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Abstract

Any effort to discuss or study psychopathology (by any name) must decide how to distinguish between psychopathology and narratively comprehensible reactions to adverse circumstances of life. A pathology framework, which views the distressed individual as acted on by impersonal forces, is incompatible with an agential framework, which views the individual as the protagonist in a unique story. Although the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* recognizes this issue, it addresses it by postulating that “primary mental disorder” results from a “psychological dysfunction” and non-culturally sanctioned reactions to life events indicate mental disorder. In this essay, the authors examine whether the concept of “psychological dysfunction” can withstand an analogy to that of biological dysfunction. They also examine the *DSM*’s view that “culture” has already prepared an official evaluation of any reaction to the vicissitudes of life. They conclude that the *DSM* has failed to convincingly distinguish between psychopathology and reactions to life’s vicissitudes. They suggest that the *DSM*’s insistence on separating people’s feelings and actions from their own unique circumstances

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and context amounts to a moral, not scientific enterprise. The study of how people fare in living should abandon the concept of mental disorder and related terms.

Keywords

psychological dysfunction, biological dysfunction, mental disorder, psychopathology, human agency

The tendency has always been strong to believe that whatever received a name must be an entity or a being, having an independent existence of its own. And if no real entity answering to the name could be found, men did not for that reason suppose that none existed, but imagined it was something peculiarly abstruse and mysterious.

—John Stuart Mill, 1843

If a person's thoughts, feelings, or behavior deviate from what is socially or culturally valued or expected, then the question "What is wrong?" usually arises. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (*DSM-IV-TR*; American Psychiatric Association [APA], 2000) states that when the deviations amount to "clinically significant" distress or disability, what is wrong is a "mental disorder" resulting from "behavioral, psychological, or biological dysfunction" (p. xxxi). Among mental disorders, *DSM-IV-TR* further distinguishes "primary mental disorders": "those that are not due to a general medical condition and that are not substance induced" (p. 181). The reason for calling clinically significant distress or psychosocial disability a mental disorder, and attributing it to a dysfunction, is to remove the distress and disability from the everyday agential or person-in-situation framework of understanding and discourse and to place it within the pathology framework (i.e., the person, through no action or intention of his or her own, has become the setting for the operation of impersonal, harmful, cause-effect processes).

In its introductory section titled "Definition of a Mental Disorder," however, the *DSM-IV-TR* acknowledges explicitly that it is unclear when the pathology framework is called for, as sufficiently severe adverse circumstances can induce distress or disability in anyone. This amounts to recognition that unless primary mental disorders can be convincingly distinguished from justifiable reactions to the vicissitudes of life, it would be pointless to expound on *varieties* of primary mental disorders. The *DSM-IV-TR* suggests two criteria to

make the distinction. First, it proposes that some reactions to adversity are “sanctioned” by culture whereas others are not; sanctioned reactions are excused from being considered a primary mental disorder whereas nonsanctioned reactions may be so considered. Second, it states that primary mental disorders are produced by “psychological dysfunction.” This term is not defined or discussed in the manual, and no suggestions are offered on how to detect psychological dysfunction independently of its “symptoms.” Based on its position in the quote cited in the first paragraph of this essay, however, the expression is presumably to be understood as isomorphic with “biological dysfunction.” In other words, if the meaning of biological dysfunction is understood—and one must assume that the authors of *DSM-IV-TR* take this for granted—then psychological dysfunction means the same thing as biological dysfunction except that when it comes to the former, the mind and not the body is dysfunctioning. Yet, despite this causal attribution to psychological dysfunction in the *DSM-IV-TR*, psychiatric research in general clearly does not seek to discover psychological dysfunctions that produce primary mental disorders. Rather, the quest is for biological dysfunctions (or *anything* biological) that could help identify any primary mental disorder (we discuss the example of depression in this essay). This is because American psychiatry, at least since the arrival of *DSM-III* in 1980, regards primary mental disorders as somatic diseases awaiting medical discovery of etiopathogenesis (e.g., Wilson, 1993).

The *DSM* acknowledges that the presence of a medical disease, diagnosed on the basis of objective physical evidence, does not in and of itself necessarily account for offensive or disappointing or otherwise untoward social behavior (e.g., see the *DSM-IV-TR* discussion of Mood Disorder Due to a General Medical Condition, pp. 401-403). In other words, judging social behavior cannot be reduced to identifying the presence of somatic disease. This could be the basis for arguing that identifying somatic disease is one thing while evaluating social behavior is another (Szasz, 1960), but for the purpose of this article, we confine ourselves to examining whether “psychological dysfunction” bears anything more than an acoustic resemblance to biological dysfunction.

Although the *DSM-IV-TR*'s introduction recognizes that personal distress or psychosocial disability may be understood in terms of *story*, the rest of the manual disregards story altogether when it comes to distinguishing mental disorder present from not present. This accords with conceptualizing each primary mental disorder as an autonomous medical disease whose identification in no way depends on investigating the patient's personal history. The *DSM-IV-TR* even grants users of the manual permission to ignore Axis IV (Environmental and Psychosocial Problems; p. 37) if they wish.

We argue in this essay that the *DSM-IV-TR* fails to solve the problem of distinguishing psychopathology from narratively comprehensible reactions to adversity. The *DSM-IV-TR* is unable to convincingly distinguish *any* form of personal distress or psychosocial disability that cannot be attributed evidentially to biological pathology, from *story*. Our discussion mostly focuses on whether “psychological dysfunction” actually means anything like “biological dysfunction,” and we conclude that it is merely a slogan whose appeal lies in extending a familiar medical idea to the psychological realm.¹ We also critically examine, and then reject as nonsensical, the notion that “the culture” has already decided on “sanctioned” and “nonsanctioned” reactions to anything that might happen in a person’s life. Therefore, we conclude, explanations of distress and disability should remain in the ordinary alternative framework of agential doings, or understanding through personal history, or “story.” Unless “primary mental disorder” can be given a nonarbitrary, non-tautological meaning, the term should be considered as an expression of disapproval (a form of “You’re out of your mind!”), a kind of trope. The content of a trope cannot be scientifically investigated and explained nor can one argue about the facticity of a trope (i.e., is this person really suffering from a primary mental disorder or not?)

Biological Dysfunction as the Model for Psychological Dysfunction

In a 1982 book, *Psycho Politics*, Peter Sedgwick presented a heuristic way to comprehend what pathology and dysfunction might mean when applied to the concerns of medicine and to those of psychiatry and psychology. Sedgwick argued that no intrinsic biological pathology or dysfunction exists in nature. Rather, all that exists is what usually occurs and deviations from what usually occur. People’s *interests and values* indicate what states are desirable and undesirable (normal and pathological) in regard to their own physical health or the status of another organism or species. One cannot conclude that proper function or dysfunction is immanent in nature itself, because nature has no plan or purpose for any organism or species.² Natural selection has not literally “designed” anything, thus an organism cannot fail to develop or function as it is “supposed to” (e.g., simply on the basis of the most common fate for species, the conclusion would be that nature’s favorite plan is extinction; Gould, 1989, 2000; Rose, 2000; Ruse, 2000). The APA in effect conceded this point in the 1970s when it decided that maintaining homosexuality as a mental disorder was indefensible (Bayer, 1987).

Although biological pathology or dysfunction is not immanent in the observable facts themselves, people easily *agree* on what constitutes desirable

and undesirable, or good and bad, bodily health. Therefore, because agreement based on values seems indispensable to identify pathology in medicine, Sedgwick (1982) concluded that nothing in principle blocks the application of values to identify pathology in psychiatry. This reasoning opens the door to identifying psychopathology based on deviation from what is socially or culturally expected or desired of a person, but Sedgwick's thinking on this matter did not go far enough. We advance that although people easily agree on proper function versus dysfunction in the realm of bodily health *regardless of circumstances*, in the realm of human affairs, the need to consider circumstances *specifically from the perspective of an agent* demolishes any facile analogy between biological dysfunction and psychological dysfunction. Being unable to walk is easily recognized as undesirable, regardless of circumstances. In contrast, the evaluation of thoughts, feelings, and actions are typically "defeasible," meaning that evaluation changes with context and circumstances. For example, deliberately causing a human being to die might result in the Congressional Medal of Honor under some, but not other, circumstances. Also, who gets to define or depict "circumstances" is by no means given and should not be overlooked.

Sedgwick's (1982) second point concerning biological dysfunction is that neither proper function nor dysfunction falls into the realm of agential doings. That is, when one gets or does not get colon cancer, the explanation for continued health or disease lies in impersonal processes and mechanisms that occur without one's contribution as an agent (unless one chooses to act in ways that one knows increase the likelihood of getting colon cancer). Thus, if one should understand psychological dysfunction on the model of biological dysfunction or pathology, then psychological distress or disability should also be explicable *impersonally*, that is, separate from agential doings.

In sum, Sedgwick's (1982) analysis leads us to suggest that a strict analogy or isomorphism of psychological dysfunction with biological dysfunction requires that in human affairs, what is supposed to occur can be identified independently of situation and circumstances and that both what is supposed to occur and deviations from what is supposed to occur can be explained on the basis of impersonal processes and mechanisms.

Medicine Versus Human Affairs

What the *DSM* regards as symptoms of mental disorder is usually unwanted by the individual person and by others, but this does not demonstrate that the person *qua* person is malfunctioning. Consensus about dysfunction is relatively unproblematic in medicine because deviations from what is desired (e.g., cardiac insufficiency, impaired mobility) are usually unacceptable to us

no matter what. By contrast, evaluating the point, purpose, meaning, or desirability of feelings or actions or thoughts is inescapably context dependent.

For example, food bingeing and purging certainly seems to deviate negatively from what is usually expected or desired. But what a specific person who is bingeing and purging is *doing*, and why, cannot be understood on its own, stripped of familial, interpersonal, and probably even societal context. Generally, and in contrast to happenings that can be meaningfully divorced from *personal* history and context from the point of view of the agent, what a person feels, does, or says does not “speak for itself.” Clinical experience with families in which a member binges and purges brings to mind the old saying, “Desperate times call for desperate measures.” The presence of “symptoms” may indicate that times are desperate as far as the patient is concerned. The *DSM’s* pathology framework, however, is about what *happens* to people based on impersonal processes and mechanisms; it does not address the person’s situation as far as he or she is concerned. Indeed, once any “symptoms” are seen as having *happened* to the person, it no longer makes sense to piece together a story from the protagonist’s perspective that might render the “symptoms” narratively comprehensible (e.g., I have come to feel a certain satisfaction in being able to indulge in food and remain slim, unlike my overweight parents).

The agential (story) framework of thought and the pathology (impersonal cause–effect processes) framework of thought are incommensurable, incompatible, and antagonistic. In the first, human events and actions are connected and explained by “because,” not cause. “Because” connects elements of a story in terms of meaning, not in terms of cause and effect. In the agential framework, a person feels depressed *because* of something (rejection, loss, disability, etc.), but the story may be exceedingly complex and idiosyncratic. In the pathology framework a person has become depressed because of the operation of impersonal causal processes. If one wants to propose that an individual is depressed because he or she suffers from a mood disorder, then story becomes irrelevant.

For example, reviewing biological mechanisms that might produce depression, R. H. Belmaker and Galila Agam (2008) declare that depression in major depressive disorder is “disproportionate” to the event that provoked the depression. They do not reveal how they know this or how anyone would know this. One would first have to possess the whole story from the protagonist’s perspective, including the provoking event, series of events, or circumstances. One would then have to judge that the whole story did not warrant the depression under consideration. We do not know how this could be done objectively. The search for biological mechanisms to explain “disproportionate

sadness” presupposes that it can be decided as a matter of fact (by whom?) that someone’s sadness is disproportionate to the provoking events.

Guided by the *DSM* definition of major depressive disorder, Belmaker and Agam (2008) take for granted that *no* story can justify feeling sad for a few weeks. This is difficult to take seriously, but our point is that once it is decided that the pathology framework is required, the interest shifts from story to mechanism. Thus, these authors review several possible biological mechanisms before arriving at an all-too-familiar conclusion: It is important not to prematurely foreclose on any biological possibility. We believe their conclusion accurately summarizes the fruit of biological research in psychiatry for nearly 50 years. The enterprise rests on dismissing the relevance of story, but neither the review nor the *DSM* discusses when or why story should be dismissed.

At least two sources of complication must be faced in human affairs that do not appear in the realm of biological dysfunction. First, the agent is always in or facing a situation as far as he or she is concerned. We suggest that this cannot be ignored if the object is to understand, as opposed to judge or label another person from the outside, for example, if one wishes to avoid the reasoning that leads to drapetomania, the “disease” that caused slaves to flee from their masters (Cartwright, 1851). Indeed, drapetomania can be taken as the model for all primary mental disorders in the sense that the person’s story, if it emerges at all, is regarded as irrelevant for the purpose of evaluation/diagnosis. For that purpose, the professional adopts an “I–it” stance toward the person being diagnosed, precisely as the physician adopts an “I–it” stance toward (say) lung cancer (this point seems to be an important part of Arthur Kleinman’s persistent objection to contemporary biopsychiatry, see Kleinman, 1988; Kleinman & Kleinman, 1991). Second, even depicting an occurrence in human affairs cannot be done without in effect taking a position where arguably more than one position might be advanced. The privileged, triumphant, or “official” position frequently owes its victory more to the relative power of the participants than to persuasion (in this regard see Habermas’s idea of an “ideal speech situation,” 1980, 1984).

One might ask, with *DSM-IV-TR*, whether symptoms are not “inherently pathological” (APA, 2000, p. 8), but “inherently” means regardless of circumstances, so it is not surprising that the *DSM* also does not define or discuss this expression. If one says something such as, “Given her situation as she sees it, we can grasp at least partly why bingeing and purging has become something she does for relief, for control, as protest,” one is not simultaneously implying that the symptom is a good thing (any more than, say, killing in self-defense would be called a good thing). There is no situation *per se*; there is only a

situation for a person. In medicine, one can approximate a “view from nowhere,” because agreement about what is desirable and undesirable *regardless of circumstances* is frequently so easy. In human affairs, a view from nowhere is just make-believe.

The Scope of the Agential Framework

The agential framework is not coterminous with voluntary, deliberate, or ideal. Indeed, the bulk of mental life cannot be so characterized. Preparing a speech is a good example of directed, deliberate mental activity, although every phase from preparation through delivery is suffused with unwanted or off-topic thoughts, feelings, and reactions. The voluntary mental activity exists alongside with or is embedded in mental activity that surely cannot be characterized as deliberate or chosen.

The issue that concerns us here is when, if ever, one may think of a person's feelings, thoughts, or reactions as the product of *impersonal* processes that are no more *his* or *hers* than how the person digests food or how the person's blood clots. Few people, presumably, choose to feel devastating grief in response to the loss of a loved one. Devastating grief indicates that the survivor is forced to face a terrible loss and its personal implications for living. The significance of the loss for the grieving individual cannot, it would seem, be replaced by any formulation that expunges *strictly personal, subjective* considerations. Thus, knowing how long a sample of bereaved people felt grief stricken on average would reveal nothing about the meaning and significance of *this* loss for *this* person. Indeed, it remains unclear just *what* aggregate scores are supposed to reveal about real people considered one at a time (see Mischler, 1996, for a discussion of this issue as it bears on developmental psychology research. This is an old issue that is usually “handled” by overlooking it). In sum, unwanted thoughts, feelings, or reactions hardly announce that one should shift from the agential to the pathology framework, because the bulk of mental life seems to just happen without intention, deliberation, or control. Perhaps the authors of the *DSM* recognize this point by cautioning that “mental disorder” cannot be identified by the presence of dyscontrol, disadvantage, disability, inflexibility, or irrationality (APA, 2000, p. xxx). There is a simple reason for this: Everyone displays such features of mental and emotional life.

The psychopathology framework must demonstrate that impersonal psychological processes and mechanisms exist and produce personal distress or disability if a strict analogy or isomorphism with biological dysfunction is postulated. If so, what impersonal processes or mechanisms do the authors of the *DSM* have in mind? When grief lasts “too long” or sadness is “disproportionate

to the external cause,” is some impersonal process making the person grieve too long or feel too sad? Or is this simply a judgment that an external observer makes without knowledge of, or with indifference to, the whole story? If, on the other hand, no strict analogy or isomorphism with biological dysfunction is being postulated in the *DSM*, it remains unclear what exactly is being postulated.

Deviations from what is ordinarily desired or expected in the psychosocial realm always implicate a *story*, unless the operation of a real biological dysfunction, such as Huntington's disease, trumps personal history. But biological dysfunction must be demonstrated on the basis of evidence, not ideology or speculation.³ As William Ryan (1971) observed in his classic *Blaming the Victim*, if people are viewed separately from personal history and context, as self-contained psychological entities, then observers (who might naturally face a difficult and time-consuming challenge to co-construct the story with the distressed individual) are tempted to think about them as “dysfunctional,” like diseased organs.

Posttraumatic Stress Disorder (PTSD): The Incompatibility of the Pathology and Agential Frameworks

The only diagnosis of long-lasting distress or disability in the *DSM* that requires the clinician to consider personal history, indeed extreme personal history, is PTSD. Arguably, PTSD was foisted on the leadership of the APA and the *DSM* and also on the U.S. Veterans Administration, on the basis of organized pressure from Vietnam War veterans and their supporters (Blank, 1985; Scott, 1990). In 1968, *DSM-II* dropped the diagnosis of “gross stress reaction” despite the presence of hundreds of thousands of American military in the Vietnam War theatre, despite psychiatric experience in both World Wars and in the Korean War, and despite domestic psychiatric experience and clinical research involving a wide spectrum of deliberate and accidental violence (Archibald & Tuddenham, 1965; Grinker & Spiegel, 1945; Houts, 2000; Leopold & Dillin, 1963; Young, 1995). Veterans who sought recognition that they had been harmed as people by their experiences in Vietnam found themselves either forced into traditional psychiatric categories and treatments that could not address their problem as they saw it or disqualified from disability awards.

The PTSD diagnosis is a hybrid: It requires a disclosed history of extreme personal experience yet is folded into the pathology framework. The person diagnosed with PTSD must reveal having experienced an extreme situation

but is not so evaluated by the diagnostician because living in or through “desperate times” falls outside the pathology framework, wherein “symptoms” are proof of dysfunction because their existence is unjustifiable under any circumstances (like cardiac insufficiency). This sounds absurd when the logic of the pathology framework is made explicit and applied to human affairs.

In an extreme situation such as combat, a soldier’s terror would not be a candidate for psychiatric diagnosis. It would fall into the common sense, agential framework. The PTSD diagnosis rests on the seemingly obvious proposition that traumatic stress is in the past, and therefore the person’s fear, rage, and other reactions in the present are symptoms of mental disorder (the result of psychological dysfunction). Within the *DSM* pathology framework, objectively measured time constitutes the proper guide to what a person should find relevant right now. The more objective time has elapsed, the less relevant to the present the old traumatic stress experience presumably should become. Not in combat right now, the veteran is thus “symptomatic.” The key *DSM* assumption seems to be that the “present situation” as assessed by *someone else* should be the definitive account.

Presumably, the veteran realizes he is no longer physically in the combat zone, but his experiences there have changed him—changed what he thinks and worries about, how he construes actions and situations. From an external perspective he would be better off if he could bracket the intense war experiences as something that no longer has any personal import for him. Unfortunately, this is easier said than done. More to the point, “the present” is not a straightforward psychological concept at all. For example, in conversing with another person, the speaker has no choice but to draw on his or her linguistic and interpersonal experience to understand what the interlocutor is saying and also to (however tacitly or implicitly) construe the meaning and significance of the social interaction that is taking place in real time. Without drawing on personal history, people do not know where they are or what they are doing “in the present.” Yet from the *DSM* perspective (and this applies to all “primary mental disorders”) the present is construed as a straightforward matter *as seen by the diagnostician*. Thus, although PTSD requires disclosure of “desperate times,” in our view, its status as a mental disorder in the *DSM* exposes the ethos that no excuse or justification exists for “clinically significant” distress or disability that does not swiftly remit.

Anything someone does can be depicted impersonally from the outside. Michael Polanyi (1958) provided a classic illustration for the case of bicycle riding. What the bicyclist must do to negotiate a curve in terms of mechanics can be expressed mathematically. The bicyclist does not know this and, even

if he or she does, cannot calculate rapidly enough to use the formula in practice (Collins & Kusch, 1998). Yet it may be tempting to postulate that the bicyclist's brain must "know" the formula and be applying it. Referring to a mathematical formula in mechanics as "explaining" how a person on a bicycle negotiates a curve confuses depicting and solving a problem from the outside with what the *agent* is doing. This recalls for us the lament by Jerome Bruner (1990), a founder of the cognitive revolution in psychology, on how the original interest in meaning and meaning making on the part of a person became progressively transmuted into a technical framework of information processing and computation.

In medical pathology, an unacceptable state of affairs ("pathology") can be identified without regard to circumstances (think of cardiac arrest). It is true that "ideology" (values) play a role in identifying medical pathology, but in the main "ideology" here is a simple matter of commonplace consensus (few people would think that cardiac arrest is *not* a bad thing). In human affairs, a range of considerations are necessary that are irrelevant in/outside of medical pathology: appropriate, justifiable, defensible, warranted, intelligible, and so on. Such considerations are both unavoidably context dependent and ideological. A conscientious effort to depict human behavior in a manner that avoids context and ideology (values) is usually of little interest to actual human concerns. For example, think of ignoring context and ideology when trying to decide if a person deserves the Congressional Medal of Honor or the death penalty.

Medical psychiatry, as advanced in the *DSM*, seeks to, or better yet has decided to, regard human distress and (certain) problematic social behaviors as part of the realm of medical pathology. Pathology is a bad/unacceptable state of affairs evaluated without regard to circumstances. There is little or no controversy regarding how to depict the state of affairs under consideration. Pathology is separate from the human world in which considerations like appropriate, warranted, extenuating circumstances, and so on are necessary to speak sensibly. Because the *DSM* depicts clearly negative states of affairs (suffering, disability) without any context or background, the reader might be forgiven for assuming that the authors have silently included a qualification that might be read as "of course we mean that untoward background conditions are absent." This is decidedly not the case. For example the "Associated Features and Disorders" section for major depressive episode notes that "Major Depressive Episodes often follow psychosocial stressors" (*DSM-IV-TR*, p. 352). However, the "Use of the Manual" chapter clarifies (p. 8) that information listed under "Associated Features and Disorders" is *not* considered essential for diagnosis. In other words, in the *DSM* framework, answering

“What is the matter?” (for diagnosis) does *not* include background information, context, circumstances, and so on. The reason for this is straightforward: Medical pathology is separate from the human world, and during the 1970s American psychiatry decided that its subject matter was part of conventional medicine (Wilson, 1993). Many years have elapsed since the publication of *DSM-III* in 1980 to the planned publication of *DSM-V* in 2012, but it is none the less anticipated (First, 2008; Frances, 2009) that it will be necessary for *DSM-V* to continue the tradition of including *no* biological information of any kind for the purpose of diagnosing the conditions unique to psychiatry (“primary mental disorders”). In short, once again the *DSM* will present a system of medical diagnosis that does not refer to biological information or findings of any kind from any source. Once again the authors of the *DSM* (e.g., Carpenter, 2009) are confident that the future will justify the official 1980 shift from the Meyerian framework of thought (based on the influence of Adolph Meyer, 1866-1950) to a conventional medical framework. For readers unfamiliar with the history of American psychiatry, here is how Gerald Klerman, a prominent American psychiatrist who became head of National Institute of Mental Health in 1980, approvingly depicted American psychiatry’s imminent switch from the Meyerian framework to a conventional medical framework in a 1978 publication:

The Meyerian approach stresses the importance of personal experience and the uniqueness of the individual in his social context, in contrast to the Kraepelinian [after Emil Kraepelin, 1856-1926] emphasis on categorizing disease, an emphasis derived from continental European medicine. (Klerman, 1978, p. 105)

PTSD might be thought of simply as an extreme example of American psychiatry’s determination to medicalize distress and (certain) behaviors. Here, considerations that are usually relegated to the “Associated Features and Disorders” section are incorporated into the textual description of the disorder and criteria set, but PTSD is still considered part of the realm of medical pathology. As we have argued, this realm does not refer to persons, only to diseases that afflict persons. The accomplishment of PTSD as a psychiatric disorder has been to incorporate what might otherwise be construed as highly contentious human issues (waging war, preventable industrial accidents, interpersonal violence, etc.) into a medical pathology framework. It is true that an extremely negative personal experience must be disclosed to qualify for a PTSD diagnosis, but the “symptoms” are by definition regarded as “a manifestation of [an unknown] behavioral,

psychological, or biological dysfunction in the individual.” This is indeed the overall “accomplishment” of the *DSMs* since *DSM-III* in 1980: The human world disappears, that is, the form of discourse necessary to depict a person in the world is systematically expunged. American medicine overall only leaves a little room for the concern that people live in specific physical and social environments that may significantly affect their health (e.g., Navarro, 1993). To “rejoin medicine,” American psychiatry resolutely denies the relevance of the person’s social history in its official “What is the matter?” manual. Unlike general medicine, which can if it desires make room for “conditions of life” (as they bear on host resistance, for example), if psychiatry tries to make room for conditions of life the illusion that psychiatry is part of medical pathology disappears because “primary mental disorders” make no reference to biological phenomena.

“Culturally Sanctioned Response” as Criterion for “No Disorder”

We have been arguing that judging dysfunction in the biological realm is not ordinarily a stumbling block because what is desirable and undesirable *no matter what* is usually apparent to all. Substantial agreement exists about how a kidney is *supposed to* function or about the need to explain its function and dysfunction in terms of impersonal causal mechanisms. In the human world, however, the existence of social norms and expectations (“culture”) does not indicate that disorder or dysfunction can be recognized or even exists, because there is no basis for agreeing on how a person should feel or think or act *no matter what*. That even the law is not blind to extenuating circumstances highlights how strange it is for the *DSM-IV-TR*—and the larger field of psychopathology—to separate depiction and evaluation of thought, feeling, and behavior from circumstances and contingencies that apply only to *this* person.

Social norms would appear to furnish a reasonable explanatory frame for human conduct. Yet even the most powerful norms are always qualified by a tacit *ceteris paribus* (“all else being equal”) clause, which recognizes both that extenuating circumstances are limitless in number and that what counts as genuinely extenuating cannot be settled in advance, if at all. This renders human life differently complex *in kind* than what theories about the natural world attempt to capture. For example, at least from the perspective of the educational institution, a child in the typical American classroom is expected to be mainly silent, immobile, and attentive to the teacher and the lesson in the classroom (we say “typical” to remind the reader that variation

in educational philosophy and views about what is “natural” for a child do exist). But perhaps *this* child is malnourished and hungry, or was physically abused that morning before she came to school, or is upset about her mother’s alcoholism, or is disturbed over the conflict between the school’s presentation of evolution and her parents’ beliefs, and so on ad infinitum. In sum, although abstract or general expectations can always serve as a starting point when seeking to understand someone, a real person is always in a strictly local and personal situation. If that situation is overlooked, then any hope of understanding (as opposed to labeling or judging or evaluating) a person disappears.

In keeping with a medicalized view of human problems, the *DSM* deliberately directs the diagnostician to regard the individual’s situation (i.e., *his* or *her* situation) as irrelevant. The *DSM* does so by separating circumstances from the textual discussion of what each primary mental disorder *is* and from the official criteria set for each primary mental disorder. Earlier, we cited the extreme example of drapetomania to make the point that evaluation from the outside can only masquerade as a neutral or objective “view from nowhere.” A specific individual may appear to others as “too” something or “not enough” something, but if that is to serve as evidence of a psychological dysfunction then “psychological dysfunction” must mean more than a negative evaluation by someone who does not know or does not care about the individual’s past or present. By separating feelings, thoughts, and behavior from the context *for* the person in question, the *DSM* defines how a person should not be *regardless of circumstances* (e.g., the person should not be in a depressed mood most of the day, every day, for two weeks). This can only be characterized as a moral position masquerading as a medical diagnosis.

In the section titled “Definition of Mental Disorder,” the *DSM’s* recognition that there may be a justifiable reason for “clinically significant” distress or disability, follows the admission that “although this manual provides a classification of mental disorders . . . no definition adequately specifies precise boundaries for the concept ‘mental disorder’” (APA, 2000, p. xxx). The inability of the *DSM’s* authors to give precise boundaries places them in the position of having to say something not only reasonable but also convincing about when circumstances do and do not exempt an individual from being placed in the category “mentally disordered” if it is to seem that there is any basis for proceeding.

What the *DSM’s* authors provide at this critical juncture is this: “the clinically significant syndrome or pattern” at hand “must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one” (APA, 2000, p. xxxi). Objections come easily to mind. America is hardly a monolithic culture—to which or what culture

does the *DSM* refer? A real person may have more than one reference group—does the *DSM* mean the individual's actual reference group or the diagnostician's reference group? Under "Bereavement" (V62.82, pp. 740-741), the *DSM* notes "the duration and expression of 'normal' bereavement vary very considerably among different cultural groups." Yet the very next sentence establishes a 2-month limit to bereavement, after which the *mental disorder* diagnosis of major depressive disorder may be made. In sum, the view of culture of the *DSM's* authors permits them to suppose that *some* cultural group has established a precise time limit on grieving a loved one, regardless (this now sounds familiar) of circumstances (e.g., who the loved one was to the bereaved). More broadly, the *DSM's* authors seem to hold the view that "culture" establishes an expected and sanctioned response for any "event" that may occur in the course of living. Simply thinking about this concretely, however, reveals it is a mistaken assumption (e.g., what is the culturally sanctioned response to being left at the altar?).

Second, "the death of a loved one" is public and uncontentious enough to evade the reality that most "events" clients disclose in therapy that are germane to persistent distress or disability occurred privately, if not secretly, and if discussed with those involved in the "event" commonly lead to bitter debates about what "really" happened and why. It is unlikely anyway that persistent distress or disability can be unambiguously attributed to *one* particular event. All this is to say that in the practical situation of one person listening to another about the circumstances in which something distressing or disabling arose (we will simply skip over how difficult and time consuming this may be), the diagnostician has nothing to go on but intuition and empathy to decide if the distress or disability being discussed is justified by personal history as revealed by the patient. Surely, this cannot be the basis for identifying mental disorder present or absent *as a matter of fact*.

Third, one should not forget that the behavioral or psychological syndrome being evaluated to decide whether or not mental disorder is present is itself highly elusive. As the manual admits in the very next section, "Limitations of the Categorical Approach," individuals' problems cannot be realistically categorized without doing injustice to the total clinical picture for each individual. The *DSM's* authors offer only one justification: Categorization is the fundamental approach used in all systems of *medicine* (Jacobs & Cohen, 2003).

Concluding Remarks

In contrast to identifying disorder or dysfunction in a physical body, one cannot adequately depict or evaluate what a *person* is doing without reference to the person as an agent, the protagonist of *his* or *her* story. Formulating

a real person's story (always a version, never the final account immune to revision) is a challenging task involving conversation and interpretation. Organs and organ systems do not have personal interests to defend and advance, but people do. When an individual's story is fleshed out (history, context, meaning), we suggest that the only evaluative comment possible is moral: either "I see your point" or "Nonetheless, you should not have thought or felt or done that." In either case, the notion of "dysfunction" does not apply, because people are not designed by anyone for specific purposes or functions, thus they cannot fail to function as they are "supposed to" (of course a person can fail to perform a certain duty, like falling asleep on the job, but this is not the sense of mental disorder or psychopathology). Noticing that someone has deviated from what is expected or desired is only a reason to understand what happened; it does not constitute understanding.

What stands out about the *DSM's* approach to "mental disorder" is that the entire issue of circumstances for the agent and the possibility of accessing this through dialogue are considered largely irrelevant. Professional talk is directed everywhere but to the agent's unique history, and many professionals continue to take for granted that people may be categorized as mentally disordered or not, as a matter of fact. Yet, all the concepts used in the *DSM* to help demarcate mental disorder present from mental disorder not present (clinically significant distress, psychological dysfunction, inherently pathological symptoms) are either undefined, or inscrutable, or (in the case of culturally sanctioned response) largely irrelevant to the adversity that real patients endure or have endured.

The conviction that mental disorder exists can be likened to the conviction that pornography exists, to be recognized by people who have been trained to look discriminatively. Pornography and nonpornography may both present sexually arousing material, but (it is maintained) a nonarbitrary line can be drawn between one and the other, which consists of "artistic merit," "redeeming social value," or some such that unfortunately can no more be objectively defined or specified than pornography itself. It would be more intellectually honest to admit that pornography is a term of disapproval. Disapproval is real, but this is irrelevant to postulating that pornography is a "thing" that can be clarified by scientific investigation. The term *reification* is appropriate here; Thomason (1982) provides a useful definition: "The term 'reification' has normally referred to certain cognitive processes by which an unjustified concreteness, autonomy, facticity, impersonality, objectivity and independence is attributed to various elements of experience" (p. 1). Hopefully the similarity between mental disorder and pornography is apparent. The *DSM* recognizes that mental disorder must be distinguished from intelligible reactions to the

vicissitudes of life, but the fact that the basis for making the discrimination cannot be pinned down neither dampens faith in the reality of mental disorder nor prevents the creation of an apparently endless series of manuals of mental disorders.

Mental disorder is predicated on the conviction that a difference in kind exists between one person's emotional distress and/or social difficulties and another person's emotional distress and/or social difficulties. The *DSM* cannot say what the difference is in a manner that is not vacuous and circular. Emotional distress and social difficulties are real enough; what is lacking is a rationale for decontextualizing emotional distress or social difficulty in one case but not in another—in one instance discussing emotional distress or social difficulty in terms of an agent's (person's) history and position in the human world, in another instance rejecting the relevance of the person's history and position in the human world and advancing as explanatory an unknown dysfunction. A "psychological dysfunction" suggests the individual is in the grip of an impersonal process or mechanism or perhaps lacks some critical mental competence. If the life of any real person is scrutinized, however, it becomes apparent (as discussed above) that much of mental life can hardly be depicted as voluntary, selected, chosen, wanted, or valued. A person may sincerely believe (for example) that holding a grudge is indefensible but may hold it nonetheless. In the absence of consideration for an agent, we get drapetomania and other impersonal disorders.

The disorders are impersonal in a double sense; firstly in the familiar sense of hypothesized (nonagential) processes or mechanisms, secondly in the sense that the person on the wrong side of diagnosis is relegated to a position in which his/her story is considered irrelevant. A mental disorder diagnosis is based on an "I-it" relationship between the professional and the person who is diagnosed (see, e.g., Habermas's 1983 discussion on the difference between an "objectivating attitude" and engaging in communication, which he calls a "performative attitude"). The *DSM* tries to justify this by stating that, as in general medicine, it classifies disorders, not persons, but in the absence of a convincing reason to think of a real person's distress or social difficulties impersonally, the "drapetomania" stance is de facto embraced. In his groundbreaking longitudinal study of schizophrenia, Manfred Bleuler (1978), the son of the Swiss psychiatrist who coined the term, lamented that his colleagues routinely excoriated him for holding fast to the rule that the physician's first duty is to inform the patient whether physical disease can be objectively verified or not, and in the case of schizophrenia, so-called, this cannot be done. The same is true for so-called schizophrenia today, as it is for all primary mental disorders. In the absence of verifiable somatic disease, the

DSM advances an unknown psychological dysfunction as explanatory, but it is to be hoped that we have shown that the *DSM* cannot even state what a psychological dysfunction is supposed to mean, much less how to recognize it on evidentiary grounds. “Clinical significance” in the case of mental disorder is the homologue of “lacks artistic merit” in the case of pornography.

A fundamental difference between the natural sciences and the human sciences is that the subject of investigation or interest in the human sciences is a person who is always in a context as far as he or she is concerned. “Context” has a double meaning in the human world: It could refer to a situation as consensually or institutionally defined, to a situation for only one person (subjectivity), or to both (a conversation between two people contains both subjective and consensual elements). Also, “context” is open-ended as to time frame; for example, the meaning of an interaction between two people “now” in real time may draw on decades of relationship history. When a person deviates from what is usually expected or desired “contextually” (e.g., how a nominal student behaves in school), one could explore what “the context” is as far as the “deviant” is concerned; another possibility is to cease viewing the person as an agent and hypothesize disorder or defect. The latter move de facto terminates interest in and exploration of personal history, simultaneously taking social context for granted as unproblematic. In each instance in which a move is contemplated or has already been made to terminate interest in/exploration of an individual’s personal history and “for him/herself” social context and substitute a disorder category to answer “What is the matter?” one should ask why interest in the individual as a fully fledged person and agent has been terminated and who benefits in what way. We suggest that one should be deeply suspicious of creating “natural” disorders out of disjunctions between individuals or groups and the smooth operating needs of institutions, including assessment instruments that grow out of institutional needs and purposes (see, e.g., Gould’s, 1996, history of the intelligence testing movement in America). We hope to have shown that whether a person’s thoughts, feeling, or behavior “meet the criteria” for a *DSM* primary mental disorder diagnosis is not a sufficient reason to shift from an agential to a nonagential framework of thought.

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Notes

1. We focus on “psychological dysfunction” because we could find no way to begin to define “behavioral dysfunction.”
2. Even if the human brain and human mental capacities were designed through evolution, one cannot reconstruct what they were designed *for* because the relevant environmental and social conditions that exerted selective pressure on our species in the remote past are unknown to us. With regard to inferring from the present to the remote past in the case of human life, Gould (1987) writes the following:

Historical origin and current function are different properties of biological traits. This distinction sets an important general principle in evolutionary theory. Features evolved for one reason can always, by virtue of their structure, perform other functions as well. Sometimes the principle is of minor importance, for the directly selected function may overwhelm any side consequence. But the opposite must be true for the [human] brain. Here, surely, the side consequences must overwhelm the original reasons—for there are so vastly more consequences (surely by orders of magnitude) than original purposes. (p. 122)

Additional useful discussions concerning the problems inherent in “reverse engineering” in the human case can be found in Richardson (2007) and Scher and Rauscher (2003).

3. The neo-Kraepelinian doctrine of defining discrete clinical entities on symptomatic grounds, with the expectation that biological research will clarify the situation by identifying distinct pathophysiology and etiology (Blashfield, 1984), has produced nothing tangible at all since *DSM-III* to the present. Proposing a neuroscience research agenda for *DSM-V*, Charney et al. (2002) concluded “that the field of psychiatry has thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacologic treatment” (p. 33). Among biologically committed psychiatric researchers, this has finally resulted in a crisis of confidence in the entire system of *DSM-III* and successors (Caine, 2003; Hyman, 2003; Kendell & Jablensky, 2003; Klein, 2008; Merikangas, 2003; Tucker, 1998; van Praag, 2000; Widiger, Thomas, & Coker, 2000).

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Bios



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