. H. Freeman/Times Books/Henry Holt & Co.

ophthalmology, was only a medical disguise as psychiatry's raison d'être continued to be the moral judgment of people and their conduct.

The *DSM* did not arrive on the scene until the mid-20th century, but, since then, it has been the scaffolding used to drastically expand the number of diagnoses. The first *DSM* was published in 1952. Over the subsequent 70 years, it has undergone seven revisions. During that time, it grew into a hefty tome, increasing from its original 132 pages to 1,120 pages in *DSM-5-TR*, which was published in 2022.

The number of mental disorder diagnoses also increased, but the American Psychiatric Association doesn't provide an official tally. One source reported that the 2013 *DSM-5* had 541 separate categories.[35] However, the actual number is debatable depending on how one counts its categories, subcategories, and specifiers. The *DSM-5* has 22 main categories. If all midlevel subtypes of the main categories are counted, there are 193 separate diagnoses, not counting 72 additional "unspecified" and "other specified" categories. Each midlevel category has at least one these, such as "unspecified depressive disorder" and "other specified anxiety disorder," that identify problems as mental disorders even when they don't meet the full *DSM* criteria. It is very telling that more than one out of four *DSM* categories has such ambiguous rules for diagnosing. It leaves much of the decision up to the diagnostician's personal moral values.

Yet, despite this explosion of apparent diagnostic specificity, subdividing human problems any further than Up, Down, and All-Around has little value other than to create the illusion that the *DSM* is a medical catalogue facilitating precise understanding and diagnoses of several distinct kinds of mental disorders and, thus, more (putative) fine-tuned and effective treatment.

Treating the Name?

Advocates of conventional psychiatry believe that getting the correct mental disorder diagnosis is essential in determining how to help the

[35] Blashfield, R.; Keeley, J.; Flanagan, E.; & Miles, S. (2014). The cycle of classification: The DSM-I through DSM-5. *Annual Review of Clinical Psychology, 10*, 25-51.

person. Whereas it is important to pay attention to and understand the specifics of their problems, and then to address those problems and not others, many professionals spend a lot of time parsing criteria and fretting about which diagnosis is the correct one. This makes it appear as if they haven't heard the news about the *DSM*'s unreliability and invalidity or the *DSM's* own admission that "mental disorders do not always fit completely within the boundaries of a single disorder," as mentioned earlier. Quibbling over the correct *DSM* diagnosis is like debating whether a person's behaviors and interests make them a Capricorn or Aquarius without knowing their birth date.

A mental disorder diagnosis is irrelevant for purposes of helping since it doesn't point to a dysfunction in the individual that can be treated. This is especially evident when we consider the fact that there are a limited number of interventions available to psychiatrists and psychotherapists. Psychiatrists typically prescribe drugs that have generally inebriating effects or, in the more serious of cases, they might administer electric shock to the brain or perform surgery to disable certain brain functions.

Describing psychiatric drugs as antidepressants, antianxiety, antipsychotic, and mood stabilizers is more of a marketing tactic than a true description of their chemical properties or effects. Prescribing one over another is mostly a trial-and-error process, not one dictated by precise medical rules or how each chemical affects the brain. This is in stark contrast to real medical problems such as diabetes, where insulin is prescribed to lower dangerous levels of blood sugar. There are no drugs tailored for a particular disorder, notwithstanding what the advertisements claim, and how some psychiatrists and patients will anecdotally swear that certain drugs work better than others with certain types of problems.

This lack of psychiatric chemical specificity is further revealed in the fact that drugs in one class are frequently used for problems in another class. For instance, antidepressants are used for anxiety, antipsychotics are used with depression, antianxiety and stimulant drugs are used for depression, and anticonvulsant and blood pressure drugs are used for psychiatric reasons. This lack of chemical specificity is also why antidepressants can cause suicidal thoughts and depression while antianxiety drugs can cause

agitation and anxiety. Which drug works the best is based mostly on what each person taking the drug feels, not the drug's chemical properties or what the drug is advertised to do.

This same problem with the imprecision of psychiatric drugs applies to electric shock treatment and surgery as well. They don't target specific brain dysfunctions. Instead, electric shock is a "Hail Mary" attempt to reset the person's experiential world and "wipe the slate clean" while psychosurgery intentionally damages brain areas that are involved in the development of distress and behaviors so that the distress and behaviors are no longer possible.

Along similar lines as psychiatric drugs, electric shock, and psychosurgery, psychotherapy is not based on the diagnostic names given to the person. It is based on an understanding of the specific problems the person is complaining about. Basically, this kind of work is a process of exploring and helping people to better understand their life problems and to identify possible solutions. It is not a process of the precise application of a treatment protocol that targets specific symptoms of a dysfunction in the individual or the dysfunction itself. How could it be if the diagnostic criteria themselves (which contain the symptoms) are so unreliable and invalid?

The *DSM* is flawed at its foundation. It falsely presents a multitude of mental disorder categories as the effects of dysfunctions in the individual similar to how the symptoms of diabetes are the effects of an insulin dysfunction in the individual. However, at closer examination from a scientific and critically reasoned perspective —not a clinical lore perspective (which is currently the perspective of orthodox psychiatry)— there are no theorized or verified dysfunctions in people that cause "mental disorder." At best, the morally-derived dysfunctions and the mental disorder symptom clusters are one and the same. At worst, each *DSM* category is merely a moral injunction about the appropriateness of behaviors and experiences. Either way, the scientific value of the *DSM* is nil. Instead, it has taken on only an administrative and bureaucratic position within the conventional mental health system and removing it (as is warranted) poses a significant existential threat to that system.

The Alternatives

Do We Need a New Taxonomy?

Richard Hallam

Abstract: *The classification of human problems in the field demarcated as 'mental health' is presented as just one expression of the transformation of help and advice-giving, traditionally part of friendship, into professional services that have to justify what is on offer, advertise their services, and subject themselves to ethical and legal regulation. As a commercial service or one that government health departments are keen to streamline at minimum cost, there has been a trend towards "McDonaldization," that is, reducing the product to standardized components, simplifying the description of problems, aiming for predictability and control of service-provision, and quantifying outcome with minimal effort. The classification of 'mental health' problems therefore has to be understood as reflecting a much wider process, which will vary according to whether this is e-therapy, trimmed-down state provision, extended one-to-one psychotherapy, or an open-ended group drop-in session providing free-support. A case is made for avoiding taxonomic preconceptions, in line with the author's advocacy, in various publications, of a process of individual case-formulation, arguing that alternatives are likely to be a false economy and lead to burn-out in the personnel providing them.*

I will state my belief at the outset that seeking advice and help from others has always been a feature of socialising in human societies and that we should be careful to preserve it in forms that are, as far as possible, free from commercial interests and government policy. Life rarely runs smoothly for individuals, families, or communities—and since time immemorial people have worked together to find their way through difficulties.

I will focus here on one-to-one helping which, for around a century, has created opportunities for an increasing number of professionals to offer their paid-for services. In general, these professionals have been well-trained, subjected themselves to supervision, and have abided by good

ethical standards. Quite apart from informal helping, societies have always made a space for these specialised roles which includes shaman and priest.

Help-seekers buy into a convincing rationale which means that advertising and salesmanship are always part of the enterprise. Potential clients seek out suppliers who have the right credentials and a good reputation. In practice, satisfaction with the outcome is frequently luck-of-the-draw. Advertising is necessarily formulaic, and the product can only be properly evaluated when translated into practice.

The process of seeking "certified guidance" in the last millennium of western culture can be traced back to religious practices. John Myrc, in the 15C, produced a kind of self-help handbook for parish priests with examples of how to deal with issues that commonly arose during confession (Hallam, 2015). In the background lay all the doctrines of the Catholic Church.

In the often-unstated premises of current expertise lie shared assumptions about "mental health," taxonomies of psychiatric disorders, and psychological models of "dysfunction." Unless the potential client is extremely sophisticated, all of this is taken on trust and not even questioned.

The title of this book, *Theoretical Alternatives to the Psychiatric Model of Mental Disorder Labeling: Contemporary Frameworks, Taxonomies, and Models*, implies that new frameworks are needed. Alternatives in the plural also implies that we should be suspicious of any single model of help or the substitution of a psychological taxonomy for a medical one. The concept of a "mental health problem" is a historically recent fabrication that fails to mean anything much at all, and we should be wary of a new terminology that is equally vacuous.

A request for help can be prompted by so many different reasons with so many contributary causes (relating to ingrained habits, ignorance, somatic disorder, existential dilemmas, overwork, past trauma, rigidity of belief, family breakdown, etc.) that it makes little sense to lump them together into one overarching category. It is for this reason that I advocate a process of *individual case formulation* before proceeding on to suggest potential