Philosophy *of* Medicine

The DSM and Its Sociomedical Discontents

Simone Raudino[1*] and Francesco Raudino[2]

1 Law and Tax Department, HEC Paris, Paris, France.
2 Department of Neurology, Valduce Hospital, Como, Italy.

*Correspondence: simoneandy@yahoo.com

1. Introduction

The American Psychiatric Association (APA) has been publishing the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) since 1952, when its first version, mostly based on a census of US psychiatric hospitals and a US army manual, began systematizing mental disorders. Across its five editions and three revised versions,[1] the DSM has shaped an increasingly comprehensive taxonomy, which is used today in both clinical and research settings. The DSM has also influenced other taxonomies dealing with mental and behavioral disorders—including the World Health Organization's *International Classification of Diseases* (WHO ICD)—thus further contributing to the standardization of psychiatric praxes worldwide.

While the DSM is generally credited with having introduced a much-needed nosology of mental disorders, creating a common language among clinicians, researchers, health insurance companies, and the pharmaceutical industry, the process has also been mired in controversy, and is regularly criticized from different disciplinary angles, including medicine, biology, and anthropology. Setting aside radical approaches to the very concept of mental illness (Szasz 1974), criticisms from the medical profession have typically focused on two arguments: (1) low validity and reliability of DSM categories, especially in non-Western settings; and (2) diagnostic inflation. We propose a third set of sociomedical considerations, looking at how medical readings of mental illness are always conditioned by social values. Our considerations are based on the observation that the DSM has not yet resolved basic questions resulting from the fact that, throughout history, medicine has had to adapt to the social norms that different societies attach to abnormal behavior.

2. Core Medical DSM Criticisms

The first set of considerations is based on the low validity and reliability of DSM categories: studies on the prevalence of mental disorders using the DSM categories do not yield the

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[1] In addition to the five DSM editions (I, II, III, IV, 5), there have been three revised versions: DSM-III-R, DSM-IV-TR, and DSM-5-TR .

coherent results one would expect from a universal nosology system (Wakefield 2016; Khoury, Langer, and Pagnini 2014). This is also attributable to the lack of any scientific link between biological or neurological markers, genetics, and DSM categories (Carroll 2013). These considerations are particularly powerful when coupled with allegations of culture-centrism, as the APA's diagnostic process remains fundamentally centered in Western—especially anglophone—psychiatric praxes. [2] Thus, studies investigating discrepancies between Chinese (*Chinese Classification of Mental Disorders*—CCMD-2) and American (DSM-III) diagnostic systems concluded that remarkable differences exist, for example, in diagnosis rates of categories such as neurasthenia and hysterical neuroses (Zheng et al. 1994). Questions were also raised about the validity of specific DSM categories in China, such as hoarding disorder (Wang et al. 2016). Japanese experts reached similar conclusions when considering the validity of 11 DSM diagnostic categories in Japan, and remained particularly skeptical of categories such as social communication disorder (SCD), attention deficit hyperactivity disorder (ADHD) and gender dysphoria (Kuroki et al. 2016).

A second common set of criticisms is based on the progressive "pathologization" of what had been previously considered physiological symptoms and behaviors (Frances 2009, 2013). "Diagnostic inflation" has been thought to additionally contribute to the progressive swelling of the DSM from the 31 pages and 102 diagnostic categories of its first edition (DSM-I, 1952) to the 775 pages and 297 categories of the last edition (DSM-5, 2013). Diagnostic inflation would thus be responsible—along with better detection capacity in the psychiatric profession and a higher prevalence of medical conditions—for a worrying phenomenon: strict adherence to the DSM-5 would result in diagnosing 50 percent of Americans with a "mental disorder" by the age of 40 (Rosenberg 2013). The trend is ongoing: the DSM-5 considers as conditions deserving future psychiatric clinical attention categories such as "Relationship distress with spouse or intimate partner," "High expressed emotion level within family," and "Economic problems." The problematic side of such trends is felt in the West as much as it is in the East: the overwhelming majority (81.8 percent) of a sample of 211 members of the Chinese Society of Psychiatry indicated that any psychiatric classification system should have 100 or fewer categories (Dai et al. 2014). Some in the medical profession have also raised questions about the correlations between the high diagnostic inflation phenomenon, the 70 percent of DSM task force members having ties to the pharmaceutical industry (Collier 2010), and booming sales of psychotropic medications (Frances 2013)—a market that in 2022 was already worth more than US$20 billion worldwide, and is projected to grow at a compounded growth rate of 6.4 percent a year, till reaching a value of US$37.6 billion by 2032 (GMI 2023).[3]

3. Sociomedical Perspectives

Sociomedical and global mental health perspectives are favorably positioned to detect the social, political, historical, cultural, and economic forces that influence health outcomes. That would naturally include observations on how these factors are taken into consideration, or ignored, in drafting the DSM, and in its diagnostic usage. However, such considerations have traditionally come more from the social, rather than the medical, end of the spectrum (Foucault 2003; Vanheule 2014). In our view, considerations from the history and geography of medicine—showing how medicine itself subsumed prevalent social

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[2] The APA has widely publicized its efforts at democratizing the diagnostic process (see, for example, APA 2013). However, even a cursory look at the names listed in the DSM-5 task force section immediately reveals that it substantially remains a North American exercise.

[3] Growth estimates based on historical sales data (2018–2022) in 21 countries.

norms at different points in time in the history of different societies—would assist a great deal in understanding the validity and limits of DSM categories.

Social norms inevitably condition medical understandings. If we retrace the history of Western social norms on "madness" and "abnormal behavior," we can distinguish at least three different conceptualizations. One of the oldest is as a manifestation of the divine: according to Homer's *Iliad,* for ancient Greeks, unusual behaviors were the expression of the will of a divinity (XIX.12–76), to the point that gods could deliver messages via the mad individuals (Kahn 1981, XXXIV). An alternative interpretation was madness as a disease, or weakness, of the soul,[4] whereby people's instinctual impulses gained the upper hand over their rationality (Cornford 2014, 344–346). These readings coexisted for millennia, with Christian thinkers contributing in their portrayal of folly both as the work of the devil over people of weak moral fiber (Phillips and Boivin 2007) and as a surreptitious human virtue (Erasmus 1876). In parallel, organicist views—which consider madness the result of biological dysfunctions in specific organs such as the diaphragm, the heart, or the brain— have also been circulating since ancient times (Hippocrates 2009), and eventually went on to become the basis of contemporary Western medicine.

These different socio-normative conceptualizations of madness inevitably conditioned medical praxes. Medicine had to adapt to the broader social context in which it was embedded, and did so by designing compatible medical praxes. This implied devising indicators (symptoms); causes (etiology); detection methodologies (anamnesis and diagnostic criteria); and treatments, both individual (therapies) and social (public health and safety policies), that could sit well with prevalent social norms.[5]

The influence of current social norms upon psychiatry is seldom discussed—in the global West or elsewhere. In our view, such a blind spot represents the "original sin" at the core of the DSM's logical inconsistencies and theoretical weaknesses, whose contingent, seemingly unrelated manifestations are picked up by its many critics. Psychiatry needs to trace what it understands as *physiological* and *pathological* to the socio-normative values of the very same societies from where it comes. Without such an exercise, there can be no satisfactory answer as to the value of any universal psychiatric nosology system.

Disclosure Statement
No competing interest was reported by the authors.

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[4] "Soul" here is understood as breath, vital principle, spirit inhabiting each person alive.
[5] A well-known example regarding the diagnostic phase includes the de-pathologization of homosexuality, which until 1973 was listed on the DSM-III. Given the current pace at which the LGBTQIA+ community has been gaining visibility and rights across the world, it is only natural to expect similar outcomes for the gender dysphoria category.
   On the social treatment of "madmen," this has ranged from substantial acceptance, and even social respect, as in ancient Greece, to progressive marginalization, as in continental Europe since the Middle Ages, till confinement and physical elimination in the contemporary age (Foucault 2003).

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