

# Psychiatry and the DSM: Cracks in an epistemic empire

## Abstract

*In this article it is argued that the ontological integrity of psychiatry as a medical science remains deeply problematic. Psychiatric practice and attendant descriptive methodology in the form of the Diagnostic and Statistical Manual of Mental Disorders (DSM) have come under mounting scrutiny and criticism. Some of the most strident criticisms of psychiatric practice and theory have come from within its esteemed quarters (see Szasz, 1970), and have been reinvigorated through a recent publication by Allen Frances, the head of the DSM-IV Task Force. The arguments put forward by Frances are not new but carry added significance in that they stem from one of the professions most revered voices. Frances' heretical attack on psychiatry's "bible", the DSM, offers the reader a glimpse into the operations taking place within the "inner sanctum" of psychiatry, the DSM Task Force. It is argued that psychiatry's co-option by Big Pharma is reflective of a form hegemonic alignment that is consistent with the historical and political functioning of the psy-complex in modern bureaucratic society. This article provides a brief historical review of psychiatry's deployment under various political regimes as well as an analysis of the evolution of the DSM and its growing role in the proliferation of psychopathology. The paper closes with an ironic resolve by offering a new discursive architecture for the profession of psychiatry.*

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## Introduction

*“... if you are not like everybody else, then you are abnormal, if you are abnormal, then you are sick. These three categories, not being like everybody else, not being normal and being sick are in fact very different but have been reduced to the same thing.”*

– Michel Foucault, 1975: 95

It seems incontrovertible at this point that psychiatry in concert with large pharmaceutical corporations represents a grand success story for the adaptability and spread of modern capitalism. Marx (1867) theorized about capitalism's innovative capacity, its ability to re-invent itself. It would have been difficult though to imagine at the end of the nineteenth century that the everyday nuances and variances of human behaviour would become one of the most profitable sites for exploitation by capitalist forces. Today, the pharmaceutical industry remains the most profitable in the United States with psychotropic drugs steadily raking in the bulk of this profit (Huskamp, 2006). Let it be noted that a wholesale denigration of pharmaceutical intervention would be crass, insensitive and grossly naïve. For many people, these medicines mark the most important and welcome intervention when facing treatable illnesses. It should be noted as well that a significant component of the resolution forwarded in this paper will speak to the inherent strengths residing within a revised biomedical model of psychiatry. The primary critique offered in this paper is directed toward the manner in which pharmaceutical corporations are able to stretch the parameters of illness to encompass all manner of existential struggle.

At the risk of drawing insensitive metaphorical parallels (see Sontag, 1978), capitalism operates in the mould of a vast and relentless economic cancer. An ever-expanding metastatic force, capitalism spreads ceaselessly and is capable of remarkable adaptation. From its industrialist origins, capitalism has left in its wake a long legacy of exploitation. Colonialism, arguably the nadir of brute capitalist exploitation, warrants brief reflection within the context of the present discussion. Capitalism under the guise of colonialist modernization crudely carved out African geography with scant regard for ethnic nuances, tribal affiliations and the kinship patterns of its local people. Its major mandate was the extraction and exploitation of African locations rich in mineral resources (see Amin, 2003). Its brutal disregard for the people inhabiting these locations is exemplified in the horrors perpetrated by the Belgian colonial empire during their occupation of the Congo. Capitalist industries evince little interest in the human faces behind profit margins. This psychopathic lack of empathy and gross distancing from human suffering lies at the very heart and success of capitalism. This enduring feature of capitalism remains pivotal in its enormous success and adaptability today. Specifically,

modern capitalism has continued to evolve mechanisms for perpetuating its exploitative economic model. It is well established that psychiatry in concert with pharmaceutical corporations offers a compelling illustration of this evolution (see Frances, 2013).

An important caveat warrants issuing at this juncture, namely, that this paper is not a neo-Marxist critique of modern capitalism. The above articulation serves to draw a series of connections that may help elucidate the success and power of this paper's core subject matter: psychiatry and the psy-complex (Rose, 1985). The term psy-complex here designates "a complex of discourses, practices, agents and techniques, deployed within schools, clinics, the judicial and penal processes, the factories and the army ..." (Rose, 1985: 9), and find their material manifestation in psychiatry and related disciplines. The paper also attempts to maintain a critical distance from the type of myopic fervour evinced by some quarters (i.e. Scientology) in their critique of the psy-complex. Any argument directed at completely discrediting particular practices is prone to a narrow and blunt analysis. Central to this paper is a critical reflection on psychiatry and its attendant metanarrative of human suffering, the DSM. It is suggested that psychiatry through its creation and popularization of the DSM disorders provides the linguistic architecture upon which pharmaceutical corporations are able to medicalize our existential interiors. Psychiatry's alignment with pharmaceutical corporations marks the extension of a long history of hegemonic co-option. It is the contention of the author that this unbridled and profit driven form of psychiatric capitalism operates with limited empathy and regard for human nuance, difference and diversity. It too, *al a* colonialism, carves out and defines the coordinates of human suffering with little interest in individual difference and homogenises our rich and varied existential interiors.

## Psychiatry's hegemonic co-option: An unsavoury legacy

*"We can choose to use our growing knowledge to enslave people in ways never dreamed of before, depersonalizing them, controlling them by means so carefully selected that they will perhaps never be aware of their loss of personhood."*

– Carl R Rodgers, Former President of the American Psychological Association (APA), as quoted in **People shapers** by Vance Packard, 1979: 288

Excellent scholarly efforts exist offering a detailed historical sketch of the discipline of psychiatry (see Shorter, 1998). It is the somewhat shorter history of the discipline, which attempts to establish its scientificity (see Rose, 2007), that is of particular interest to the present paper. The analysis limits its purview to the period beginning with the development of psychiatry as a modern medical discipline up to the present day.

It should be clear at this point that the scope of the review is also constrained by the critical nature of this enquiry. Specifically, attention is given to psychiatry's hegemonic alignment with global capitalism as well as its deployment as a tool for advancing oppressive theories and practices.

One of America's founding fathers, Benjamin Rush, has been dubbed by the American Psychiatric Association (APA) as the "father of American psychiatry". So influential was Rush's legacy on psychiatry that his portrait still adorns the official seal of the APA. Rush was one of the first physicians to begin locating the source of psychiatric disease within human biology. For instance, he claimed that insanity derived from an excess of blood in the head. He employed the crude technique of trephination in order to extract excess blood from the brain earning him the epithet "master bleeder". Rush also proselytized a panoply of "cures" such as the restraining chair, cold water baths and other inhumane techniques. In line with the racist ideology permeating his time, Rush also declared negritude to be a form of disease akin to leprosy, for which the only cure was a transition to white skin (Szasz, 1970). The political deployment of such mental health pseudo-science as a vehicle for bolstering racist hegemony served to help entrench segregation in the United States. In 1851, Samuel A Cartwright, a eugenics physician contributed greatly to the development of pseudo-science aimed to justify the enslavement of black people. Cartwright claimed blacks were afflicted with a condition, drapetomania, which caused them to have uncontrollable urges to run away from their "masters". His prescribed treatment for the disease was "whipping the devil out of them" (cf Cartwright, 1851).

Isolating these figures as crucial voices in the antecedents of institutionalized racism in the United States would be overly simplistic. Their contributions, while relevant to the trajectory of psychiatry, plugged into an overarching racist hegemony developing in the United States and Europe during the 18<sup>th</sup> and 19<sup>th</sup> century. Once the preserve of religious appeals to a preordained and divine order, racist theories began to find explication within a variety of pseudo-sciences during this period. While not an overt explication of racist ideology, Darwin's (1859) **Origin of the species** possessed all the theoretical trappings for misappropriation as a unified framework for racist and fascist ideas. Its publication also coincided with a period where a fundamental paradigm shift was happening regarding the spiritual underpinnings of humanity. The notion of human beings as spiritual entities was slowly eroding. Nietzsche (1882) declared "God is dead"; Freud (1970) conceived of a base, hedonistic humanity driven by the "will to pleasure"; and Wundt (as cited in Farr, 1983) declared that humanity has no soul as it cannot be measured. As if released from the moral shackles of religious and humanistic discourses which cast human beings as higher entities, this violent epistemic rupture set in motion a series of important developments. Critically, science came to the fore as the primary

explanatory model for all manner of phenomena, including the complex terrain of human behaviour. This tradition found its apotheosis in the behaviourist movement in psychology, which largely dismissed notions of human beings as psycho-spiritual entities and attempted to explicate human behaviour through recourse to a rigid empiricism founded upon innovative animal studies (see Watson, 1913; Skinner 1974). As a corollary of this turn to a paradigmatic model free of moralistic overtones and underpinned by evolutionary tenets, an even greater and insidious force would emerge in the form of the eugenics movement.

The eugenics movement was initiated by Sir Francis Galton, a Victorian scientist. Galton's chief interest areas were in factors determining "talent and character" and its hereditary basis (Pilgrim, 2008). In elucidating this relationship, Galton would borrow heavily from the theoretical corpus of his cousin, Charles Darwin. His delving into psychiatry, psychology and related fields of study would also have a massive influence in shaping the trajectory of these disciplines in the early twentieth century. America's eugenics movement drew heavily on Galton's theories and culminated in the birth of several research groups and organizations, such as the Eugenics Research Association (ERA), and the Human Betterment Foundation (HBF) (Black, 2003). This emerging epistemic empire would materialize in the implementation of laws that criminalized the reproduction of numerous groups of individuals. Of course, eugenics pseudo-science positing of the superiority of certain race groups would reach its nadir in Nazi Germany during the 1930s and 40s where its wide-scale and systematic implementation would result in the deaths of scores of retarded, mentally ill, as well as politically and sociologically undesirable peoples. The role of the psy-complex in the implementation and justification of these policies is telling. In Germany, psychiatrist Ernst Rüdin was an intellectual leader of the Nazi program of enforced eugenic sterilization and under the 1933 Sterilization Law initiated the systematic extermination of children and mental patients under the euphemistic guise of "euthanasia" (Joseph & Wetzels, 2012). Historical records show that six major psychiatric euthanasia centres utilized medical professionals, fabricated death certificates, operated gas chambers disguised as showers, and were involved in the mass burning of corpses (Breggen, 1993). It is also telling that revisionist historical accounts by leading voices in biological and genetic psychiatry either omit the contributions of Rüdin or frame them in a positive light. This is significant within the context of modern psychiatric practice efforts to elucidate genetic models of mental illness (cf. Fatemi & Clayton, 2008), and the need for distancing from such dubious historical figures in charting this narrative.

The political deployment of psychiatry as a coercive mechanism of the state was also a prominent feature of Soviet Russia. Psychiatrists described political dissidents in Soviet Russia as suffering from a condition called "sluggish schizophrenia", which

was characterized by a lack of political conviction. This politicized form of pathology represents a compelling early illustration of psychiatry's capacity to develop and dispense linguistic labels that reflect the ideological slant of specific historical and political periods. Another politically laden fabrication appeared in the DSM up until the 1973 – a disease called “homosexuality”. It too vanished with the increasing societal acceptance of heteronormative trends in sexuality at the end of the twentieth century. The recent inclusion of the disorder “gender dysphoria” in the DSM 5 is likely to expose once more psychiatry's immense difficulties in separating medico-psychological facts from social values and expectations. Fortunately, DSM-5 committee members opposed the inclusion of “racism” as a mental disease in the latest manual, a diagnosis that would have perniciously obfuscated a harrowing social evil as an individual mental illness (Profit, 2004). What these examples serve to illustrate is psychiatry's functioning as a fluid construct that is shaped by and in turn shapes socio-political events. As such, notions of madness are mutable and are largely based on dominant and imposed notions of social norms (Jones, 2012).

The psychiatric sector in apartheid South Africa also evinces a long, disreputable history of being associated with human rights violations (cf Jones, 2012). Certainly the extent of psychiatric mistreatment during apartheid is to some degree comparable with those in Soviet Russia and Nazi Germany and stemmed from similar ideological and political roots. The architect of apartheid, Hendrik Verwoerd, studied at Leipzig University in Germany during 1926 and expressed a particular affinity with German nationalism (Marx, 2013). Verwoerd was strongly opposed to the representation of non-white groups in the House of Assembly and declared that this biological assimilation would lead to the “bastardization” of Afrikaners (Naicker, 2012). In reviewing the oppressive role of psychiatry during apartheid, it warrants noting that this analysis is prone to gross over-simplification, which may not reflect that mental health delivery during this period was diverse and multi-layered and that practitioners often held conflicting ideological views. To couch this analysis with such caveats and hedges is to hopefully plant a flag for the reader alerting them that this review is constrained to a critique of the psy-complex and is not a homage to counter-hegemonic voices during this period. Regarding psychiatric human rights abuses in South Africa, the private company Smith Mitchell and Company courted much notoriety. Fleur de Villiers (1975) highlighted the appalling conditions within the Smith Mitchell hospitals and accused the company of profiting from psychiatric illnesses, claiming that they held a “monopoly on madness”. Smith Mitchell were essentially able to profit from apartheid policies by minimizing expenditure and utilizing black “psychiatric patients” as a labour force in these institutions. What was dubbed “industrial therapy” in the Smith Mitchell Institutes included the maintenance of buildings and the subcontracting of patient labour to other firms (Fernando, 2004). In their defence, psychiatric institutions in South Africa

were not systematically manipulated in the same manner as in Nazi Germany and Soviet Russia, where political dissidents and sociologically undesirable peoples were sent for extermination. The mistreatments of South African psychiatry pertained more to the gross disparities in the quality of care offered to the different race groups. In 1978, the American Psychiatric Association found that psychiatric care for black people (including that offered by Smith Mitchell) was grossly inferior to that for white people, that unacceptable medical practices had resulted in the needless deaths of black patients and that psychiatric practice as deployed by the apartheid government had a destructive impact on families, social institutions and the mental health of black South Africans (American Psychiatric Association, 1979).

After the tragedy of twentieth century totalitarianism and following the spread of liberal-democratic values in society, one would have envisaged a clawing back of the use of psychiatry as an apparatus for political and ideological activities. It would appear though that the covert use of psychiatric and psychological professionals by state functionaries continues to the present day. A recent press release by the American Psychological Association (2015, July 10) highlighted the collusion among mental health practitioners and US Defence Department Officials in the use of interrogation techniques on political prisoners at Abu Ghraib prison in Iraq. Psychiatrists and psychologists were accused of devising and implementing torture techniques including waterboarding, sleep deprivation, food restriction, and use of threatening dogs, solitary confinement and the use of restraining stress positions. It is important to emphasize that the denunciation of such activities by the APA is reflective of the fact that the many unsavoury activities blemishing the history of psychiatry were very rarely orchestrated from the top in a uni-directional manner. The notion that psychiatry operates as a passive purveyor of oppressive ideologies offers a rather blunt analysis and fails to capture the myriad contradictions and nuances within the historical trajectory of the discipline. What this brief review has attempted to demonstrate is that there is a degree of historical continuity in the deployment of the psy-complex for hegemonic purposes. The focus up to this point has been predominantly on the material manifestations of the psy-complex through its deployment under various political regimes. Critical interrogation of its theoretical machinery marks an important corollary to this enquiry. The focus in this analysis will fall on the key methodological apparatus attempting to locate the practices of the psy-complex within the parameters of science, namely, the DSM. This analysis will elucidate the relationship between the DSM and Big Pharma as well as draw on critique offered by Allen Frances, leader of the DSM-IV Task Force. What the above historical review has endeavoured to illuminate is that the psy-complex has not always operated with the most benevolent intentions and possesses great potential for hegemonic co-option. One would argue that this track-record necessitates a measure of scepticism when considering the expansive and increasingly influential

economic machine that is psychiatry's DSM in concert with Big Pharma. It also warrants mentioning that there are many other important ideological inventions that comprise the vast armament of psychiatric pseudo-science which fall outside the scope of the present enquiry.

### **DSM nosology and Big Pharma nostrums: Creating an “epidemic”**

Assertions that DSM in concert with Big Pharma represents a coordinated collusion to commodify psycho-spiritual space smacks of crass conspiracy and exists largely within an evidentiary void. Such sweeping statements, as proselytized by Scientology and other extremist arms of the “anti-psychiatry” movement, should be regarded with much scepticism and understood as part of a propagandistic effort to completely discredit the profession of psychiatry. The current corporate hegemony between psychiatry and major pharmaceutical companies is by and large a recent development. A brief overview of the evolution of the DSM will help frame this position.

Following World War II, American psychiatry was besieged by a classification crisis. Four disparate diagnostic classification systems were in use across different sectors of the mental health field, creating a veritable “Tower of Babel” situation within psychiatry (Houts, 2000). To address this linguistic impasse, the APA published the DSM I in 1952. The DSM I contained 106 disorders, which were referred to as “reactions”. The term reflected the psychodynamic orientation of the text, which was adopted by the APA as the mainline model for understanding mental illness during this period. The text differentiated organic brain syndromes from “functional” disorders, the latter further subdivided into psychotic versus neurotic versus character disorders (Blashfield, Keeley, Flanagan & Miles, 2014). Essentially an attempt to stabilize psychiatric nomenclature and equip clinicians with a shared language, the influence of the DSM I was fairly modest when compared with that of its successors. Driven by the theoretical musings of its originators, the text was also fairly conservative in its scope. The diagnoses were largely inpatient centred; focusing predominantly on organic and psychotic disorders which were prevalent in these settings (Blashfield et al, 2014). One could argue that this fairly constrained clinical focus rendered the text less permeable to interference by a burgeoning pharmaceutical industry that were yet to discover the enormous potential of the DSM for propagating mental illnesses and attendant psychopharmacopoeia outside of psychiatric institutions. In the mid-1960s, a review of the DSM I was conducted with a view to aligning it closer with the World Health Organization (WHO) funded International Statistical Classification of Diseases and Related Health Problems Eighth Revision (ICD-8). The end product, the DSM II, published in 1968 was almost identical to the ICD-8 barring minor category differences. The term “reaction” was also removed to reflect a growing shift toward a behaviourist and empiricist epistemology in conceptualising mental disease. The second edition of the DSM accrued an additional

76 disorders. Critically, many of the new categories added in the DSM II were pitched at an outpatient level, allowing for a deeper intrusion of discourses of mental disease into the imagination of the general public. Specifically, diagnostic expansion of anxiety, depressive, personality and childhood/adolescent disorders was a major feature of the DSM-II. The rampant expansion of psychiatric diagnosis into the normatively flux and volatile terrain of child and adolescent development is particularly disconcerting and will collect critical reflection when the present discussion provides an interrogation of the DSM 5. Regarding the encroachment of DSM II diagnosis into non-institutional spaces, there was also a potentially important parallel development taking place during the 1950s and 60s in the pharmaceutical industry. During this period, Big Pharma made a series of serendipitous drug discoveries: chlorpromazine as a treatment for psychosis as well tricyclic antidepressants for the treatment of depression. The perceived efficacy of these drugs ushered in a period of unbridled optimism in biological psychiatry. It is perhaps no coincidence that theories of psychopathology emerging in later revisions of the DSM would find explication within an etiological framework based on processes of neurotransmission, which was proposed as the major explanatory framework for psychotropic drug efficacy. Like its predecessor, DSM II continued to be blighted by serious reliability and validity concerns, an issue that would become ingeniously exposed through a seminal piece of research.

In 1973, an audacious experiment was conducted by David Rosenhan in which pseudopatients feigning mental disorders gained admission into psychiatric institutions in five different states in the USA. Titled "On being sane in insane places", the study highlighted the reliability and validity concerns plaguing psychiatric classification and more importantly, the inhumane conditions in many psychiatric hospitals. In the 1980's, Robert Spitzer, leader of the DSM III Task Force attempted to address reliability and validity concerns through the creation of the Structure Clinical Interview for DSM III (SCID). This largely tautological exercise served to modestly improve diagnostic reliability within psychiatric practice. Tellingly, DSM III continued to entrench the origins of psychopathology firmly within an empirical model based on neurotransmission, molecular biology and neuroanatomy. As a corollary of this neurobiological framework for mental disease, the etiological origins of most major mental diseases was attributed to chemical imbalances in key neurotransmitters such as serotonin, norepinephrine, and dopamine. As suggested, this epistemological shift in understanding the aetiology of mental illness became entrenched during a period when there was mounting optimism in the efficacy of psychotropic drug interventions. DSM III also ushered in major technical changes in clinical diagnosis with the development of a multiaxial system, which required the clinician to form a diagnosis along five axes. Clinicians were drawn to this new feature of the DSM as it provided a greater degree of structure in the diagnostic process. Perhaps unwittingly though, the multiaxial system made a crude distinction

between a mental disease (Axis I) and a medical disease (Axis III). This seemed curiously at odds with the APA's concerted media campaign to market the DSM-III as a text that would re-medicalize psychiatry (Kriegler & Bester, 2014). The DSM IV retained this framework and further buttressed the reification of mental diseases through recourse to newly developed imaging technologies.

Technologies such as functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) were heralded as ushering in a new era of psychiatric science where psychopathological states would potentially become connected to specific neuroanatomical sites. Coinciding the "Decade of the brain" (1990-1999), DSM IV's publication brought with it unprecedented optimism founded on the belief that psychiatry was on the cusp of developing a scientifically robust brain based model of psychopathology. Empirical research findings to date have failed to support many of the brain based hypothesis for DSM's catalogue of mental illnesses and the perennial "ghost in the machine" has continued to elude psychiatry. These gaping holes in psychiatry's "empirical" darling of neurotransmission and neuroanatomy should have provided a much needed sojourn from two decades of relentless reorganizing of our existential terrain. Astonishingly, US policy changes in 1997 only served to reinvigorate the aggressive expansion of these spurious scientific modalities into the public imagination. Specifically, the Food and Drug Administration (FDA) passed a ruling allowing for Big Pharma to engage in direct to users advertising (DTCA) (Frances, 2013). The result of this ruling has been an expansion of mental illness even further from its traditional institutional confines and deeper into our terrain of everyday living. Very quickly, what the public would traditionally deem problems of everyday living were suddenly transformed into pathologies of everyday living. It is effectively this ruling that marks the beginning of DSM and Big Pharma collusion proper as this opened up a space for drug funded mass marketing campaigns to sell psychiatry's spurious science of "chemical imbalances" to the general public. Currently, Big Pharma spends three times more on advertisement campaigns than they do on research into the elusive etiopathogenesis of these "diseases". The sheer financial force of the drug company hegemony also enables them to absorb huge fines and even criminal penalties for their illegal sales and marketing practices (Staton & Palmer, 2012). Deeply disconcerting is the contemporary pharmaceutical trend for increasingly encroaching into the normatively malleable, flux, and at times volatile terrain of childhood and adolescent behaviour. Typifying this trend is the disingenuously dubbed "temper dysregulation disorder" which has the unnerving potential for pathologizing temper tantrums in children. The pernicious pattern of pathology proliferation is particularly evident in the DSM 5, the latest instalment in what reads as a perverse and poignant human drama about a society with a seemingly morose propensity toward madness. To illustrate this notion of unrestrained and proliferating pathology, consider for a moment that the DSM I came in at a meagre 132 pages and

contained 128 diagnoses. DSM 5 is a mammoth 947 pages and houses 541 diagnoses. That translates into an almost fivefold increase in variants of mental illness within a mere 60 years. It is difficult to imagine comparable statistical and classification trends in any of the other medical disciplines. DSM 5 also made a somewhat heretical departure from what clinicians had come to perceive as one of its most sacrosanct features, multiaxial diagnosis. Were the DSM 5 underpinned by rigid scientific and statistical models, a departure from the type of Cartesian dualism evident in the Axis I and III distinction between mental and medical diseases may have marked a progressive move. Instead, the wholesale conflation of all manner of existential angst within the strict confines of the biomedical model is arguably not in the services of science and instead plays directly into the hands of the pharmaceutical corporate hegemony.

Allen Frances, Chair of the DSM-IV Task Force, provides a compelling critique of the collusive relationship between Big Pharma and the DSM in **Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma and the medicalization of everyday life** (2013). As Chair of the task team whose mandate was to review and update DSM III, Frances exercised much control over the reorganization of disease taxonomies for the DSM IV. Most telling in his portrayal of this process is the power of the Task Force to legitimize psychiatric disorders where there is in fact a vast evidentiary void. Frances is transparent and critical about the rather flimsy science driving the creation of many diagnostic labels. He conveys an image of Task Force decision making as more of a popularity contest than a process of scientific rigour and deduction. While his critique is damning, he is careful to weight it with utilitarian undertones, arguing that this lack of scientific evidence should not deter from the descriptive utility of psychiatric labels in dealing with patients beset with pervasive and severe psychiatric problems. For this small subset of the population, psychiatric diagnosis and attendant pharmaceutical interventions represent a breath-taking breakthrough in mental health practice.

Frances contends that the major issue with modern psychiatry through its relationship with Big Pharma is the growing push to pathologize the normal variants of human behaviour and he argues that DSM IV and 5 aid this process by lowering of diagnostic thresholds for current mental diseases as well as in the origination of new diseases. Frances contends that Big Pharma has become an insidious and influential force operating in the dissemination of the growing number of these mental diseases. He argues that the power of Big Pharma to transform already ill-defined diagnostic creations into vehicles for profit is staggering. Investigations into this relationship have revealed that Big Pharma tacitly participates in the origination and collation of the diseases in the DSM (Cosgrove, Krinsky, Vijayaraghavan & Schneider, 2006). Cosgrove et al (2006) revealed that of the 170 DSM panel members, 56% had one or more financial associations with

companies in the pharmaceutical industry. Notably, all of the members of the panels on “Mood disorders” and “Schizophrenia and other psychotic disorders” had financial ties to drug companies. This is telling in that pharmacological interventions are the standard treatment for these disorders.

One could argue that the panoply of psychotropic panaceas flooding the market today operate under the pretence of “epidemic”. The concept of an “epidemic” has evolved to become a catch-all phrase for a variety of fad psychiatric ills and holds vast economic potential (Frances, 2013). It would appear that psychiatry’s capitalist ambitions supersede its loyalty to the principles and science of rational deduction. Instead, psychiatric “science” operates as a smokescreen for what is essentially a highly idiosyncratic, profit-driven, and pharmaceutically engineered language game. In playing this game, psychiatry vivifies vacuous linguistic entities through a process of reification (Grover, 2005). It breathes life into fallacious concepts through linguistic sleight of hand and concretization in the form of a codified discourse. This discursive architecture is exemplified by the DSM. Psychopathology as articulated in the DSM did not arise because medical doctors unearthed an underlying preordained biomedical reality that could be connected to the behaviours of the “insane”. It arose out of fundamental need for state regulation and organization of human behaviour (see Foucault, 2003). Here, diagnostic creations such as the now defunct “homosexuality”; long-debated “rapism disorder”; or the newly included “gender dysphonic disorder” spring to mind. It is also clear that the possibilities for human behaviour are narrowed within the constraints of modern bureaucratic society and this process is further bolstered by globalization. Globalization represents an economic trend of transnational domination by a limited number of capitalist organizations and a cultural trend of international convergence and homogenization (Barker, 2013). These homogenizing forces have clear implications for what is deemed mental health and this is revealed in the World Health Organization (WHO) report on mental health (see Sayers, 2001) which consolidates a medicalized approach to mental health and prioritizes the use of psychotropic drugs as the first line of treatment (Rogers & Pilgrim, 2005).

Further, this medicalized definition obfuscates the ethical and political role of psychiatry in society and consequently should not be conflated with science in the pure sense. Instead, DSM promulgates reification through its ever expanding taxonomy of existential angst. Hyman (2010) noted that this reification of what are essentially only descriptive concepts has produced an “epistemic prison”, where the profession of psychiatry finds itself locked in a process of having to continually legitimize linguistic/descriptive concepts through appeals to scientific models. Any psychiatrist with a modicum of insight into epistemology knows that the vast empire of diagnostic entities in the DSM operate essentially as descriptions of observable symptoms.

Psychiatrists who exercise this level of reflexivity and adopt a meta-perspective in relation to illness are comfortable with the utility of these descriptors and would rightly consider the notion of these entities as ontological givens as absurd. Unfortunately, this small pocket of counterhegemonic voices within the profession has been drowned out by the profit-driven metanarrative of these ever-proliferating psychiatric diseases as distinct bio-medical entities, which require specific treatments. It should be fairly clear at this point as to why this narrative persists and who it serves. However, psychiatry's claims of scientific status and its delineation of distinct disease entities have lost traction following the widespread denunciation of the DSM 5. The DSM 5 has received denunciation for its poor reliability and validity indicators as well its tendency toward extreme diagnostic inflation, with the latter issue playing directly into the hands of Big Pharma (see Frances, 2013). At the same time, one could argue that DSM 5 makes some advances toward a more refined model for conceptualizing psychopathology. Key changes to the DSM 5 offer an important point of departure for rethinking psychiatry. The implications of certain DSM 5 based revisions will be explicated in the "ironic resolve" to follow.

In light of the critical interrogation of psychiatric diagnostics and attendant methodological apparatus outlined in this paper, the tentative and somewhat ironical set of suggestions that follow may potentially confuse and unsettle the reader. It might appear that the author is suggesting a rather retrogressive embrace of a hard-line biomedical model for understanding mental illness. In some ways, the argument does take this trajectory and might mark somewhat of a rupture to the seemingly anti-biological tone of the paper. There are however key distinctions in the proposed model that serve to delineate it within a more progressive and conservative framework. Prior to the elucidation of such a framework, it might be worth reflecting on the possible alternatives to the location of mental diseases within a homogenising biomedical epistemology. Fabrega (2001) for one argues for an appreciation of cultural differences within the neurobiological paradigm. A practical illustration of such a framework would be the Chinese Classification of Mental Disorders (CCMD) which attempts to preserve features of the local cultural context within the broader biomedical western episteme (Kriegler & Bester, 2014). This framework offers a desirable alternative to the somewhat facetiously framed "culture-bound syndromes" currently included in the DSM. These poorly constructed diagnostic categories simply offer cursory commentary on complex cultural behaviours from the vantage point of colonial medicine (Kriegler & Bester, 2014). It is the contention of the author that the typology espoused by Fabrega (2001) is attainable within a fairly homogenous culture such as China but arguably more difficult to develop within a floridly multicultural context like South Africa, a nation so replete with ethnic and behavioural nuances.

These cultural heterogeneity issues aside, a neuro-anthropological model to understanding mental diseases holds many merits. While such a framework will not receive extensive explication within the current paper, it warrants mentioning that there is a large corpus of empirical data demonstrating that cultural and social dynamics shape individual biology (Kolstad, 2012). This complex interplay between brain and culture should become a feature of diagnostic frameworks going forward and the attendant technicalities of such a model should be given the requisite research attention. However, a key caveat in the development of these culturally diverse diagnostic frameworks is the potential watering down and pernicious relativizing of robust biomedical realities. It is the stance of the author that a growing body of research suggests that the neurobiological basis for certain mental diseases is indubitable. It is further suggested that such mental diseases represent only a tiny subset of the plethora of psychopathology currently contained in the DSM. Further refining these robustly neurobiological mental diseases has the potential to yield treatment specific outcomes comparable with those now being realized in oncology and other medical sciences. In contrast, the discursive dilution of these neuro-biologically robust entities through culturally relativistic frameworks, while politically progressive, may potentially hamper and undermine the discovery of treatment specific clinical outcomes comparable with medical sciences such as oncology. Specific examples will be furnished in the section to follow with a view to further sketching out this argument.

### **An ironic resolve: Reconfiguring a defunct taxonomy**

As suggested, in abandoning the unfounded distinctions distilled in the five axial diagnostic systems, DSM 5 arguably moves toward a more refined model of psychopathology. Evidentiary issues and the potential for pharmaceutical exploitation notwithstanding, there may be some benefits in bringing psychiatric disorders closer to medical disorders by removing the Axis I and III distinctions. Ironically, it is the position of the author that this marks a progressive shift that will benefit both the status of psychiatry as a science as well as protect the public at large by limiting the effects of stigma attached to social and behavioural labels as well as curtailing capitalist origination and exploitation of these ever proliferating labels. The author suggests that the materialization of the proposed benefits of a revised biomedical model is predicated upon psychiatry adopting a conceptual framework in line with what is to be formulated below.

Interestingly, Szasz (1977), the arch critic of psychiatry formed a stark distinction between physical illnesses and mental illnesses, as if the former was entirely unproblematic. Szasz declared that only bodies can be sick in a literal sense and minds can only be sick metaphorically, an extreme position that negates emerging evidence for the biological basis of certain psychiatric conditions (see Fatemi & Clayton, 2008). It

is also clear that many physical illnesses are ill-understood in terms of aetiology (that is, multiple sclerosis) and unresponsive to treatment (like oesophageal cancers,) and yet their ontological integrity as real illnesses remain intact. The potential strengths of the biological narrative of psychiatry lie in the emerging corpus of neurobiological evidence for certain mental illnesses and the attendant ambition to achieve treatment specific outcomes, which is the gold standard of other medical disciplines like oncology. For instance, bacteria and viruses have been demonstrably associated with mental illness (syphilis and encephalitis); temporal lobe epilepsy shares a clear relationship with anxiety and florid psychotic states; there is also the induction of abnormal mental states by brain lesions, drugs, toxins, low blood sugar and fever (Rogers & Pilgrim, 2005). All of this might point to the sense in regarding certain forms of mental illness as a biological condition. Further, breakthroughs in neuro-imaging research have unearthed a plethora of potential neural pathways implicated in mental disease and while these correlative connections do not presuppose causality, they remain compelling and potentially significant findings. The weakness of this model, as exemplified by later editions of the DSM, is that it has cast its ontological net too wide in trying to account for the ever proliferating terrain of mental diseases and is losing traction and credibility as a viable explanatory framework. The DSM currently reads like a catalogue of social and behavioural ills which appear strikingly pejorative, simplistic and arbitrary. It deploys an everyday vernacular that is highly transparent and easily misappropriated by those in broader sectors of society. This may in part be an intended effect of the DSM success story, namely, to impregnate the public imagination with an easily digestible discourse about the pathologies of their everyday existence. Just as Freud's notions of "defence mechanism" or the "unconscious" have entered everyday parlance, so too have notions such as "depression", "ADHD" or "anxiety" through the DSM. The power of psychiatry and Big Pharma to infiltrate the private spaces of individuals with information about these disorders has also been greatly enhanced through technological developments such as the internet and social media.

What is clear then is that the current framework for classifying and defining psychopathology as offered up in the DSM is no longer tenable. Such a critique of the DSM need not mark a nihilistic descent into the relativist abyss of mental illness as "myth" (see Szasz, 1977). Instead, this paper contends that the practice of locating mental illness within a bio-medical narrative carries credence and advances in imaging technologies are beginning to buttress this position. However, the current nosological system formulated by the DSM does not speak to this science. It fails to delineate clear nomological networks and connect symptomatologically shared variance in meaningful ways. What is needed is for the entire discursive architecture of psychopathology to be refashioned. The new narrative must strive for simplicity and parsimony. It must circumvent the literary traps that spring up when politics, morality, corporate interests

and professional egos are the driving force behind diagnostic inventions. For psychiatry to garner important professional integrity, it needs to delimit its primary focus on those mental illnesses that are underpinned by compelling neurobiological evidence. This delineation will serve a triad of purposes. Firstly, it will potentially restore scientific credibility to the discipline of psychiatry by creating more stringent bio-medical and statistical thresholds for promulgating disease entities. The specifics of this framework will be elucidated shortly. Secondly, a purely bio-medical and discursively refashioned model of mental illness will potentially minimize the impact of social stigma attached to DSM based diseases, which currently read as pejorative judgements and moral injunctions on human behaviour. Thirdly, delineating mental illness through stringent statistical models and clear neuro-biological markers may restrict the capacity for capitalist driven expansion of scientifically decrepit diseases as well as potentially enhance the search for treatment specific outcomes.

Perhaps audaciously, it is my position that the current DSM based disease descriptions of a variety of widespread social and behavioural have stripped away the pretence of science that may function as an important ideological edifice.

As suggested, appeals to highly technical and obfuscating terminological trickery will potentially curtail some of the stigma around mental illness by impregnating the public imagination with notions of mental illnesses as scientifically robust biological entities. Cloaked in this less pejorative discursive dressing, the language of psychiatry will more closely mirror that of other medical disciplines by providing definitions of mental diseases that speak to the pathophysiological responses which underpin them. What is proposed here transcends the notion a “noble lie” but instead signifies a concerted effort to develop a nomenclature for mental illness predicated on the most compelling neuro-biological evidence. The proposed model should endeavour to accrue all existing neuro-biological data in pulling together a rigorous model for mental illness that is able to meet very stringent statistical and clinical thresholds. In some ways, such a model parallels the Research Domain Criteria (RDoC) initiative (Insel et al, 2010), which represents a concerted effort to develop a psychiatric model based on biomarkers. Any “disease” that fails to demonstrate stable nomological networks (convergent, discriminant and factorial validity) and at least tentative neuro-biological underpinnings should not retain its mental illness status. Only once this “gold standard” for delineating mental diseases is reached can we begin to appropriate the term “science” in designating the activities of psychiatry.

An explication of the more nebulous variants of distressing behaviours, cognitions and affectivity should unfold through recourse to their appropriate non-medical antecedents such as poverty, crime, abuse, trauma, and the like. Shifting the focus

onto socio-political ills will reduce stigma attached to pejorative moral injunctions such as “gender dysphoria”, “temper dysregulation disorder” or “prolonged grief disorder”. Vanquishing these vacuous linguistic creations from the realms of science will also help shed the ontological deadweight currently plaguing psychiatry. Variants of distressing and anomalous cognition, behaviour and affect devoid of clear biomedical etiopathogenesis should alternatively be understood in relation to social and contextual problems that contribute to their development. Framing these issues in this manner may help elucidate a spectrum of macro-pathological ills outside of the individual. It bears mentioning that this is not an entirely unproblematic position. Attempts to scientifically sever biology from attendant contextual factors are invocative of an anachronistic Cartesian dualism that fails to capture the complexity of the brain/culture interplay. I am weary of these inherent contradictions within the proposed model. While some of the features explicated in this resolve attempt to cast this fairly narrow neurobiological model within a more progressive scientific framework, many of these contradictions will remain unresolved. The rationale for such a narrow biologism is predicated upon the astonishing gains now being realized in other medical disciplines. It is the position of the author that the attainment of such gains within psychiatry will likely derive from a concerted research campaign to delineate specific biomarkers for mental disease and treatment specific outcomes for such conditions.

The revised model should attempt to live up to the DSM’s namesake and implement adequate statistical computations and compelling neuro-biological data in developing ontologically stable illnesses. A case in point would be Khiel’s (2014) “paralimbic dysfunction model of psychopathy” which illuminates a stable set of neural pathways implicated in the disease. An even more parsimonious approach is encompassed in Baron-Cohen’s (2011) theory of personally pathology which integrates narcissistic, borderline and psychopathic personalities through clear elucidation of overlapping neuro-circuitry implicated in these disorders. Through drawing connections between important neurological pathways involved in empathy, his model brings together disparate disease entities into a unified framework. The DSM should employ a similar methodology. Through the latest research in molecular biology, neuro-science, behavioural genetics and other state of the art empirical methodologies, psychiatry should strive to posit a model of similarly breathless simplicity and parsimony. At the helm of this new typology should sit statistically robust mental illnesses such as depression and anxiety but reinvigorated with new linguistic purpose. This would not necessitate much creativity on the part of the psychiatry profession as much of the terminological terrain is already mapped out. Cloaked in this technical language and grounded in robust neurobiological correlates, mental disease might be wrestled from public misappropriation as pejorative judgements and moral injunctions. To illustrate this simplistically, consider the use of the term “serotonin dysregulation disorder” to designate depression, “HPA axis dysfunction” for anxiety or “paralimbic

dysfunction disease” to signify psychopathy. Cast in this sterile, clinical discourse, these diseases are no longer imbued with such pejorative potential. By entrenching them within the technical terminological terrain of molecular biology, neuroscience, behavioural genetics and related scientific disciplines, their status as “real” diseases is enhanced. Should their location within such models be predicated on stringent statistical thresholds, clear neurobiological correlates and extensive nomological networks, then psychiatry too may begin garnering status as a “real” science.

## **Conclusion**

It would be permissible were the reader to retract in repulsion at the endorsement of such a narrow articulation of mental disease. Surely this obfuscating of diverse non-biological etiopathogenesis into mental illness will just further pathologize and isolate people. Surely the staggering proportion of South Africans living with mental diseases as reported by the South African Depression and Anxiety Group (SADAG) can be as easily understood through a Fanonian explication that colonization carries with it severe psychological consequences. Surely the horrors of child abuse and neglect in the country should account for the soaring substance abuse, depression and suicide rates amongst our youth. The answer of course is an emphatic yes. The reality though is somewhat different. The bio-medical framework for psychiatric illness is so deeply entrenched within the entire mental health model that appeals to it are inescapable. Advancing technologies and treatments point to the sense in retaining a revised neuro-biological model of psychopathology. It also bears mentioning that the bio-medical framework for disease has facilitated remarkable breakthroughs in a number of medical disciplines. Consider oncology for a moment: a century ago most cancers carried a certain and painful death sentence and the treatments of choice largely compounded patient suffering with minimal gains. Today, the discovery of oncogenes (i.e. BRCA 1 and 2) and target specific cancer drugs (Herceptin) has resulted in astonishing screening and treatment efficacy for specific cancers (Mukherjee, 2010). Cutting edge and innovative developments in immunotherapy have allowed researchers to militarize the body’s natural immune response by genetically enhancing T-cells to attack cancers. Recent research suggests that these latest treatments have proven effective in the treatment of up to 90% of terminal cancer patients (Gallagher, 2016). It bears mentioning that these advances were founded upon a bio-medical model to understanding disease that at various point during its history seemed archaic, brutal and backward. Psychiatry studies an inordinately complex organ in the human brain and the search for clear-cut mental diseases, specific etiological pathways and efficacious treatments has been very slow. That said, an emerging body of neuro-biological data as facilitated by the latest imaging technologies appear to point at least in part to the tentative development of unified frameworks for mental disease (see Baron-Cohen, 2011).

Developing a typology for mental disease predicated on stringent evidentiary thresholds and committed to expunging capitalist influenced disease origination will serve the profession and the public. Behavioural, cognitive and affective anomalies that fail to meet the stringencies of this scientific framework will be more appropriately accounted for through adequate attention to socio-political ills plaguing society. Tentative ponderings forwarded in this paper have been posited with a view to opening up and stimulating debate around an alternative mental health episteme.

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