SEMANTIC CHANGE IN
PSYCHIATRIC CATEGORIES: THE
CASE OF DSM-III

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Abstract

Psychiatric terminology has undergone a number of significant shifts over time. These have reflected broader social circumstances surrounding mental illness. One of the biggest upheavals was publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, which created a strictly defined categorical system of diagnostic labels. A framework from historical sociolinguistics, proposed by Weinreich, Labov and Herzog (1968), has been used to investigate this change. Three terms were analysed in detail – Schizophrenia, Bipolar Disorder and Panic Disorder – and were found to have very different histories leading up to DSM-III. The Weinreich et al. framework is evaluated for its utility in this type of complex semantic change, and is found to be effective with some minor modifications. Broader effects of language on shaping perceptions of mental illness are also briefly sketched.
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Chapter 1: Introduction

In 1851, Samuel A. Cartwright, of the Louisiana Medical Association, proposed the clinical diagnosis of *drapetomania* for runaway Negro slaves. He wrote in an article in the New Orleans Medical and Surgical Journal that with ‘proper medical advice, strictly followed, this troublesome practice that many Negroes have of running away can be almost entirely prevented.’ (1851:707). The diagnostic symptom of the condition was declared to be ‘the absconding from service’, and severe whipping was suggested as a preventative measure.

Cartwright made the following comment in his article describing the disorder. ‘In noticing a disease not heretofore classed among the long list of maladies that man is subject to, it was necessary to have a new term to express it.’ It is often easy to forget that the disease names in everyday medicine were once the outcomes of particular decisions made by individuals – and that these individuals were themselves shaped by a particular time and place. The process of naming and defining diseases has perhaps been more revealing in psychiatry than in any other branch of medicine, a field that is deeply rooted in social conceptions of normality, illness and deviance.

The problem of naming and defining disease entities is of course primarily a scientific problem. Illness categories would ideally be based on a combination of systematic research and solid scientific theory. However in the area of mental illness, no such theory exists at present. This means that there is still no scientific means of characterising the difference between mental illness and normal human experience. As historian of psychiatry Edward Shorter (1997:288) poetically observes, ‘Science wanders astray easily in the world of quotidian anxiety and sadness, in the obsessive traits of behaviour and the misfiring personality types that are the lot of humankind.’ Small decisions made here, about exactly how to define the semantic space of mental disorder and then carve up that space into words, can go on to have an enormous impact on individual human beings and how their experiences are categorised. These small decisions are deeply sensitive to context. Assumptions about the acceptability of slavery are clearly implicit Cartwright’s *drapetomania*, just as a changing social context – and some vocal political activism – prompted the removal of homosexuality from the list of mental disorders in 1973. The shifting in disorder names in response to social context is perhaps most in evidence for war-related disorders, where changing attitudes towards war have led to such terms as low moral fibre, nostalgia, shell shock, battle fatigue, brainwashing and (most recently) post-traumatic stress disorder (Hyams et al, 1996).

In each of the above instances, the social context encoded by the diagnostic labels is fairly transparent. But what about terms that are more obscure in origin? For many of the current ‘giants’ of mental illness – schizophrenia, bipolar disorder, panic disorder, obsessive-compulsive disorder – it is difficult to decode social context by simply looking at the word. It is, however, the contention of this thesis that social and historical context have been equally important in shaping these diagnostic labels, and in determining when and to whom they can be applied. If the diagnostic labels themselves are taken as focal points for analysis, mapping the shifts in their meanings may give important insights into
how people have been categorised differently over time. This is an area in which insights from linguistics, and from historical sociolinguistics in particular, might be very useful.

No work has yet been done that looks at the categories themselves from a linguistic perspective. However the important question of the boundaries between sanity and insanity has been considered by philosophers (Foucault, 1965; 2003), sociologists (Goffman, 1961; Kirk & Kutchins, 1991; Kutchins & Kirk, 1997), historians of medicine and psychiatry (Shorter, 1997; 2005; Porter, 2002; Millon, 2005) and psychologists (Bentall, 2003). Linguistic explorations of psychiatric territory have tended to pinpoint specific aspects of the linguistic strategies used by mentally ill patients when communicating. Crazy Talk (Rochester & Martin, 1979), for example, uses theory from discourse analysis to analyse coherence in the speech of schizophrenic patients, shedding light on why such people are often difficult to understand. Constructing Panic (1995), a collaboration between clinical psychologist Lisa Capps and linguist Elinor Ochs, examines the personal narratives of a woman who has been diagnosed with panic disorder.

Here, a theoretical framework from historical sociolinguistics will be used to examine the social factors driving linguistic change in psychiatric diagnostic categories. This framework consists of a set of questions posed by Weinreich, Labov and Herzog (1968) concerning how and why a particular change comes about and comes to spread throughout a community. Other areas of linguistic theory also allow us to go one step further and consider the implications of these semantic changes on a broader level. It has been argued since Humboldt, and most famously by Whorf (1956), that the linguistic categories made available by language have a pervasive effect on structuring our perception of the world. The Soviet diagnosis of ‘sluggish schizophrenia’ illustrates this clearly. Used by the ruling Communist Party to institutionalise political dissidents, it had symptoms such as disagreement with the government, disagreement with Communism, neurotic self-consciousness, conflicts with parental and other authorities, reformism, social contentiousness, and philosophical concerns (Bentall, 2003). The following comment is equally relevant to psychiatry today:

Those Soviet psychiatrists really saw the patients as schizophrenic; or, to put in another way, the system created a category, first on paper and then, with training, in the minds of Soviet psychiatrists, which was eventually assumed to represent a real class of patients and which was inevitably filled by real persons. (Reich, 1984: 202, italics in original.)

This thesis aims to apply the framework outlined by Weinreich et al (1968) to a particularly important instance of semantic change in psychiatry. This instance is the formulation of the conceptual reorganisation that occurred in 1980, and resulted in publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (also known as DSM-III). Three terms have been selected from the manual – Schizophrenia, Bipolar Disorder and Panic Disorder – and their histories have been tracked both before and after the conceptual shift. The framework is then briefly evaluated for its usefulness in relation to this particular highly complex example of semantic change. Finally, the power of diagnostic categories for structuring perception is
considered, with reference to theories of linguistic relativity, anthropological linguistics, and grammatical metaphor.

In particular, the following questions will be the focus:

(1) What were the changes that occurred in each of the terms *Schizophrenia, Bipolar Disorder* and *Panic Disorder* leading up to the formulation of DSM-III in 1980?
(2) How well is the social context of these changes captured by the framework of Weinreich, Labov and Herzog (1968)?
(3) How has the shift in terminology shaped the way in which mental illnesses are perceived?

An essay by Jorge Luis Borges describes a classification of animals in the Chinese encyclopaedia *The Celestial Emporium of Benevolent Knowledge*:

In those remote pages it is stated that animals can be divided into the following classes: (a) belonging to the Emperor; (b) embalmed; (c) trained; (d) sucking pigs; (e) mermaids; (f) fabulous; (g) stray dogs; (h) included in this classification; (i) with the vigorous movements of madmen; (j) innumerable; (k) drawn with a very fine camel hair brush; (l) etcetera; (m) having just broken a large vase; (n) looking from a distance like flies.

With this reminder that not all detailed taxonomic systems are models of scientific rigour, we now turn to linguistic theories of classification systems and their development.
Chapter 2: Literature Survey

2.1 Linguistics

2.1.1 Historical linguistics and semantic change
Semantic change is generally considered far more unpredictable than other types of linguistic change (Campbell, 2004). More recently, however, researchers have begun to identify broad patterns in the direction of meaning changes – most notably from concrete to abstract (Sweetser, 1990; Traugott & Dasher, 2002).

2.1.2 Prototype theory
Prototype theory has also been adopted to account for semantic change. Originally proposed by psychologist Eleanor Rosch (1975), prototype theory states that each word can be seen as representing a cluster of meanings. This cluster is circular with fuzzy edges, with the centre representing ‘core’ referents and the periphery representing more marginal category members.

DSM’s categories as prototypes
The categories of the Diagnostic and Statistical Manual of Mental Disorders are probably most accurately described as prototypes (Horowitz et al, 1981). Consisting of a range of criteria for duration, disability and symptom profile, their structure allows them to bring a large number of slightly differing presentations under one diagnostic umbrella. The diagnostic criteria for a Panic Attack (APA, 2000) are reproduced below.

<table>
<thead>
<tr>
<th>Criteria for Panic Attack</th>
</tr>
</thead>
<tbody>
<tr>
<td>A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:</td>
</tr>
<tr>
<td>1. palpitations, pounding heart, or accelerated heart rate</td>
</tr>
<tr>
<td>2. sweating</td>
</tr>
<tr>
<td>3. trembling or shaking</td>
</tr>
<tr>
<td>4. sensations of shortness of breath or smothering</td>
</tr>
<tr>
<td>5. feeling of choking</td>
</tr>
<tr>
<td>6. chest pain or discomfort</td>
</tr>
<tr>
<td>7. nausea or abdominal distress</td>
</tr>
<tr>
<td>8. feeling dizzy, unsteady, lightheaded, or faint</td>
</tr>
<tr>
<td>9. derealization (feelings of unreality) or depersonalization (being detached from oneself)</td>
</tr>
<tr>
<td>10. fear of losing control or going crazy</td>
</tr>
<tr>
<td>11. fear of dying</td>
</tr>
<tr>
<td>12. paresthesias (numbness or tingling sensations)</td>
</tr>
<tr>
<td>13. chills or hot flushes</td>
</tr>
</tbody>
</table>

This list of criteria gives 715 possible different combinations of symptoms, describing a
heterogeneous class of entities with an assumed semantic core.

2.1.3 Prototype theory and semantic change
The structure of a prototype lends itself well to theories of semantic change. Over time, word meanings can be seen as migrating from the periphery to the core and back out again. The fuzzy borders of the prototype allows for expansion and contraction in the denotational range of a particular word, as well as for the introduction of new meanings at the margin. Geerhaerts (1997)'s treatment of leggings is an example of such a theory, showing the word entering into Dutch fashion magazines with a fairly narrow meaning and expanding over time to encompass ever shorter and looser examples. An advantage of this particular example is that it can be examined in relative isolation from wider social changes. In an area as socially and politically loaded as mental illness, however, it is not generally possible to isolate changes in word meaning from their context. The ‘core’ characteristics of schizophrenia, for example, are the result of a continuous process of remodelling that takes place according to the received psychiatric wisdom of the day.

2.1.4 A framework for identifying the causes of linguistic change
Historical linguists have generally avoided discussing the causes of the changes that they describe. This is understandable since cause, effect and context are often difficult to untangle. One framework that does attempt to address the influence of external factors is proposed by Weinreich, Labov and Herzog (1968). These authors outline a framework for any theory that hopes to consider the causes of linguistic change, identifying five problems that any such theory must address. These are:

(1) The constraints problem. What are the constraints on change that determine possible and impossible directions for change?
(2) The transition problem. How, or by what route or routes, does language change? Is the change gradual or abrupt?
(3) The embedding problem. How is a particular language change embedded in the surrounding system of linguistic and social relations?
(4) The evaluation problem. How is the change evaluated? What are the effects of the change on the overall structure of the language?
(5) The actuation problem. Why does a given linguistic change occur at the particular time and place it does? By what mechanism does a given change begin and proceed?

These questions will form the basis for Chapter 4. The same authors also argue that, much as in biological evolution, variation is a necessary prerequisite for linguistic change to occur. This idea will not be considered here but has potentially interesting implications for a system such as the DSM, which has become highly standardised and now allows little room for natural variation.

2.1.5 Language and thought
The capacity of language to structure thought was first formally articulated by Wilhelm
von Humboldt (1767-1835). He suggested that the world view (Weltanschauung) of
speakers of different languages was fundamentally different (Penn, 1972), and perhaps
even incommensurable. The theory was most famously expressed by North American
linguists Benjamin Lee Whorf (1956[1941]) and Edward Sapir. Known as the Sapir-
Whorf Hypothesis, or the theory of linguistic relativity, this theory proposes that the
differing structure of languages causes speakers to perceive the world in different ways.

We dissect nature along lines laid down by our native language. The
categories and types that we isolate from the world of phenomena we do not
find there because they stare every observer in the face; on the contrary, the
world is presented in a kaleidoscope flux of impressions which has to be
organized by our minds — and this means largely by the linguistic systems
of our minds. (Whorf, 1956:212–214)

This claim has proved to be contentious, and has prompted a number of studies that have
attempted to determine its validity. One of the broad topics of research exploring
Whorf’s claim has been cross-linguistic studies of colour terms, beginning with Berlin
and Kay (1969). These studies tended, at least initially, to produce results inconsistent
with the hypothesis, suggesting that colour perception is determined by human
physiology and not by the idiosyncratic ways languages divide up the colour spectrum.
Studies of colour terms have more recently been criticised on a number of
methodological grounds (Lucy, 1997), and other domains have begun to be explored.
Experiments in the domain of spatial orientation would seem to suggest that language
does in fact shape cognition in this area at a fairly basic level. This work by Levinson
and colleagues (see for example Levinson, 2000) compares speakers of languages that
employ compass-point ‘absolute’ spatial coordinates, such as the Australian language
Guugu Yimithirr and the Mayan language Tzeltal, with speakers of languages that
employ egocentric, ‘relative’ spatial coordinates, such as Dutch and English. These
experiments would seem to indicate that the location of objects is processed and
remembered differently, and that this difference is dependent upon the language of the
speaker. The validity or otherwise of the theory is still unresolved, and more recently
researchers have begun to move towards a more intermediate position. The astonishing
diversity of human language is now thought to be bounded by universal constraints on
human cognition (Gumperz & Levinson, 1996).

2.2 Psychiatry and Psychology

2.2.1 A Historical Dictionary of Psychiatry

A work that has provided a large amount of raw material for this thesis is the recently
published Historical Dictionary of Psychiatry (Shorter, 2005). This collection of current
and past terms follows the development of concepts from first appearance to their present
meaning, or to the point at which they became obsolete. It is a complex route, and often
the same name is co-opted by different researchers to serve different functions over time.
The dictionary reveals that a large number of the terms in current use originated between
1860 and 1920 in France and Germany. This appears to be due to the rise of the
therapeutic asylum, which generated the need for a classification scheme that would help
psychiatrists to treat their patients.

2.2.2 Other broad historical works
Two other important historical overviews are Porter’s (2002) *Madness: A History* and eminent theoretical psychiatrist Theodore Millon’s (2005) *Masters of the Mind: Exploring the Story of Mental Illness from Ancient Times to the New Millennium*. Both of these books chronicle the development of concepts of mental illness, starting in ancient Egypt and Mesopotamia and culminating in the present era of classification, medication and brain chemistry. These works come on the back of Shorter’s engaging *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (1997) and are representative of an emerging literature by leading medical historians that focuses on psychiatry and mental illness. Their accounts speak to a need for integration and synthesis of psychiatry across its diverse historical contexts.

2.2.3 Healy and Bentall
Much material on the social and scientific contexts of evolving disorder terms has been drawn from psychiatrist David Healy’s *The Creation of Psychopharmacology* (2002) and psychologist Richard P. Bentall’s *Madness Explained* (2003). Healy focuses primarily on the development of antidepressants, antipsychotics and other psychoactive drugs, but also highlights the importance of other scientific discoveries – often completely unrelated to psychiatry – in the development of ideas, descriptions and explanations in mental pathology. Bentall’s book is an argument against the disease-classification model of mental illness and uses a large volume of research findings to piece together an approach based on specific symptoms. Although this remarkable book is not primarily focused on language, a chapter is included on cross-cultural psychiatry. Bentall also demonstrates how language and categorisation systems serve as both the scaffolding that is needed to build a theoretical approach, and as ‘blinkers’ that may guide attention away from potentially important details.

2.3 History of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

2.3.1 Previous attempts to classify mental illness

Cause-based approaches to classification
Attempts to describe and classify mental disorder are at least as old as ancient Egypt, where the first known psychiatric text (on the causes and treatment of hysteria) was written in the twentieth century B.C. Hippocrates (460-370BC) believed that hysteria was caused by ‘a wandering of the uterus’ throughout the body, within a humoral theory that gave *melancholia* its name: a condition of partial insanity caused by an excess of

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1 Psychiatrists are medical doctors who specialise in mental illnesses. Psychologists are trained as scientists and use this training in clinical practice with patients. In Australia, only psychiatrists are authorised to prescribe medication. Psychologists tend to favour cognitive and behavioural therapies.
black bile. In his encyclopaedic, three-volume The Anatomy of Melancholy, What it is: With all the Kinds, Causes, Symptoms, Prognostickes, and Several Cures of it (1621), Robert Burton based his classification system on areas of the body from which the condition was thought to arise:

The most received division is into three kinds. The first proceeds from the sole fault of the brain, and is called head-melancholy; the second sympathetically proceeds from the whole body, when the whole temperature is melancholy; the third ariseth from the bowels, liver, spleen, or membrane called mesenterium, named hypochondriacal or windy melancholy (Burton, 1621:175).

Burton also classifies more distal causes, ranging from ‘God a cause’ to ‘From the devil immediately, with a digression of the nature of spirits and devils’. These are listed alongside such other causes as ‘Parents, it being a hereditary disease’, ‘Fumes arising from the stomach’, ‘A blow on the head’, and ‘Heat of the sun immoderate’.

The birth of psychiatry as a discipline
The word psychiatry was coined by German medical professor Johann Christian Reil in 1808 from the Greek words psyche and iatros, meaning mind or soul healing. Psychiatry was to be the third branch of the art of medicine, alongside surgery and physic (medication). Initially suffering from a lack of systematic descriptions for its techniques and treatments, the field received a considerable boost at the turn of the twentieth century on the back of developments in other areas of medical science.

Advances in 19th-century science
The success of biological taxonomic systems triggered a number of copycat taxonomies in medicine and psychiatry. The most imposing of these was one attempt that outlined ten classes of disorder, broken into 295 genera and around 2400 species (described by Menninger et al, 1959). Other scientific developments also influenced the way in which mental disorder was viewed. For example, Healy (2002) argues that a key moment in the transition to a biomedical view of the mind occurred in 1828, with the artificial synthesis of the first organic chemical (urea) by Friedrich Wöhler. This disproved vitalism, the dominant belief that the chemicals in living organisms differed fundamentally from those in inorganic matter. A second key development was germ theory, proposed in the 1870s by Robert Koch and Louis Pasteur. Germ theory identified diseases as being caused by specific microscopic pathogens, which we now know as bacteria and viruses. ‘Syndromes’ (clusters of symptoms that commonly co-occur) could now be described, and these descriptions used to investigate the microscopic causes of the disease. This theory is very much in use today, with syndromes like AIDS and SARS having been described symptomatically before their microscopic viral pathogens were identified.

The ‘founding father of psychiatry’
Most importantly for the purposes of psychiatric classification, germ theory prefigured the idea that mental disorders might be meaningfully classifiable even if their causes were still unknown. The theory inspired a flurry of observation and classification, triggering what Shorter (2005) has described as a ‘nosological fervour’ in French and
German asylums around 1900. (‘Nosology’ is a term specifically for medical taxonomies.) Principal among these was Emil Kraepelin, who was to become known as the founder of psychiatric nosology. His goal was to delineate mental disease entities, with the expectation that these would be eventually linked to specific pathogens. Kraepelin distinguished three main classes of illness: *Dementia Praecox* (now Schizophrenia), *Manic-Depressive Insanity* (now the group entitled ‘Mood disorders’), and *Dementia Paranoides* (now defunct).

### The psychoanalytic hiatus

The urge to classify has waxed and waned considerably throughout the twentieth century. Freudian-style psychoanalysis, with its focus on childhood impulses and internal conflicts, was uninterested in classifying disorders. Psychoanalysis became the dominant approach for the first half of the twentieth century. Its rise in popularity coincided with the migration of many Jewish psychoanalysts from Europe to the US before the Second World War. With a view that all people are dealing with various psychological conflicts that might emerge as pathological during a stressful period, psychoanalytic theory was uninterested in delineating ‘diseased’ from ‘normal’. Prominent psychiatrist Donald Klein has commented that during this period, which lasted well into the 1970s, ‘to be interested in descriptive diagnosis was to be superficial and a little bit stupid.’ (Spiegel, 2005).

#### 2.3.2 DSM-I and DSM-II

The first version of the *Diagnostic and Statistical Manual of Mental Disorders*, published in 1952, fell squarely into this period of psychoanalytic dominance. Compiled mainly from asylum statistics, it was intended solely for the managers of US mental institutions. DSM-I was 130 pages long and described 106 different types of ‘reactions’ to stressful environmental circumstances, including ‘schizophrenic reaction’ and ‘manic-depressive reaction’. Its publication, argues Grob (1991), reflected the continued weakening of the biological tradition in psychiatry and the rise of the psychoanalytic.

DSM-II (1968) followed in the same psychoanalytic vein. It, too, was largely ignored, a 134-page paperback that was sold to mental institutions for $3.50. The 182 ‘neuroses’ it outlined were mostly elaborations of those found in DSM-I.

#### 2.3.3 DSM-III

DSM-III was published in 1980 and constituted a revolution in psychiatric thinking. It created a nosology, complete with clearly defined and categorised disorders. The manual greatly streamlined the diagnostic process, and also ensured that clinicians were speaking the same language. DSM-III was also a fundamentally different document to DSM-II. The previous manuals had outlined psychiatric conditions such that only one of the described symptoms was necessary and sufficient for a diagnosis. DSM-III introduced prototypical disorder categories (see section 2.1.2) according to a syndrome-based model. Although nominally agnostic as to the causes of these syndromes, the implicit
assumptions were biological. With its 265 clearly defined disorder names, DSM-III flagged a return to the biological psychiatry of almost a century before.

At first DSM-III and its architect, Robert Spitzer, were anomalies in an establishment dominated by psychoanalysts. Spitzer, who was originally trained in the psychoanalytic tradition, has recently said about his former patients: “I was always unsure that I was being helpful, and I was uncomfortable with not knowing what to do with their messiness.” (Spiegel, 2005). Another colleague adds, “He doesn’t understand people’s emotions. He knows he doesn’t. But that’s actually helpful in labelling symptoms. It provides less noise.”

2.3.4 DSM-III-R, DSM-IV and the projected DSM-V

The revised version of DSM-III, known as DSM-III-R, was published in 1987 and saw little change in structure but a substantial increase in size. From the 494 pages and 265 disorder names of DSM-III, DSM-III-R swelled to 567 pages and listed 292 different disorder names. DSM-IV (1994) expanded again to 886 pages and 297 disorder names, and the text revision DSM-IV-TR kept the disorder names and diagnostic criteria the same but extended to almost 1000 pages. The current Task Force committee for DSM-V is currently conducting meetings around the world, and the new version of the manual is projected to appear in 2012.

Inclusion of a particular disorder is generally backed up by a number of scientific studies, although this seems to not always be the case. Walker (1996) writes that DSM-III Task Force director Robert Spitzer and two psychiatrist colleagues reportedly came up with the idea of Self-Defeating Personality Disorder during a fishing trip. On their return, they wrote up a description of the disorder (characterised by, among other things, a person who is ‘drawn to situations or relationships in which he or she will suffer’). They convinced colleagues at their medical centre to conduct one study on the disorder, and presented it to the DSM-III-R committee. The result was a new disorder category for DSM-III-R – one which then disappeared again at publication of DSM-IV.

2.3.5 Structure of the diagnostic categories

All of the versions of the DSM since DSM-III are structured as a compendium of

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2 The same article also quotes Spitzer as saying, “I find it very hard to give presents. I never know what to give. A lot of people, they can see something and say, ‘Oh, that person would like that.’ But that just doesn’t happen to me. It’s not that I’m stingy. I’m just not able to project what they would like.” This modest empathic ability allowed Spitzer to truly see each patient as a collection of symptoms to be classified and treated – with enormous repercussions for subsequent psychiatry. It is important to remember, however, that even though he worked to classify disorders and symptoms without much reference to the attached people, the ultimate goal of his work was to help people who were ill or troubled to become well.

3 Psychologist Roger Blashfield has used statistical techniques to calculate somewhat cynically that, based on trends in DSM-I to IV, DSM-V will have 1256 pages, contain 1800 diagnostic criteria and 11 appendices, and generate $80 million in revenue for the American Psychiatric Association (Blashfield, 1996).
prototype categories. Each of these categories is associated with a set of criteria, consisting of:

1. a list of symptoms, of which a certain number are necessary for a diagnosis;
2. a criterion for functional disability; and
3. a duration criterion.

An example of the symptom list for a Panic Attack was given in section 2.1.2. A set of DSM-IV diagnostic criteria for schizophrenia (APA, 2000) is given below:

### Diagnostic criteria for Schizophrenia

**A. Characteristic symptoms:** Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. delusions
2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. negative symptoms, i.e., affective flattening, alogia, or avolition

**Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

**B. Social/occupational dysfunction:** For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

**C. Duration:** Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

DSM-IV is organised into 15 sections:

- Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Sexual and Gender Identity Disorders
Eating Disorders  
Sleep Disorders  
Impulse-Control Disorders Not Elsewhere Classified  
Adjustment Disorders  
Personality Disorders  

Each of the diagnostic labels is associated with a numeric code, which is now required for reimbursement of health insurance. So pervasive is the DSM-IV system now that any researcher seeking funding from the National Institute of Mental Health, the major sponsor of psychiatric research, must apply using specific DSM classification labels. This means that the manual is no longer simply a practical tool for psychiatrists to use in clinical practice. It is now a template that decides which scientific questions can be asked about mental illness – and which equally important scientific questions are ignored.
Chapter 3: The Evolution of Three DSM-III Categories: Schizophrenia, Bipolar Disorder and Panic Disorder

This chapter outlines the changes in each of the three terms leading up to the formulation of DSM-III.

3.1 Definition of Terms

The following definitions are adapted from DSM-IV (APA, 2000).

Schizophrenia

The diagnostic criteria for schizophrenia are given in section 2.3.5. Briefly, schizophrenia is a mental disorder characterised by delusions (fixed false beliefs), hallucinations (anomalous sensory perceptions such as hearing voices or seeing things that are not there), social withdrawal and mental confusion. It is thought to occur in the general population at a rate of approximately 1 in 100. There are no diagnostic laboratory tests for schizophrenia as of 2007, nor is there any one factor that unifies all of those who receive the diagnosis.

Bipolar Disorder

Bipolar Disorder is characterised by alternating periods of clinically depressed or elevated mood. These periods are recurrent and interspersed with long periods of normal functioning. The condition is currently divided into two subcategories. Bipolar I Disorder describes alternating periods of mania (elevated or expansive mood, excess activity, grandiose delusions and little need for sleep) and major depression. Bipolar II Disorder involves the alternation of hypomania (a less extreme form of mania) and major depression. Like schizophrenia, it is thought to occur in the general population at a rate of approximately 1 in 100.

Panic Disorder

Panic disorder is characterised by repeated, unexpected ‘panic attacks’: sudden episodes, usually lasting around 10-15 minutes, in which the patient is seized by intense fear or terror. The full diagnostic criteria are given in section 2.1.2. Panic attacks may be a symptom of several different disorders. Panic Disorder itself describes repeated, unpredictable panic attacks, as well as at least a month of worrying about the attacks and/or their consequences. The diagnosis is relatively common, with its prevalence in the population estimated to be 2 to 3 in 100.
3.2 The evolution of Schizophrenia as a diagnostic category

As defined in the previous section, Schizophrenia is a mental disorder characterised by delusions, hallucinations, social withdrawal and mental confusion.

3.2.1 Prehistory of Schizophrenia

Schizophrenia was not recognised and named as a mental disorder until the early 1900s. A search of ancient Greek and Roman literature (Evans et al, 2003) has found nothing resembling the disorder in its current form – seemingly due to the simple fact that someone hearing the voices of spirits and having religious visions was far more likely to be believed than diagnosed as mentally ill. Delusions and hallucinations, which are now seen as the more flagrant symptoms of schizophrenia, have tended to be the domain of religious or other social institutions rather than of medical science.

3.2.2 Development of the concept

In 1860, French psychiatrist Bénédict-Augustin Morel described an adolescent form of insanity that he named démence précoce, or ‘premature dementia’. Morel was the first psychiatrist to classify an illness based on its course rather than on a hypothesised cause. Outcome was also a key factor in Kahlbaum’s 1863 classification, with Vesania typica (typical insanity) also following a deteriorating course. In 1871, Kahlbaum went on to describe hebephrenia (from the Greek hebe, ‘youth’ and phrenia, ‘mind’). Hebephrenia formed the template for Kraepelin’s dementia praecox. This was in turn to become the foundation of the modern concept of schizophrenia.

Hebephrenia
Catatonia                     Dementia Praecox
Vesania Typica

A brief schematic of the major changes, beginning with dementia praecox, is shown in Table 3.1. The core features at each stage (features considered to define the disorder) are highlighted in yellow.
### Table 3.1: The evolution of Schizophrenia as a diagnostic category

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Course</th>
<th>Onset</th>
<th>Domain</th>
<th>Clinical Presentation</th>
<th>Hypothesised Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dementia Praecox</strong></td>
<td>1899</td>
<td>Progressive deterioration</td>
<td>Adolescence</td>
<td>Asylum patients</td>
<td>Disorganised thought, dementia</td>
<td>Metabolic abnormalities (specifically in the sex organs)</td>
</tr>
<tr>
<td><strong>The Schizophrenias</strong></td>
<td>1908</td>
<td>Usually progressive</td>
<td>Usually in</td>
<td>Asylum patients</td>
<td>Split’ in psychic functions</td>
<td>Metabolic abnormality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deterioration</td>
<td>adolescence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Schizophrenic Reaction</strong></td>
<td>1952 (DSM-III)</td>
<td>Not specified</td>
<td>Any age</td>
<td>Community, psychiatric institutions</td>
<td>Psychologically self-protective delusions, hallucinations, withdrawal</td>
<td>Stressful environmental circumstances (especially during childhood)</td>
</tr>
<tr>
<td><strong>Schizophrenia</strong></td>
<td>1980 (DSM-III)</td>
<td>Symptoms can be controlled with medication.</td>
<td>Any age, typically 18-35</td>
<td>Community, psychiatric institutions</td>
<td>Symptoms: Delusions, hallucinations, thought disorder, social withdrawal, disability or functional impairment</td>
<td>Not specified</td>
</tr>
</tbody>
</table>

#### 3.2.3 Kraepelin and Dementia Praecox

It was not until the sixth edition of Kraepelin’s textbook in 1899 that the two monolithic categories of *dementia praecox* and *manic-depressive illness* (considered in more detail in section 3.3) were created. The two were distinguished on the basis of prognosis. The course of dementia praecox was unerringly downhill, whereas the course of manic-depressive illnesses was cyclic, with patients experiencing periods of illness interspersed with periods of normal functioning. Kraepelin’s concepts became popular with other psychiatrists because they allowed a prognosis to be given to patients and their families.

#### 3.2.4 Dementia Praecox is renamed Schizophrenia

In 1908, Swiss psychiatrist Eugen Bleuler renamed dementia praecox ‘the schizophrenias’, based on the Greek *schizein* (σχίζειν, ‘to split’) and *phren-* (φρήν, φρεν-, ‘mind’). This redesignation was partly because dementia praecox was inconvenient to use as an adjective (Shorter, 2005) and partly because Bleuler considered the condition to involve a split in the psychic functions of personality, intellect, emotion and perception. Bleuler’s new term broadened and softened the boundaries of *dementia praecox*. The course, he argued, was not always irrevocably downhill; nor was it only adolescents who were afflicted.

Kahlbaum Kraepelin Bleuler

Hebephrenia
Catatonia
Vesania Typica

Dementia praecox (broadened) Schizophrenia
3.2.5 Developments after Bleuler
Bleuler’s term was kept largely unchanged thereafter, languishing along with all other diagnostic labels through the period of psychoanalysis that lasted up until the 1970s. DSM-I and DSM-II included the category of schizophrenic reaction, considering the delusions and hallucinations to be a ‘frequently self-protective’ psychological reaction to stressful life circumstances.

3.2.6 Schizophrenia in DSM-III and beyond
DSM-III, as previously discussed, was a return to the view of mental disorders as biological in nature. A set of ‘Research Diagnostic Criteria’ published in the early 1970s (Feighner et al, 1972) was the first step in a significant tightening of the term’s semantic range. In one study, of 163 patients that had been diagnosed schizophrenic under the criteria used in the 1960s, only 19 satisfied the new DSM-III criteria (Bentall, 2003). DSM-IV (published in 1994) changed little.

3.3 The evolution of Bipolar Disorder as a diagnostic category
As defined in section 3.1, Bipolar Disorder is characterised by the alternation of depressed and abnormally elevated (or irritable) mood, interspersed with periods of normal functioning.

3.3.1 Prehistory of Bipolar Disorder
The mid-1800s saw a flurry of work published on the alternation patterns of mania and melancholia, which had shifted from its previous meaning of ‘partial insanity’ to denote a decline in cognitive functioning and low mood. These conditions tended to be known as circular insanity.

Table 3.2 shows the major changes. Core diagnostic elements are highlighted in yellow.
### Table 3.2: The evolution of Bipolar Disorder as a diagnostic category

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Course</th>
<th>Onset</th>
<th>Domain</th>
<th>Clinical Presentation</th>
<th>Hypothesised Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Das Manische-Depressive Irresein</strong> (Manic-Depressive Insanity)</td>
<td>1899</td>
<td>Cyclical throughout the lifespan</td>
<td>Typically early adulthood</td>
<td>Asylum patients</td>
<td>Episodic Mood Disturbance: Both bipolar and unipolar</td>
<td>Metabolic abnormality</td>
</tr>
<tr>
<td>Manic-Depressive Illness</td>
<td>1960s</td>
<td>Cyclical</td>
<td>Any time</td>
<td>Psychiatric hospitals, Community patients</td>
<td>Mood Disturbance: Bipolar only</td>
<td>Genetic factors</td>
</tr>
<tr>
<td>Bipolar Disorder (DSM-III)</td>
<td>1980</td>
<td>Cyclical; symptoms can be controlled with medication</td>
<td>Average age of onset = 20 years</td>
<td>Community patients, psychiatric hospitals</td>
<td>Mood Disturbance: Bipolar only</td>
<td>Not specified</td>
</tr>
</tbody>
</table>

3.3.2 A consistent diagnostic core

As can be seen in Table 3.2, the diagnostic core of Bipolar Disorder has remained the same since first introduced – with the exception of the separation of unipolar depression from the bipolar form. This occurred in 1957 and was the result of research into genetic influences on the disorders conducted by Karl Leonhard. His examination of the family trees of his patients seemed to indicate that both bipolar and unipolar forms were heritable, but that families seemed to be consistent in which of the two forms was present.

The semantic constancy of this disorder over time contrasts markedly with that of Schizophrenia (see Table 3.1). This may be because comparatively little research attention has been paid to bipolar disorder (Bentall, 2003), or because the label more accurately coincides with a ‘true’ disease entity.

3.3.3 Shuffling of bipolar and unipolar mood disorders

Prior to 1899, bipolar and unipolar mood disorders were considered to be distinct. Kraepelin decided in his 1899 textbook to group these together under the heading of *Das manische-depressive Irresein*, manic-depressive insanity:

Manic-depressive insanity… includes on the one hand the entire area of so-called periodic and circular forms of insanity; on the other hand it includes most of the hitherto separately treated simple manias. In the course of the years I have become increasingly convinced, that all of the above mentioned clinical pictures are only aspects of a single disease. (Kraepelin, 1899, translated Shorter, 2005:167)
3.3.4 Bipolar Disorder in DSM-I, DSM-II and DSM-III

DSM-I and DSM-II referred to manic depressive reaction and manic depressive illness respectively, in keeping with psychoanalytic theory. In 1978, a succession of studies on the reliability of psychiatric diagnoses caused a large number of previously diagnosed schizophrenics to be reclassified as having bipolar disorder (Bentall, 2003), indicating significant diagnostic confusion over the two distinct disease entities. The DSM-III term bipolar disorder was introduced to reduce the stigma attached to the manic depressive label. DSM-IV divided Bipolar Disorder into Bipolar I Disorder and Bipolar II Disorder but changed little else.

Estimated rates of Bipolar Disorder have remained relatively constant over time at around 1% of the population. This contrasts markedly with developments in the diagnosis of its twin, unipolar depression (Major Depressive Disorder), which has seen a massive increase in estimated prevalence over the last quarter of a century – from 5,000 per million people to 100,000 per million. Major Depressive Disorder also shows a decreasing age at diagnosis: an astonishing 330,000 antidepressant prescriptions were written for Australian children in the last year (Elder, 2007).

3.4 The evolution of Panic Disorder as a diagnostic category

3.4.1 Prehistory of Panic Disorder

The word panic is taken from the Greek god Pan, who if woken while napping in the forest let out a blood-curdling scream that caused the hearer to panic. It first entered English in 1603, with the meaning of ‘mass terror’. The term ‘panic disorder’ itself is of much more recent origin, being suggested in 1978 and crystallised in the 1980 DSM-III.

The major changes are shown in Table 3.3. Core diagnostic elements are highlighted in yellow.
### Table 3.3: The evolution of Panic Disorder as a diagnostic category

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Course</th>
<th>Onset</th>
<th>Domain</th>
<th>Clinical Presentation</th>
<th>Hypothesised Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melancholic Anxiety Attacks</td>
<td>1872</td>
<td>Part of general nervous and mental illness</td>
<td>Asylum patients</td>
<td>Clinical</td>
<td>Clouding of the senses, ringing in the ears, seeing sparks, nausea, palpitations, plus a sense of anguish in the heart area</td>
<td>-</td>
</tr>
<tr>
<td>(der melancholische Angstanfall)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety attacks</td>
<td>1940</td>
<td></td>
<td></td>
<td></td>
<td>As above; triggered by rebreathing Carbon Dioxide with pre-existing Anxiety Neurosis</td>
<td>Metabolic abnormalities</td>
</tr>
<tr>
<td>‘Panic’ (differentiated from Anxiety)</td>
<td>1962</td>
<td>Treatable with medication</td>
<td>Mental hospital patients; then to community</td>
<td></td>
<td>Sudden attacks of fear that made patients run to the nurses’ station to have their hands held</td>
<td>Unspecified biochemical causes</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>1980 (DSM-III)</td>
<td>Variable - Both chronic and temporary</td>
<td>Variable, typically late adolescence - mid-30s</td>
<td>Mostly community patients</td>
<td>4 of 13 symptoms, including heart palpitations, gastrointestinal discomfort, fear of dying</td>
<td>-</td>
</tr>
</tbody>
</table>

3.4.2 Development of the modern concept

Shorter (2005) traces the first description of panic attacks to the late nineteenth century, although something similar was described by Burton in 1621 and most likely by other writers, even earlier. German psychiatrist Rudolph Gottfried Arndt described der melancholischer Angstanfall, ‘melancholic anxiety attacks’, in 1872, almost concurrently with a description of ‘paroxysmic attacks of panic’ by Maurice Krishaber in Paris. In both cases, the attacks were thought to be physical in nature. In 1940, ‘anxiety attacks’ were provoked in patients with existing anxiety neuroses by having them rebreathe carbon dioxide. The researcher involved, Mandel Cohen, is now seen as the originator of the concept (Shorter, 2005).

3.4.3 Response to imipramine and the role of medication

In 1962, Donald Klein found that certain patients in his care responded to the drug imipramine. These patients were people who periodically rushed to the nurses’ station asking for a nurse to hold their hand. Patients who had more generalised anxiety did not respond. This led to the differentiation of panic from anxiety on the basis of drug response, and was the first step in justifying panic as a separate disorder in the DSM-III.
As historian Edward Shorter has commented:

The whole panic story is interesting as an example of how symptoms wax and wane in the history of psychiatry, treated as one among many at one point, and the focus of all nosology at the next. There may be good scientific reasons for the fluctuating historical courses of such symptoms, yet commerce plays a role as well, for if industry needs a symptom for a compound it has developed, one may be sure that entities such as panic will stand in good service. (2005:203)

The next chapter considers these reasons – scientific, commercial and otherwise – and how they have contributed to shaping the three diagnostic labels of Schizophrenia, Bipolar Disorder, and Panic Disorder.
Chapter 4: Applying the Weinreich et al Framework

The following chapter explores the extent to which the context of the terminology changes is captured by the framework of Weinreich, Labov and Herzog (1968).

4.1 Outline of the five problems to be addressed

Introduced in section 2.1.4, this framework consists of five problems to be addressed when considering the causes of semantic change. These are the constraints problem, the transition problem, the embedding problem, the evaluation problem, and the actuation problem. The constraints problem concerns factors that restrict possible and impossible directions for change. The transition problem asks about the route or routes by which language changes and the timescale over which this occurs. The embedding problem is the place of the change in its wider network of social and linguistic relations, and the evaluation problem concerns the way in which a change is viewed by the linguistic community. Finally, the actuation problem asks about more immediate and specific triggers for the change.

There has been surprisingly little work that has adopted this framework as a methodological basis. The work that exists has tended to be very specific. Martinez (2000), for example, discusses the embedding problem in detail for a treatment of the absolute construction in nineteenth-century Tejano narrative, while Gerritson (1999) examines dialect divergence near the Belgian-Dutch-German border.

4.2 Problem 1: Constraints

Need for a common language. The development of DSM-III was an important bureaucratic change. If the DSM classifications were to be made reliable, psychiatrists all over the world needed to have consistent lexical entries for the terms in use. This was not previously the case. The mismatch between British and US concepts of schizophrenia is illustrated in the following Venn diagram, taken from Kendall et al (1971).
DSM-III was developed at a time when studies increasingly indicated that schizophrenia was diagnosed at different rates in different countries: an International Pilot Study of Schizophrenia, for example, had revealed Russia and the US showed far higher rates of schizophrenia diagnoses than Britain and other countries sampled (WHO, 1973).

**Predetermined structure of a medical model of mental illness.** Poor diagnostic reliability was a predicament for the medical model. A scientific taxonomy of mental disorder, and one that claims to delineate natural classes of human mental illness, must be as culturally invariant as possible. With this in mind, Klerman (1978) spelled out a ‘neo-Krapelinian manifesto’:

1. Psychiatry is a branch of medicine.
2. Psychiatry should utilise modern scientific methodologies and base its practice on scientific knowledge.
3. Psychiatry treats people who are sick and who require treatment for mental illness.
4. There is a boundary between the normal and the sick.
5. There are discrete mental illnesses. Mental illnesses are not myths. There are not one but many mental illnesses. It is the task of scientific psychiatry, as of other medical specialties, to investigate the causes, diagnosis, and treatment of these mental illnesses.
6. The focus of psychiatric physicians should be particularly on the biological aspects of mental illness.
7. There should be an explicit and intentional concern with diagnosis and classification.
8. Diagnostic criteria should be codified, and a legitimate and valued area of research should be to validate such criteria by various techniques. Further, departments of psychiatry in medical schools should teach these criteria and not depreciate them, as has been the case for many years.
9. In research efforts directed at improving the reliability and validity of diagnosis and classification, statistical techniques should be utilised.

The principles outlined in this paper were used to constrain the shape of the emerging
The changing environment of psychiatric practice. Prior to 1980, the clinical criteria for schizophrenia – the meaning of the term – had already shifted considerably. Kraepelin had access to his asylum patients every day and, tragically, often throughout their entire lifetime. This led him to view course as the core feature of the disease: the meaning of *dementia praecox* was a progressive mental deterioration beginning in adolescence. Bleuler’s 1908 term *schizophrenia* described the same types of patients as *dementia praecox* did, so the referents of the two terms were more or less the same. The semantics of the term, however, were quite different, as was shown in Table 3.1. The concept of *Schizophrenia* had cognitive disruption, not course over time, at its core. Like Kraepelin’s term, *schizophrenia* was initially constrained to be applicable only in an asylum setting.

This constraint was removed with the advent of ‘antipsychotic’ medication. The first generation of antipsychotic chemicals (which were, interestingly enough, antihistamines) was synthesised in the 1940s and 1950s; chlorpromazine, the first indisputably effective treatment, became available in 1952. This allowed inmates who otherwise would have stayed permanently in asylums to be reintegrated into the community. The number of people held in psychiatric hospitals dropped from 150,000 in 1950 to 30,000 in the 1980s (Porter, 2002:211). Since people tended to become ill again after stopping their medication, they could not be described as ‘cured’ of their condition. Instead they were given the label of ‘schizophrenia in remission’. Medication thus removed the constraint on referents for the term and expanded its scope from asylums into the community.

This led to a further meaning shift. Since psychiatrists no longer had constant access to their patients over a long period of time, the course of the disorder became less of a defining feature. Symptomatic presentation, which could be determined in a much shorter space of time, became the focus of attention – and the new core meaning of the term. This was the meaning that was adopted by Spitzer and his colleagues in DSM-III.

Carving out a new niche. Panic Disorder, unlike the other two disorders considered here, was one of many new additions at DSM-III. This meant that its boundaries were constrained by those of the disorders already present. A new disease had to either carve out a position from the edges of other disorders, or it had to describe a new population that did not previously exist. The ‘melancholic anxiety attacks’ described by European psychiatrists more than a century previously had been considered part of another, broader condition. The DSM-III task force decided to introduce diagnostic criteria specifically for these attacks – but were careful to state that they could be a symptom of other medical and mental conditions, as well as the primary defining characteristic of Panic Disorder.

Constraints on future change. It might be argued that the constraints on future change are now far more bureaucratic than ever before. Health insurance rebates,
access to treatment, and grants for research are all dependent on the provision of a DSM-IV code. As more and more comes to ride on this classification system, the terminology has less and less freedom to move around as needed to accommodate changes. For example, research now indicates that schizophrenia and bipolar disorder might in fact be better thought of as lying on opposite ends of a continuum, with one end showing more psychotic (schizophrenia-like) symptoms and the other end more mood-related symptoms (see Bentall, 2003). This is very difficult to reconcile with the current categorical system – and an overhaul of the entire system would now be very costly for the set of industries that have grown up around DSM.

4.3 Problem 2: Transition

Routes for change. DSM-III was taken up by researchers in the major universities before being adopted by psychiatrists for clinical practice. In total, 500,000 copies of the manual were purchased. DSM-IV was even more popular, and by the year 2000 had sold over 960,000 copies – a remarkable figure in light of the mere 42,000 registered psychiatrists and 300,000 other mental health professionals at the time. These figures indicate a significant uptake of the new system, an uptake that expanded well beyond psychiatry and into the wider community.

Abruptness of the change. The DSM-III itself was an abrupt change and quick to catch on, contrasting with the gradual changes that had percolated through psychiatry since 1900. The psychoanalytic establishment that was dominant in the United States borrowed the European term *schizophrenia* and naturalised it into the local language as ‘schizophrenic reaction’. This term’s expanding semantic range had gradually incorporated increasing numbers of referents. This pattern is entirely consistent with a prototype model of semantic change such as that of Geeraerts (1997), discussed in section 2.1.3.

The introduction of clear diagnostic criteria for schizophrenia (Feighner et al, 1972) saw a sudden drop in the number of referents, and a corresponding shrinking in the term’s semantic range. As mentioned in section 3.2.6, in a study of 163 patients who had been hospitalised with schizophrenia in the 1970s, only 12 per cent qualified for a DSM-III diagnosis. DSM-III’s ‘schizophrenia’ was the whittling down of an inclusive disorder concept into one that was more strictly defined and far less inclusive.

4.4 Problem 3: Embedding

The embedding problem refers to the ways in which a change is linked to deeper social and political factors. This is probably the most complex aspect of any linguistic change. The following is an attempt to describe the main contextual drivers of the change, but is by no means exhaustive.
Defining of populations. Emil Kraepelin classified patients who had already been
designated as mentally disturbed: his referents were all asylum patients. Kraepelin’s task
was to organise and make sense of a previously defined population by applying verbal
categories. Spitzer, by contrast, was essentially defining a future population. In defining
the separate disorder terms, he was also defining the nature and boundaries of disorder
itself. This gave DSM-III far more social significance than its previous incarnations,
since everyone in the community now became potentially diagnosable.

Financial backing. Research into mental disorders has become increasingly
dependent on funding from pharmaceutical giants. The American Psychiatric
Association (APA), which publishes the DSM series, is built on this money to a
disconcerting degree. A Task Force to Study the Impact of the Potential Loss of
Pharmaceutical Support was formed to address this issue, and effectively concluded
that the APA could not survive without subsidies from pharmaceutical companies
(Walker, 1996). Because of this, the system is biased towards creating new
categories and biased against condensing or removing any of its categories. In
relation to the three terms considered here, this effect is most clearly seen in the
creation of Panic Disorder as a direct consequence of the drug imipramine.

Developments in genetics. The split of bipolar from unipolar mood disorders was
embedded in a research context that put increasing emphasis on genetic factors.
This was not the first time for genetics and psychiatry to dovetail. In far more
brutal circumstances, 70,723 mentally ill patients were put to death in the gas
chambers of Nazi Germany, and hundreds of thousands forcibly sterilised so they
would not pass on their degenerate genes. This understandably led to a reluctance
to use genetic principles in psychiatry, a reluctance which was only gradually
overcome in the years following 1953 and the mapping of DNA’s double-helix
structure. DSM-III’s medical approach then led to a dramatic resurgence in genetic
research which continues to the present day.

Broader social factors. Two broad social changes are suggested by Healy (2002)
as underlying the success of the new diagnostic system. The first applies
particularly to anxiety disorders (of which Panic Disorder is an example). Healy
notes that fear was formerly used by religions as a device for social control. Fear of
sin, and of future spiritual repercussions, was often a positive influence in society,
helping to regulate people’s behaviour in socially beneficial ways. With increasing
secularisation, fear disappeared as a means of social control and came to be
perceived as something pathological requiring treatment. The second broad change
is the increasing focus on physical health that has come over the last few decades.
As public health becomes an increasing concern and object of media coverage, the
area of mental health and illness is pulled along in its wake.
4.5 Problem 4: Evaluation

Positive evaluations. DSM-III was released into a psychiatric establishment in which psychoanalysts were the large majority. However, the reception was surprisingly warm: a nervous Spitzer received a standing ovation from the American Psychiatric Association after his initial presentation in May of 1979 (Spiegel, 2005). The diagnostic labels DSM-III provided were also useful to patients as an explanation for the seemingly unsolvable problems they had been suffering, and the pharmacological treatments that followed a diagnosis were relatively often, if not always, effective in removing the problematic symptoms.

Negative evaluations. Negative evaluations of the DSM system have generally come from theorists who believe that a dimensional model of mental disorder is more accurate than a categorical one (for example Kendell, 1991; Bentall, 2003). This proposal is an option currently being examined by the massive Task Force for the upcoming DSM-V. Most criticisms, however, have centred on the DSM as being responsible for an increasing pathologisation of unusual behaviour or ‘problems in living’ (Kutchins and Kirk, 1997) that belong to non-medical institutions. Criticism of the medication-based treatment which directly follows from a DSM diagnosis has been far more widespread. The obvious and debilitating side effects (massive weight gain, for example) often simply substitute one social stigma for another.

4.6 Problem 5: Actuation

Questioning of psychiatry’s credibility: the Rosenhan experiment. One of the main aims of DSM-III was to regain credibility for psychiatry as a scientific medical specialty. The theoretical foundations of the field had been questioned by philosophers (Foucault, 1965), sociologists (Goffman, 1961) and a few renegade psychiatrists (Szasz, 1961; Laing, 1960) in the 1960s. However, the real threat came with an experiment conducted by psychologist David Rosenhan in 1972. Rosenhan and a number of confederates consulted psychiatrists, saying that they heard a voice that said either “empty”, “hollow”, or “thud”. The psychiatrists took detailed case histories of their patients, diagnosed most of them as schizophrenic, and committed them to psychiatric hospitals. They were instructed to behave in the hospital as they would in their normal life. Unexpectedly, none of the hospital staff picked up the error. In a compelling example of the perspectivising effect of a label in an institutional situation, the note-taking of one of the pseudopatients was referred to in his file as ‘abnormal writing behaviour’ and was seen as caused by his mental illness.4

4 In a follow-up experiment, Rosenhan was challenged to send one or more pseudopatients to a particular institution. All prospective patients were to be rated by the staff according to whether they were possible impostors. Of 193 patients in total, 41 were rated as impostors by the staff, with a further 42 judged suspect. In fact, no pseudopatients had been sent.
The article that resulted, published in *Science* as *On Being Sane in Insane Places* (Rosenhan, 1973), provoked a hostile reaction from the psychiatric establishment of the time. Robert Spitzer in particular took issue with the experiment and wrote several articles disputing the study (for example Spitzer, 1975). He also began laying the groundwork for a scientific psychiatry at which no such criticisms could be levelled.

**Developments in neuroscience.** DSM-III was created at a time when emerging research findings had just begun to tip the scales back towards a biological view of mental illness. Neurotransmitters (chemical ‘messengers’ that are the means of communication between brain cells) had been discovered in the 1950s. When antipsychotic drugs were found to block receptors for the neurotransmitter dopamine in the brain, a ‘dopamine hypothesis of schizophrenia’ was proposed. Despite a few preliminary research findings, DSM-III (as with Kraepelin’s classification system 80 years earlier) was largely a leap of faith based on the assumption that all mental illnesses would eventually be explained in biological terms.

**Problems and solutions.** A biochemical definition of mental problems guided the emergence of solutions that were also defined in biochemical terms. This was initially a slow process, but before long biochemical solutions were ‘found’ before the problem had even been formulated. This occurred when the drug imipramine defined the terrain for Panic Disorder – and again on a much larger scale with the launch of the tranquillisers Valium and Prozac. Once medications had been synthesised that reduced anxiety, which of course made patients feel better, doctors and patients were increasingly inclined to ‘define their problems in terms of anxiety’ (Healy, 2002:319). Once so defined, the problem was solvable with a prescription.
4.7 Summary

The main causes for linguistic change, discussed in sections 4.2 – 4.6, are summarised below.

<table>
<thead>
<tr>
<th>Constraints</th>
<th>Transition</th>
<th>Embedding</th>
<th>Evaluation</th>
<th>Actuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for a common language internationally</td>
<td>Route from major universities to psychiatric practice to community</td>
<td>Defining of populations: asylum vs. community</td>
<td>Positive evaluations: from the psychiatric establishment</td>
<td>Developments in neuroscience leading to a biomedical view of the self and the mind</td>
</tr>
<tr>
<td>Predetermined structure of a medical model of mental illness</td>
<td>DSM-III as an abrupt change following a series of gradual changes</td>
<td>Financial backing (pharmaceutical companies)</td>
<td>Negative evaluations: from sociology and a minority in psychology</td>
<td>Questioning of psychiatry’s credibility: the Rosenhan experiment</td>
</tr>
<tr>
<td>The changing environment of psychiatric practice</td>
<td></td>
<td>Developments in genetics</td>
<td></td>
<td>The move to define problems in terms of available solutions (using newly developed drugs to define new disorders)</td>
</tr>
<tr>
<td>Carving out a new niche (esp. Panic Disorder)</td>
<td></td>
<td>Broader social factors: (1) Disappearance of fear as a social regulator; (2) Increasing focus on physical health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constraints on future change: bureaucracy; industry; research funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Summary of the factors surrounding change according to the framework of Weinreich et al (1968)

4.8 Evaluation of the framework

Application of the framework was generally straightforward. This is an important finding, given the complexity of the type of change being examined (semantic change) and the intricacy of the subject material. Nevertheless, some methodological problems did arise.

4.8.1 Separation of embedding problem from actuation problem

The first methodological issue encountered was a difficulty in separating the embedding problem from the actuation problem. The embedding problem concerns the degree to which a change is embedded in the surrounding system of linguistic and social relations, while the actuation problem considers the more proximal triggers for a change. For a
phonetic or grammatical change, the embedding problem will most likely have to do with factors such as class, gender and ethnic group. The actuation problem may be focused around specific events that foregrounded the new linguistic form at the expense of the old. For the purposes of the present study this was more difficult, since the proximal actuation events (for example, the Rosenhan study described in section 4.6) tend to arise directly out of the deeper social and scientific context (the unreliability of diagnoses that was targeted by the Rosenhan study). These actuation events were then cemented into the broader social and linguistic context for future changes. In an extra twist that highlights the difficulty of teasing apart the five problems, this context then went on to constrain the directions for future change – now becoming something to be addressed by the constraints problem.

4.8.2 The evaluation problem – effects of a change on the overall structure

The second methodological issue encountered concerned the evaluation problem. This problem has two parts: first, how the change is evaluated, and second, what the effects of the change are on the overall structure of the language. Given that the current study itself focuses on a structural change, the second part proved difficult to answer. Of the three terms studied, the most obvious change at DSM-III was the introduction of Panic Disorder, an illness that did not exist as a separate entity prior to this introduction. The impact of this on the diagnostic system as a whole was minimal, since the system is strongly biased towards the inclusion of new disease entities (see Healy, 2002 or Bentall, 2003 for a discussion).

However, the creation of a new disease name does have implications for creeping structural change on a broader scale. Reich (1984, quoted in Chapter 1) observes that the Soviet category of sluggish schizophrenia ‘was eventually assumed to represent a real class of patients and ... was inevitably filled by real persons.’ The proliferation of new disorder categories in DSM-III – a rise of 68 per cent from 182 in DSM-II to 265 in DSM-III, see section 2.3.3 – meant a corresponding need for people to fill these categories. This in turn has led to a redrawing of the linguistic boundary between normal and disordered, sane and insane. This boundary has of course been intensely interesting to philosophers and theorists for centuries. A detailed linguistic examination of this is beyond the scope of this thesis; however a brief consideration will be given in section 5.5.

4.8.3 Suggested modifications to the framework

Overall, the framework was useful for organising information on the causes of semantic change, a type of change which it was not specifically intended to target. With its focus on explaining change, it forms an excellent complement to the more descriptive methods of Sweetser (1990), Geeraerts (1997) and Traugott and Dasher (2002) mentioned in section 2.1.

One important factor in any linguistic change that is not addressed explicitly by the authors is the question of who – which people are the innovators and which are the
perpetuators of a change. This factor was particularly important in the present study, given that the changes were deliberately orchestrated by a very small number of people. Indeed, without either the early influence of Kraepelin in creating terminology at the turn of the twentieth century, or the synthesising influence of Robert Spitzer at DSM-III, we would be looking at a very different terminological system. This could be termed something like the embodiment problem or the agency problem.

The framework might also benefit from a two-tiered structure. It was noted above in 4.8.1 that the embedding problem was difficult to separate from other problems such as actuation and constraints. Elements such as transition and evaluation are also clearly embedded in deeper social and linguistic structures: the social environment affects both how a change spreads throughout the community and how it is evaluated by that community. It is therefore suggested that the embedding problem be shifted to a separate level from the others. This then allows for a contextualisation of the other problems on the list.
Chapter 5: The extended implications of diagnostic labels

The following chapter draws on various ideas from broader linguistic theory to consider how the DSM-III shift in terminology might have shaped perceptions of mental illnesses.

5.1 Linguistic relativity and diagnostic labels

The capacity of language to structure thought (Whorf, 1956; discussed in section 2.1.5), is clearly an important consideration when examining the implications of a system of diagnostic labels. All words denote a group of entities that share certain features. In doing this, they highlight these shared features and de-emphasise features that are not shared – that is, they encode a certain perspective on the world. In abstracting out the common features of each disorder and condensing these into a label, other features are unavoidably lost – features of the person being classified, of their environment, or of the psychiatrist doing the classification. The perspective encoded in each disorder label automatically becomes the perspective from which its referents are viewed.

The perspective that is currently dominant in psychiatry is a biomedical disease model. The terminology associated with this perspective is that of disorders and brain chemicals, just as the terminology of psychoanalysis catalogued internal conflicts and defence mechanisms such as denial, projection and repression. These two sets of terms are associated with vastly different perspectives on a patient’s internal life, and have tended to be treated in psychiatry as incommensurable. Freud’s ideas have generally been rejected wholesale and are now viewed with embarrassment by most practicing psychiatrists. As quoted earlier, Whorf stated that we ‘dissect nature along lines laid down by our native language’ (1956:212). This idea might be pushed even further, toward the idea that different linguistic choices within a single native language have a decided impact upon how people are viewed – and by extension, upon how they are treated.

Mental disorder terminology is an intriguing point of departure for work looking at universal constraints and diversity in human cognition. In a sense DSM-III and its subsequent incarnations are working with precisely this goal in mind: to codify universals in human mental breakdown and dysfunction, independent of the influences of culture and language. It remains to be seen whether or not a syndrome-based approach is the best method for this task.

5.2 ‘Professional Vision’ in psychiatry

Coding schemes are vital in all professional fields, and often show cross-disciplinary similarities. Archaeology is scrutinised in Professional Vision (Goodwin, 1994), in which the author examines the interplay between coding scheme and judgements about the world. These archaeology students carry a colour chart to guide their judgements about soil types. Each square of the chart has three parts: a colour name, a sample colour, and a gap or ‘window’ through which the sample can be viewed. Soil samples are compared against the shades in the chart and judged according to the best match. This
would seem a simple task but significant differences of opinion surface, especially for borderline cases. Goodwin observes that the chart represents not objective categories but a set of solutions to problems struggled with by previous generations of researchers, representing interim solutions that are part of any scientific categorisation scheme – including, of course, those in psychiatry. Further, and perhaps more dangerously:

[B]y using such a system a worker views the world from the perspective it establishes. Of all the possible ways that the earth could be looked at, the perceptual work of students using this form is focused on determining the exact color of a minute sample of dirt. They engage in active cognitive work, but the parameters of that work have been established by the system that is organizing their perception. (1994:609)

DSM-III has also closely defined the parameters of questions a clinician asks about a patient, which in turn translate into the forced choice of one or more discrete diagnostic labels for the patient.

5.3 Grammatical metaphor

Grammatical metaphor, first proposed by Michael Halliday (1995), extends the concept that language and thought are interdependent to the use of different grammatical forms. The only form to be considered here is also the most common: the nominalisation of processes. Nominalisation is the representation of a sentence that is congruent with the unfolding of actual events, such as the cast acted brilliantly (Halliday and Matthiessen, 1999:229), in a form that is more abstract: the cast’s brilliant acting – or more pertinently, the rendering of I felt panicked as The panic I felt. This theory shares interesting parallels with accounts of semantic change that view words as tending to move from concrete to abstract meanings (Sweetser, 1990; Traugott & Dasher, 2002; see section 2.1.1).

Science, with its love of taxonomies and other naming systems, is the archetypal context in which nominalisation occurs. Halliday (1987:146; see also Banks, 2003) notes an ‘explosion of process nouns in scientific Greek from 550 B.C. onwards.’ With DSM-III, nominalisation became the standard way to refer to mental disorder. The verb panic, for example, needed to become a noun before it had the necessary weight and shape to carve out a place amongst the other disorders. The extensive nominalisation in DSM-III has had a substantial impact on how both disorders and patients are viewed.

Nominalisation of symptoms is evident in the diagnostic criteria for a panic attack and for schizophrenia, given in sections 2.1.2 and 2.3.5 respectively. The following extract also illustrates the absence of personal agency that is contained in DSM disorder descriptions:

Bipolar I Disorder is subclassified in the fourth digit of the code according to whether the individual is experiencing a first episode (i.e., Single Manic Episode) or whether the disorder is recurrent. Recurrence is indicated by either a shift in the polarity of the episode or an interval between episodes of at least 2 months without manic symptoms. A shift in polarity is defined as a clinical course in which a Major Depressive Episode evolves into a Manic Episode or a Mixed Episode or in which a
Manic Episode or a Mixed Episode evolves into a Major Depressive Episode (APA, 2000).

The person is almost completely absent, with the focus of linguistic and clinical attention on abstracted symptoms and episodes. An image of the person as a passive victim of an uncontrollable, rampant disease is also noted by Capps and Ochs (1995). Nominalisation here effectively serves to refract blame from patients and their families, and would not have been possible without such a strong focus on disease names. This focus was a direct result of DSM-III.

Another recent terminological shift has been towards using ‘consumer’ to replace ‘patient’ in mental health settings. This is intended to shift perception of the person using mental health services to a more active, empowered position – an alternative to the ‘afflicted’, ‘sufferer’, and other victimising language characteristic of the medical model. However ‘consumer’ has obvious connotations of economic motivations and non-essentiality. It seems that there is no term that is not in some way value-laden.

5.4 Anthropological linguistics

This entrenchment in social values is remarked upon by Frake (1961) in his discussion of medical diagnosis among the Subanun people of Mindanao, in the Philippines. His comment that ‘[d]iagnosis is not an automatic response to pathological stimuli; it is a social activity whose results hinge in part on role-playing strategies’ (1961:129) applies equally to the Western psychiatric tradition. The importance of cultural context is highlighted in the Subanun differentiation of buni or ‘hidden ringworm’ (ringworm that is covered by clothes and not visible) from buyayag or ‘exposed ringworm’, which is ringworm on a visible part of the body. This perplexing distinction becomes far more explicable when a key cultural fact is considered: the Subanun see skin conditions as extremely disfiguring. This makes buyayag a different and more serious medical condition than buni. We see this same process in the difference between Schizophrenia and Schizophreniform Disorder in the current DSM classification. If the criteria for Schizophrenia are met but the person experiences no obvious disability (is still able to work, for example), then Schizophreniform Disorder is diagnosed. In this distinction, the cultural importance of engaging in productive work is the key dividing line between the two distinct disorder categories.

5.5 Foucault and discourses of normality

Regarding his committal to Bethlem, the Restoration playwright Nathaniel Lee reputedly declared: “They called me mad, and I called them mad, and damn them, they outvoted me.” (Porter, 2002:88)

Concepts of mental illness are permanently tethered to their counterparts of mental health, sanity, and reason, which are all considered synonymous with normality. These binary distinctions, and the dividing lines that separate them, are positioned within
broader social structures and institutions. Philosopher and trained psychiatrist Michel Foucault (1965; 2003) is well known for his ‘archaeological’ treatments of history, and his theories on the emergence of discourses that shape the ways in which their objects are categorised and dealt with. The change in categorisation of mental illness at DSM-III has corresponded with a gradual shift in the discourse surrounding the topic. An introduction of disability and distress as key diagnostic criteria has forced clinicians to make decisions about what level of distress is considered pathological. It has been suggested (Elder, 2007 and many others) that the threshold at which normal emotions shade into pathological ones has been moving upwards at a considerable rate of knots.

This raises some intriguing questions. Foucault writes of the history of madness that ‘what is in question is the limits rather than the identity of a culture.’ (1965:xiii). If culture is considered to be ‘whatever one has to know or believe to operate in a manner acceptable to its members’ (Goodenough, 1957), the notion of mental illness and pathological behaviour does indeed distinguish the limits of a culture. But the recent spike in diagnoses means that more and more people are choosing mental illness as a valid way of characterising their problems. If mental illnesses are increasingly accepted as valid descriptors for many life problems – and perhaps even as shades of normal behaviour – then Foucault’s division may be on the verge of dissolving.
Chapter 6: Conclusions

“What's the use of their having names,” the Gnat said, “if they won't answer to them?”
“No use to them,” said Alice, “but it’s useful to the people that name them, I suppose.”

- Lewis Carroll, Through the Looking Glass

Any study examining categorisation systems will inevitably encounter questions of function. Why are these objects being categorised in this particular way? Why is there even a need to categorise them at all? It has been the goal of this thesis to begin to tease out these the answers to these questions.

6.1 Summary of findings

The first research question concerned the changes in the terms Schizophrenia, Bipolar Disorder and Panic Disorder leading up to the formulation of DSM-III in 1980. It was found that the three terms studied in detail, Schizophrenia, Bipolar Disorder and Panic Disorder, showed different patterns of change leading up to DSM-III. Schizophrenia is an example of an illness name that has remained relatively static, concealing the considerable changes that took place in its semantic range. Bipolar Disorder, by contrast, went through a number of name changes while remaining essentially the same concept. Panic Disorder was a new addition at DSM-III, carved out from more generalised anxiety disorders with the help of medication and the formulation of specific diagnostic criteria.

The second question addressed the effectiveness of the framework of Weinreich, Labov and Herzog (1968) in capturing the context of these changes. This five-problem framework was found to be a useful way of organising causal information for a complex semantic change. It allowed for a discussion of constraining factors such as the need for a common language internationally, proximal triggers for change such as the Rosenhan ‘pseudopatient’ experiment, and factors embedded in the social and linguistic context such as the influence of funding from pharmaceutical companies. Two modifications were suggested: the inclusion of an additional agency or embodiment problem, and a restructuring that would shift the embedding problem to a higher level in a two-tiered structure, allowing it to be considered separately for each of the problems on the lower level.

The third question considered the extended implications of terminological shift for the way in which mental illnesses are perceived. Ideas drawn from linguistic relativity, grammatical metaphor, anthropological linguistics and Foucault’s analysis of social discourse all suggest that diagnostic categories have a significant impact on how both disorders and patients are perceived. DSM’s categorical system enables psychiatrists to reliably group their patients into a number of discrete categories according to one particular perspective on mental disorder – but it also carries a number of limitations.
6.2 Limitations of the categorical DSM system

The most significant limitation is a straitjacketing effect on research. As one researcher commented as early as 1991, ‘For the last 20 years I have been dismayed by the widespread assumption that schizophrenia and manic-depressive illness are distinct diseases simply because we have given them different names.’ (Kendell, 1991:13). The overwhelming majority of scientific studies now presuppose the diagnostic labels, searching for group-level differences between people who have been given a particular diagnostic label and ‘normals’. This obscures the distinct possibility that disorders may significantly overlap, or be related to one another in a non-categorical fashion. Crow (1991:31) also argues that the assumption of two different illnesses ‘has been paralytic to our thinking and stultifying to research.’ Implicit in this comment is the power of a classification system to shape the type of scientific knowledge that can be created.

A second limitation of the DSM system is the ‘catch-all’ NOS (Not Otherwise Specified) category. Psychotic disorder NOS might, for example, be the diagnosis for a person who shows subthreshold levels of a number of different Psychotic Disorder symptoms. Its existence alone poses a threat to the validity of the taxonomy: no biologist, for example, would allow a formal label of Bird Not Otherwise Specified. The category is perhaps justifiable on a practical basis because of the provisional nature of DSM categories. However when the NOS category is the subcategory with the highest rate of diagnoses, as is currently the case with Personality Disorders, this suggests taxonomic problems of a much deeper kind.

The related issue of comorbidity is also an obstacle to the DSM’s claim to be a coherent scientific system. Comorbidity occurs when a single person is diagnosed with more than one disorder at one time, and is itself not a problem for a medical taxonomy. It is obviously possible (though unlucky) for one person to have kidney disease and a broken leg at the same time. However in the current system, comorbidity tends to be the rule rather than the exception. DSM-IV reports that for individuals diagnosed with Panic Disorder, reported rates for comorbid Major Depressive Disorder have ranged from 10% to 65% (APA, 2000). Comorbidity with other Anxiety Disorders, including Generalised Anxiety Disorder (the disorder supposedly differentiated from Panic Disorder with the drug imipramine in 1964 – see section 3.4.3), approaches 30%. All of these limitations indicate that the DSM system (and perhaps any system of diagnostic labels) may not be the best way to describe mental illness.

6.3 Further Work

A rapidly growing literature in cross-cultural psychiatry indicates that in fact all cultures, both past and present, have identified human behavioural breakdowns – incongruous behaviour that is judged as disruptive to the social life of the community (see for example Fabrega, 1993 for a review). As indicated earlier in section 5.1, cross-linguistic studies can offer clues to the extent to which these behavioural breakdowns are universal or culture-specific. An informal survey was conducted in the preliminary stages of research
for this thesis, and it was found for example that excitement is considered a pathological mental state in Tibetan – because healthy mental states are those most conducive to meditation (Goleman, 1991). Research on culture-bound syndromes may shed some light on this issue. Examples in an appendix to DSM-IV include sekimen-kyofu, a morbid fear of blushing diagnosable in Japan and Korea, and koro, a syndrome found in many parts of the world in which a person believes their genitals are shrinking or retracting back into the body. It has even been argued (for example Swartz, 1985) that anorexia nervosa and chronic fatigue syndrome are examples of Western culture-bound syndromes.

It will also be intriguing to see the effects of new technological developments on the DSM system of diagnostic labels. It is, however, hard to see the question about what should constitute normal and aberrant mental functioning disappearing. Although no researcher would dream of searching for the neural substrate of drapetomania today, Samuel A. Cartwright may very well have been able to point to it on an fMRI scan if the technology had been available. (Brain areas involved in feelings of defiance, perhaps.) In the same vein, many of our current disorder descriptions may be considered equally preposterous twenty years from today. This makes it all the more important to stand back and view our current categories in terms of their history – and to be aware that the hidden hand of social context is always at work, subtly shaping the words that are available to us to describe and make sense of the world.
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