

Psycho-Politics and Illness Constructions in the Background of the Trauma-Concept of the DSM-5

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Introduction

Jonathan Gornall, a British journalist, starts his article with the somewhat sensational title “DSM-5: A Fatal Diagnosis?” (published in the *British Medical Journal* on 22 May, 2013, the day DSM-5 was published) by noting that it is not every day that a medical handbook achieves the same level of success with the general public as a blockbuster novel would (Gornall 2013). This is exactly what happened with DSM-5: it had received international attention comparable to the most recent Dan Brown book even before it was published. What are the reasons for the enormous interest in and the extremely heated debates surrounding the new psychiatric nomenclature?

The development of the medical sciences and technologies has brought about the discovery of new illnesses, the establishment of new diagnostic categories, and their re-classification or even elimination. These changes cannot be sufficiently explained on the basis of new biological phenomena or epidemiological patterns. Social factors, economic and political considerations, professional interests, and intellectual trends are also very important in articulating new ideas and concepts. We also have to take into consideration that professionals as well as patients constantly need legitimate, welldefined, and effectively manageable categories of illnesses; insecurity resulting from the acceptance of the limits of medicine may cause frustration for both sides. Usually, there are questions concerning the legitimacy of those categories of illnesses that either lack a clear or specific diagnosis or whose definition is strongly influenced by social and psychological factors.

This is why mental and psychosomatic illnesses are most likely to fall into this group.

In the period between 1999 and 2012—that is, during the period when the new DSM-5 was in progress—many professionals advanced broad and serious concerns about the “medicalization of normality” (Pickersgill 2013). The critics’ main worry was that the DSM-5 would “expand the territory of mental disorder and reduce the ranks of the normal” (Frances 2010, 492). Others raised the issue of the role of the pharmaceutical industry in constructing new disease categories, calling it the “engine of diagnosis” (Jutel 2009) and expanding medicalization to “pharmaceuticalisation.” As Pickersgill (2013) suggested, criticisms of the DSM should be positioned within larger critiques of psychiatry and biomedicine and treated as debates responsible for re-energizing the longstanding discussions and conflicts around the utility and validity of constructed disease categories.

The Role of “Deficit-Discourses” in Constructing Diagnoses

The problem of medical diagnostics extends far beyond issues of normality and pathology and relates to another question of ontological significance. Mostly due to the successes of psychoanalysis in the first half of the twentieth century and its influence on culture and the humanities (and the retreat of religious practice), psychological discourse has become one of the main linguistic vehicles of self-interpretation in our times. According to Kenneth Gergen (1994), this can be regarded as a “deficit-discourse” characterized by thematizing the main events of our life in the context of emotional problems. We shape the meanings of mental health along with the definitions provided by health professionals. Philip Cushman (1995) makes the point even more sharply: he thinks that nowadays people like to validate their self through the authority of science, and science reveals the self as in constant need of diagnosis and treatment. Nikolas Rose (1985) calls this the “psy-complex” of our age. Critics note that the DSM-5 also wants to fulfill the expectations described above by attempting to medicalize more and more general human life circumstances or problems, for instance grief (Strong 2012). A number of professional and non-profit organizations have expressed their disagreement over this, and critical voices appeared in highly acclaimed journals such as *Nature* (Ledford 2011) and *Scientific American* (Jabr 2012). Thomas R. Insel, director of the US National Institute of Mental Health, shared the following

critique in his regular “Director’s Blog” series a few days before the publication of the DSM-5 in 2013:

The strength of each of the editions of DSM has been “reliability.” . . . The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever. (Insel 2013)

This quote reflects the disputes about psychiatric diagnosis and definitions of “normality” in general and resurrects the atmosphere of the debates in the 1960s and 1970s, when anti-psychiatry representatives clashed with psychiatric orthodoxy. The anti-psychiatrist school also claimed that the concept of mental illness was in fact a myth, an attempt to conceal the troubles and tensions in society (Szasz 1974). Similar thoughts were expressed by Michel Foucault, according to whom psychiatric diagnoses were simply evaluative categories that secured the legitimacy of the power of medicine based on the mechanisms of “biopolitics” (Foucault [1963] 1973). According to another critical approach, psychological disturbances are simply those patterns of behavior or phenomena, which are treated by professionals *ad absurdum*, and constructed by them through the use of diagnostic systems (Hoffman 2001). Patients then get a chance to have their story re-written through the interpretive framework of the very same professional. A possible conclusion is that professional images of “normality” or healthy functioning are submerged in “deficit discourses” along with cultural ideals relating to individuals, and these are often linked to political ideologies.

Certainly, these directions are not typical in mainstream psychiatry. According to the definition of the DSM-5, the current official position of the psychiatric profession, we consider mental disorder to be culturally deviant (unexpected) reactions to a significant stress or loss:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, oc-

cupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (A.P.A 2013)

The definition can be questioned from a number of perspectives. It is hard to define what we regard as “significant” stress and “unexpected” reactions. Furthermore, as raised by some critics, why is it necessary to have a new definition in the DSM, when the phenomenon itself, mental disorder, has not changed? (Maisel 2013). Or if it has changed because the related concept was altered, then this leaves room for significant criticism, especially if we also consider the fact that the classification systems introduced prior to 1980 included no definition of any kind and that categories of pathological mental functioning were purely based on their names.

The constantly increasing diagnostic repertoire, the renaming or new nomenclature, can also have an effect on the emergence of symptoms and disturbances. Some authors think that this always corresponds to society’s ethno-psychological (unconscious) assumptions regarding illnesses and deviation (Gaines 1992). The mainstream, including the authors of DSM, evaluates the increase of diagnoses along a linear interpretation of the history of medicine, representing the development of society and science. This is reinforced by the opinion of the designers of newer and newer diagnostic systems who think that their interpretation is imbued with “higher scientific value” than the ones before. The mainstream exhibits a kind of re-medicalization tendency, where biological and statistical approaches are dominant, and the psychodynamic approach and psychotherapeutic activity are significantly pushed into the background. The American Psychiatric Association’s (APA) explicit intention is to use several evidence-based criteria such as clinical utility, reliability, descriptive validity, and psychometric performance to ensure that a condition is appropriately included as a disorder in the DSM (Fisher and Shell 2013). Nevertheless, due to the strong medicalization, the critical approaches that underline the role of discursivity in the establishment of diagnoses and the role of narrative elements in therapeutic work have also become stronger as a kind of a counter-effect (Frank 1995; Charon 2008).

The Struggle with Uncertainty: The Great Turn of the DSM into “Diagnostic Psychiatry”

Allan Horwitz (2002) remarks that the gradual shift to the biological perspective from the 1970s on—and the change reflected by the transformations of the nomenclature mostly in the DSM-III—was made necessary by the fact that psychodynamic approaches have failed to match contemporary expectations raised by scientific research and the process of verification. Therefore, people responsible for classification did not feel comfortable with the validity and reliability of these diagnoses. From this point on, medicine has turned away from the case studies that played such a significant role in Freud’s work, causing a devastating blow to the dominant position of psychoanalysis, as this new approach used only “objective facts.” Scientific psychiatry was no longer able to make use of psychodynamic notions based on analytic theories. The era of the category of neurotic disorders traditionally based on psychodynamic interpretation is a significant factor, too. While psychoanalysts were pushed into the background, in psychiatric institutions and on the editorial committee of the DSM, hysteria gradually disappeared from the official catalogue.

Psychiatrists researching the revision of the DSM-II held a session at Washington University, Saint Louis in 1974. Their main aim was to replace the “hard to adopt” process model of mental disturbances with an approach based on categories. They thought that this would enable them to diagnose each mental disorder reliably and to study them empirically in various populations. Allan Horwitz (2002) termed the era after the publication of the DSM-III “diagnostic psychiatry.” According to him, this was useful in the case of psychotic illnesses and bipolar disorders—for instance, depression and mania—, but it made the understanding and treatment of all other mental and behavioral problems more difficult. The new approach of the DSM-III was to replace the phenomenological approach with decidedly neutral, biological discourse. This caused severe problems in the interpretation of the leading illnesses in psychoanalysis: neurotic illnesses and hysteria, because, in the case of the former, emphasis was on the various forms of the expression of suffering. The changes in the general relation of medicine to the body and illness can be followed by tracking down the changes in the diagnosis and symptoms of hysteria as well (Gilman 1993). Fuelling attempts to diminish previous psychoanalytic diagnoses from the DSM-III, we also assume the desire for certainty, which subconsciously guides the authors of the various editions of DSM: only “evidence-based” illness can be “real” illness. They all hope that by proving the

“objective” existence or non-existence of a disorder, they can eliminate the uncertainty and finally gain control over mental illnesses that have caused frustration in science and therapy for thousands of years.

Femininity and Illness: Diagnostic Stigmatization as a Way of Suppression

Describing the hysterical (after DSM-III: “histrionic,” “somatising,” “dissociative” etc.) character traits, most authors mention the high correlation frequency with “feminine” traits. Equating hysteria (just as somatization) and femininity has been debated many times in the history of the illness. Indeed, most authors traditionally described hysterical persons as “feminine,” or in the case of men, as “passive homosexuals.” Paul Chodoff and Henry Lyons have stated (1958) that “hysterical” symptoms and personality traits can exist independently of each other, and have established seven personality traits. According to this list, a hysterical personality is characterized by uncertainty, egocentric but unstable affectivity, a search for dramatic attention, sex-orientation which is provocative but frigid, dependency in interpersonal situations, and demanding behavior.

However, we have to mention that Chodoff and Lyons noted already in 1958, that is, before the emergence of second-wave feminist movements, that hysteria could not be interpreted as a “caricature of femininity” on a biological basis, but rather as the distorting effect of society, which is dominated by men. We could add that professionals could have played a significant role in shaping the “caricature,” a supposition supported excellently by the now classic and still very topical research by Broverman et al. (1970). They asked psychologists, psychiatrists, and social workers to characterize a healthy man, a healthy woman, and a healthy person whose gender was not revealed. The participants’ answers indicated that the characters of healthy “person” and “man” resembled each other to a higher degree. According to this assessment, the healthy person (man) is less submissive, independent, less impressionable, more competitive, more aggressive, less emotional, and looks after his appearance to a lesser degree. Of course, social roles of men and women have changed a lot since that research took place forty years ago. From this list, a couple of personality traits would no longer ring true. Nevertheless, gender stereotypes have survived (Ussher 1991; Foss and Sundby 2003). As the statistical data relating to somatization proves, more than 90 percent of patients are women; this is partly due to

the fact that complaining, showing weakness, and openly admitting to having an illness is regarded “feminine,” and in some cases is a “hysterical” personality trait in both ordinary and professional representations even today (Creed and Barsky 2004). It should also be noted that the diagnosis itself could serve as the trigger of a trauma. As Widiger (2000, 6–7) has put it: “Even if there is no bias in the definitions or in diagnostic criteria, there may be a bias in the way they are commonly applied,” and “clinicians must be cautious and self-critical, especially when diagnosing histrionic and dependent personality in women or narcissistic and obsessive-compulsive personality in men.”

As a positive change, we welcome the omission of the categories of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder from DSM-5, which was the offspring of the earlier hysteria diagnosis, which often reflected the gender stereotypes above. Instead of these, the category “Somatic Symptom Disorder” was introduced. That has led to a major debate in the professional literature. Some writers have supported the idea that this would lead to a larger danger than the one we pointed out above relating to the issue of femininity. The most influential of these was the writing of Allen Frances, the Chair of APA DSM-IV Task Force (Frances 2013). According to his view published in the *British Medical Journal* and other periodicals, the new diagnosis “risks mislabeling many people as mentally ill.” He argues that the DSM-5 defines somatic symptom disorder too vaguely. One bodily symptom that is distressing or disruptive from the viewpoint of the everyday functions of life present for at least six months is enough for a diagnosis, as is one which produces one of the following symptoms: disproportionate thoughts about the seriousness of the symptom(s); a persistently high level of anxiety about the symptom(s); or excessive time and energy spent on health concerns. Frances thinks that, based on these vague criteria, millions of people can be labeled as mentally ill and thus be stigmatized. Women can be particularly subject to this since they are more inclined to show somatizing tendencies like the emotionally colored presentation of their symptoms and catastrophization. In his article, Frances quotes Thomas Szasz (1997): “in the days of the Malleus, if a physician could find no evidence of natural illness, he was expected to find evidence of witchcraft: today, if he cannot diagnose organic illness, he is expected to diagnose mental illness.” Have we returned to an inquiry of the “reality” of symptoms? This dilemma in the history of psychoanalysis and DSM is best illustrated by the diagnosis, which we may regard the heir of the earlier hysteria concepts classified in 1980 as post-traumatic stress disorder (PTSD).

“Real” and “iMaged” Traumas

The diagnosis of post-traumatic stress disorder (PTSD) was established following demands of Vietnam War veterans to the APA (Showalter 1997). That was a significant event in the history of the DSM, as civil society, e.g. users of psychiatric-psychotherapeutic services, directly interfered in shaping the nomenclature. Vietnam veterans wanted to receive official support and draw attention to their condition, which was not at all easy. It was met with sharp resistance by APA, despite the fact that the enduring effects of war traumas were long known in medicine and psychology.¹ “War neurosis” became well known around the end of World War I. Already at this stage, Freud and his followers associated it with the consequences of other traumas and the diagnosis of hysteria. In his work, *A General Introduction to Psychoanalysis* Freud describes it,

The closest analogies to these conditions of our neurotics are furnished by the types of sickness which the war has just now made so frequent—the so-called traumatic neuroses. Even before the war there were such cases after railroad collisions and other frightful occurrences which endangered life. The traumatic neuroses are, fundamentally, not the same as the spontaneous neuroses which we have been analysing and treating; moreover, we have not yet succeeded in bringing them within our hypotheses. . . . The traumatic neuroses show clear indications that they are grounded in a fixation upon the moment of the traumatic disaster. In their dreams, these patients regularly live over the traumatic situation; where there are attacks of an hysterical type, which permit of an analysis, we learn that the attack approximates a complete transposition into this situation. It is as if these patients had not yet gotten through with the traumatic situation, as if it were actually before them as a task which was not yet mastered. We take this view of the matter in all seriousness; it shows the way to an *economic* view of psychic occurrences. (Freud 1920, 237)

¹ Prior to Freud’s description, a few rather metaphoric terms had already been used to name the set of PTSD symptoms: “soldier’s heart” during the American Civil war era; “railway spine” in the late nineteenth century ran parallel with the war neurosis “shell shock” and “combat fatigue” during World War II (Fisher and Schell 2013).

Indeed, it is striking that the definition of PTSD in DSM-III resembles the Freudian description:

- A. The person has experienced an event that is outside the range of usual human experience and one that would be markedly distressing to almost anyone.
- B. The traumatic event is persistently re-experienced in at least one of the following ways:
 1. recurrent and intrusive, distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed);
 2. recurrent distressing dreams of the event;
 3. sudden acting or feeling as if the traumatic event were recurring (including „flashback” or dissociative episodes, whether or not intoxicated);
 4. intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries.

We do not have precise records regarding the reason as to why the APA initially opposed the demands of the Vietnam War veterans (that they receive some kind of a medical treatment and explanation for their post-war symptoms), but it would not be surprising to find that there was a conscious or unconscious rejection of an attempt to regenerate the conceptual framework of Freud. Nevertheless, these veterans eventually received public support and also relied on another very effective argument: they cited the example of Holocaust survivors. By this time, the long-standing, inter-generational consequences of war trauma had been discovered in those circles. The diagnosis of PTSD, post-traumatic stress disorder, appeared in the DSM-III published in 1980 (paradoxically exactly in the edition that was “purified” from psychoanalytic interpretations). It has since become the most frequently applied diagnosis in the world, applied to a wide range of social and private traumatization (Schiraldi 2009). Sadly, Vietnam veterans hardly benefited from the diagnosis and the therapy they fought for, as most of them rarely ever took advantage of the therapeutic services offered (Showalter 1997). The underlying reasons for this were that they would be stigmatized, labeled mentally weak, and would lose their sense of masculinity. They did not trust psychotherapy because they did not know how it worked and what effect it had. In fact, they were not fighting for a diagnosis, but for help, for (psychic) support, to be able

to get rid of the symptoms. Therefore, a number of analysts asked whether it was necessary to diagnose the victims of terror in order to help them.

The case of the Vietnam veterans shows that if people want professional help, first they must show that they are (very) ill. It is also remarkable that Gulf War veterans also rejected the PTSD diagnosis (Showalter 1997). In their case, there were a number of physical symptoms in addition to their mental ones, and the latter did not fit under the category of PTSD. The veterans desperately fought with the U.S. administration when they tried to prove that their symptoms were caused by *pyrodostigmin*, which was deployed in the war. Hundreds of newspaper articles in the British, American, and world press—many of them only gossip or rumor—described this situation in the nineties. Veterans' symptoms were interpreted by many as having been caused by media hype. This is how the phrase "Gulf War Syndrome" was coined. The background of the symptoms is yet to be elucidated while the veterans continue to spend their money on new medical tests and lawsuits instead of admitting that their symptoms were, at least partially, caused by the lasting trauma of war.

The underlying stigmatizing effects of a PTSD diagnosis are well illustrated by Fisher and Schell (2013). The APA responded to the request submitted by senior U.S. Army leadership in 2011 by suggesting a change of the term "disorder" in PTSD to "injury." The main reasoning behind the request was that "disorder" is stigmatizing and allows U.S. military service members exhibiting these symptoms to look for professional help. Psychiatric diagnoses in DSM serve the needs of the community of "helpers," "researchers," and "educators" in forming a shared basis of knowledge for communication rather than the needs of the patients in reducing their suffering and maintaining their everyday activities. Of course, these two sets of needs overlap in some ways, for example, the recognition of PTSD "as a condition to be treated, rather than as cowardice or malingering" (Fisher and Schell 2013, 4). The shared intention of clinicians and patients could be to identify a set of symptoms as unhealthy in a way that can benefit from professional evaluation and financed treatment. The authors see real disadvantages of PTSD diagnosis outside the psychiatric community, using it as an accusatory and stigmatizing social category in court e.g. when determining eligibility for security clearances, in law, or in the workplace, judging deployment and one's career trajectory. In general, mental illness is an undesirable label that devalues or dehumanizes those who have it, depicting them as more dangerous or incapable of handling their own affairs. In 2008, RAND surveyed military service mem-

bers about their inhibitions concerning psychological treatment. The harmful effect on one's career was regarded as the most important factor among respondents (44 percent). This is well illustrated by the phenomena that the U.S. Army has already informally deleted "disorder" from PTSD on certain documents and websites, and uses the term "posttraumatic stress" or "combat and operational stress reaction."

But how did PTSD become the most utilized diagnosis if veterans still reject it? This is especially interesting considering the fact that, according to research, only a minority of survivors of mass accidents, wars, and other catastrophes develop these symptoms (Carll 2007). There must be social and political reasons in the background for such a diagnosis. From the 1970s onwards, issues of abuse against women and children have entered the public discourse due to the activism of feminist and human rights movements. Following the establishment of the PTSD diagnosis, the number of patients grew gradually, mostly through the inclusion of abused women. As a consequence, the notion of trauma expanded significantly, including not only exceptional stress situations and catastrophes, but also the consequences of emotional wounds inflicted by everyday life. Caruth (1995) points out that trauma is caused by psychic content that cannot be symbolized and described with words and thus returns in direct forms. The unsymbolizable verbal nature can be a reason why modern media intervened to find visual and verbal expressions for each kind of trauma. Trauma is basically transmitted and channeled by the media, which makes global and local traumatic events directly perceivable, "normal," and overall present in the backgrounds of our lives. This turn inevitably adds a socio-political dimension to the understanding of trauma, as the definition of Kirmayer, Lemelson, and Barad (2007, 1) illustrates: "trauma can be seen at once as a socio-political event, a psycho-physiological process, a physical and emotional experience, and a narrative theme in explanations of individual and social suffering." Our view of psychic trauma as both *cause* and *consequence* has become an inherent part of present-day culture.

The Re-Construction of Trauma in the DSM-5

The debate about the concept of trauma intensified again in the 1980s. Since then, an enormous number of psychological and psychiatric publications on the subject have seen the light of day. In addition, aspects of human rights and criminal law were also addressed in these debates. These were mostly centered

around “memory therapies” in the United States, during which a number of psychotherapists tried to rehabilitate Freudian seduction theory, unveiling abusive childhood memories of the patients, which then serve as evidence in subsequent lawsuits (Pendergrast 1995; Masson 1998). The dilemma, seemingly irresolvable, was caused by the fact that it is extremely difficult to measure the weight of a trauma suffered by an individual or a group. Therefore, it is practically impossible to evaluate whether the reaction to a given stressor (or trauma) should be considered pathological or not without finding scapegoats. We should address the question whether we need to differentiate between traumatization that happened in reality and traumatization taking place in the imagination of the individual, as the damaging consequences are often similarly grave, and maybe even greater in the case of the latter.

The criteria of PTSD in DSM-5 significantly differ from earlier ones. The most important change from our viewpoint is that it more explicitly defines what is regarded as a traumatizing event and omits the earlier criteria of “subjective reaction.” This way, the space to manoeuvre in subjective evaluations of individuals became more limited. The age for the diagnosis was extended, and a separate criterion was worked out for children under six years of age. According to critics, this points towards the potential of medicalizing socialization at a very early age, which undoubtedly could have harmful consequences for the development of the individual (Rosen et al. 2008; D’Andrea et al. 2012).

Since a number of debates accompanied the issue of the “reality of the trauma” from Freud to the present day, the DSM-5 also provides a more precise definition of what is regarded a traumatic stressor (suffering the trauma directly or as a witness are considered the same in this respect). Nevertheless, it views physical trauma as the primary stressor. Emotional or verbal abuse, harassment, non-physical sexual harassment, and other potentially traumatizing factors, mostly affecting women, are not really emphasized. Again, we hear the echo of the debates around Freud’s seduction theory in the voices claiming that sexism, the objectification of women’s bodies, as well as the further legal and other inequalities between women and men could also be traumatic stressors and should find a place on the list of triggers of PTSD in the DSM (Lazaroff 2006). This problem was presented in a special light since new approaches in psychology, psychoanalysis, and the humanities have appeared in discussions about the relationship of historic truth and narrative truth as an especially significant question (Spence 1982; Caruth 1996). This indeed puts strong stress on questions about post-traumatic stress disorder as well as a number of other types of emotional suffering: who, by what methods, and from what perspective

can the various forms of expression of psychic functioning be classified? Where do the facts end and where do opinions about them begin?

When we discuss illness as a social construct, usually we refer to non-biological factors—beliefs, economic relations, or social institutions—that determine the folk and scientific concepts of illnesses. To demonstrate the validity of social constructs, analysts usually choose an illness that evokes strong reactions. That could refer to the stigmatization of the population affected by that illness (e.g., TB, syphilis, AIDS); the debatable nature of the somatization base and issues of individual responsibility that arise (e.g. psychiatric illnesses, alcoholism, psychosomatic diagnoses); and the frustration raised by the illness or the threat it poses (e.g. different forms of cancer). There are well known analyses (e.g., Sontag 1988) that show the role of social constructs and their influence on professional and popular discourse and also that illnesses possess an especially strong metaphoric power (pest, syphilis, TB, epilepsy, cancer, AIDS).

The related social constructivist, critical psychological, and anthropological literature argues that eradicating and dissecting certain diagnoses while further pathologizing everyday forms of behavior only serves to legitimize the authority of (medical) science (Kutchins and Kirk 2003). However, this reductionist standpoint has to be modified. Changes of diagnoses and symptoms certainly function as a mirror of other important social tendencies, like changes in the knowledge related to the body, discourse about particular illnesses, and the transformation of gender roles (Wenegrat 2001). As Callard (2014) proposed, those who try to use the indeterminate, uncertain nature of the diagnostic classification to support their own views also try to gain power over the discursive space around contemporary issues on the uncertain status of the body in the context of health and illness. However, attention cannot be drawn only to one-dimensional accounts of diagnosis; the rich tradition of philosophical and (psycho)political debates might also support discussion about the changes of diagnoses embedded in very complex clinical, social, cultural, legal, ethical, and psychological configurations.

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