How reification of DSM labels influences our identity

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Abstract
The increase in DSM labelling raises the relevance of investigating how DSM labelling affects people. This paper argues that people's tendency to interpret DSM labels as things that exist, influences the way they see themselves and others. In order to explain and validate this interpretation, this paper makes a distinction between "natural" and "artificial" categories, and argues that DSM categories are highly artificial. However, people tend to interpret DSM categories as being natural categories, which can be seen as "reification"; making a thing. People's tendency to reify DSM labels, causes them to think that the labels provide accurate and definitive statements about diagnosed individuals. This paper argues that this interpretation is incorrect, and people should therefore identify themselves and others in their own terms.

Keywords: *DSM; labelling; diagnostic inflation; reification; identity*

Introduction

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) provides the authorized and worldwide used definitions and criteria of "mental disorders". Since the official introduction of criterion-based diagnosis with the DSM-III in 1980, the number of diagnoses expanded exponentially, thereby also expanding the boundaries of mental illness at the cost of normality (Batstra & Frances, 2011). Approximately one in four Americans meets the criteria for one or more psychiatric disorders defined by DSM-IV (Kessler et al., 2005; Merikangas, Nakamura & Kessler, 2009). DSM-V, introduced in May 2013, created new mental disorders and reduced the thresholds in the criteria of common disorders, which will probably result in tens of millions of additional patients; as what happened when DSM-IV was introduced (Frances, 2009, 2010). This diagnostic inflation makes it increasingly important to investigate how DSM-labelling affects patients, and people in general. One way in which DSM-labels affect people lies in the way people interpret these labels. People tend to interpret DSM labels as things that exist (reification), and this interpretation interferes with one's social and self-constructed identity, whereby the 'mentally ill'-label eventually defines these identities (Grover, 2005). This paper will discuss this interpretation, explain its consequences and evaluate its validity; it is not intended as a critique on the DSM *itself*.

To understand these phenomena, we need to make an important philosophical distinction between two "kinds" of categories, namely natural and artificial categories. On the basis of this distinction, we can define the essence of DSM classifications, determine how they should be interpreted, and further elaborate on how they actually are interpreted by individuals and society. Afterward, this paper will discuss how this interpretation interacts with our identity, and determine whether or not this interaction is valid.

Natural and artificial categories

When the world is divided into categories, the meaning of these categories depends on the division. This seems very logical, but in order to recognize its significance, we have to consider an old philosophical debate about the existence of reality. Plato's essentialism claims

that reality consists of different categories which exist independent of human thinking (Nieweg, 2005). These scientific classifications form therefore *natural categories*, and refer to existing entities which share some typical structure or mechanism (Nieweg, 2005). For example, the category "gold" refers to molecules consisting of 79 protons, and everything that is correctly categorized as gold contains molecules with 79 protons. Contrary to Plato's essentialism is Aristotle's nominalism. Nominalists deny that reality consists of definitive categories, and therefore humans are unable to classify the world in a natural way that is independent of their thinking (Hacking, 1999). Instead, reality consists of continuums and all classifications are human-made and arbitrary. Nominalists name our categories *artificial categories.*

Both visions are problematic when taken to the extreme (Nieweg, 2005). Naïve realism doesn't recognize that even the clearest and most obvious categories are eventually defined by humans, not nature. Extreme nominalism is incompatible with the common sense that categories are partly based on reality, and therefore *related* to it. Instead, natural and artificial categories should be seen as compromising a continuum in which it is possible to qualify categories. To determine a category's location on this continuum, we have to look at how natural the division is. For example, the specific molecular characteristics of gold form a natural basis that distinguishes gold from non-gold and the differences can be microscopically examined. Gold therefore forms a strong natural category. Dutch people cannot be divided from German people on a natural basis, since there is no real natural basis that discriminates them from each other. Humans invented and defined this distinction themselves and these two categories are therefore very artificial.

The essence of DSM categories

With this philosophical background in mind, we will now consider how the DSM is related to the natural-artificial spectrum of categories. The authors of the DSM-IV Guidebook, Frances, First, and Pincus (1995), note that DSM classifications have a broad and *non-specific* nature: one only needs, for example, four of ten characteristics to be diagnosed with the disorder, which means that patients don't even need to have the same defining characteristics to be diagnosed with the same disorder (Nieweg, 2005). Furthermore, the vast majority of DSM categories measure behavioral symptoms that are *continuous* with those seen in the normal population, instead of separated characteristics (Grover, 2005). This non-specificity and continuity causes a huge *variability* of people within groups. In addition, researchers *have not found unitary biological mechanisms* or characteristics that underlie DSM categories (Frances, 2010). The aforementioned authors of the DSM-IV *Guidebook* summarize the foregoing by saying that DSM categories have *fuzzy boundaries* with each other and with normality, which means that they are certainly not definitive (natural) categories (Frances, First, and Pincus 1995).

With reference to these characteristics of DSM classifications, we can conclude that most DSM classifications do not seem to refer to *distinct* natural entities, which implies that they are certainly not based on natural divisions. Instead, the variability, non-specificity, continuity, etc., makes these categories highly artificial (Nieweg, 2005). This artificiality implies that DSM categories do not provide much information about the individuals they supposedly describe. For example, an ADHD diagnosis does not really give an adequate indication about *specific* characteristics (which may be behavioral, cognitive, biological, etc.) that are shared among ADHD diagnosed people and that distinguish them from non-ADHD diagnosed people (August & Garfinkel, 1989; Willcutt, Doyle, Nigg, Faraone & Pennington, 2005). This is because these specific characteristics of ADHD do probably not exist. Also, because the DSM is certainly not based on naturally separated categories with specific characteristics, it creates its own categories, and therefore forms one possible framework

among many others. It should be noted that DSM categorization is not problematic in itself, because DSM categories are heuristically valuable for psychiatrists in *globally* describing problems of patients. In addition, as part of a psychiatric system, it may provide a framework by which different treatment methods can be systematically evaluated. The problem lies in human tendency to interpret DSM classifications as being natural classifications. In order to understand the meaning of this, we have to introduce the concept of reification.

Reifying DSM classifications into diseases

"Reification" is a word of Latin origin and literally means "making a thing". Reification occurs when something abstract, manifested in human language and connected with human thought, is interpreted as being something concrete that exists in reality independent of human thinking (Nieweg, 2005). For example, a child who finds it immensely clever that we "discovered" language, interprets language as a concrete thing that exists independent of our thinking, which makes us able to find it. This seems a pretty obvious conceptual error, since it is clear that humans created their language; our language didn't exist before we did. But some of our conventional Western verities are based on the same fallacy. For example, intelligence is an abstract concept that describes the ability to solve certain problems. It is considered common sense to say "intelligence causes us to solve problems". But as just mentioned, intelligence describes this ability; it does not *cause* this ability. When intelligence is considered as something concrete that acts on the behavior it describes, the concept of intelligence is reified, because we ascribe an abstract concept that exists in our minds into a causal force that exists in reality. And when we eventually are able to explain intelligent behavior by referring to a cause, the next fallacy of reification would be that we assume that this cause can explain its own existence (i.e. the cause of intelligence causes itself). In short, language and intelligence form (very) meaningful and useful abstract constructs in our minds, but they may not be interpreted as being concrete "things".

As concluded earlier, DSM categories do not refer to distinct entities that exist in the real world (natural categories), but should instead be interpreted as abstract global descriptions of behavior (artificial categories). The interpretation of these abstract describing concepts as being biological entities is obviously a form of reification. Unfortunately, there is a universal tendency of people to reify DSM categories. That is, most (lay) people think that DSM classifications refer to *real* diseases that *act* on the behavior it describes (Frances, First & Pincus, 1995; Hacking, 1999; Kuiper, 1965; Nieweg, 2005). Even psychiatrists and researchers may commit the fallacy of reifying DSM categories (Hacking, 1999; Kuiper, 1965; Nieweg, 2005). For example, Janssens, Andries, and Ponjaert-Kristoffersen (2002) concluded that problems and conflicts in parent-child interactions in families with hyperactive children can largely be explained by the presence of comorbid behavioral disorders. Obviously, the problematic and defiant behavior of the children *led* to the diagnosis of comorbid behavioral disorders. The authors interpreted this diagnosis as the cause of the behavior, which doesn't transcend the level of saying that a specific kind of behavior is explained by specific kinds of acts; or having no work can be explained by being unemployed, etc. They (implicitly) reified a global description of behavior into a causal force that exists independent of the behavior. What they should have concluded was: the diagnosis of abnormal behavior (global description of behavior) in these children seems to be correct, since these children show more problematic and deviant behavior in the interactions with their parents. Another example is given by Luhrmann (2000). She describes how a psychiatrist suggested that the DSM didn't define a particular disorder "correctly", whereby the psychiatrist implicitly assumes that the disorder is a real disease entity that we can explore and correctly define. He forgot that the DSM label is based on an agreed set of symptoms, and changing these symptoms would create a *new* disorder. Ironically, the APA (2013), ultimately

responsible for the DSM, made the same fallacy when they suggested that DSM-V "more accurately" described the experience of adults "affected" with ADHD. The next sections will further discuss how this false interpretation of DSM categories interferes with our identity and perceived control of behavior.

The DSM as a guidebook for identity

When a DSM diagnosis is reified into a disease, it is interpreted as reflecting something stable and essential within the person so diagnosed. For example, once you are diagnosed with a bipolar disorder, you are doomed to be a fragile and unstable person. The implicit reasoning goes as follows: you *have* bipolar disorder (reification) that *causes* you to be emotionally fragile and unstable (Dehue, *n.d.*; Hacking, 1999; Kuiper, 1965; Nieweg, 2005), so *everyone* with this disorder is emotionally fragile and unstable (Grover, 2005; Susko, 1994). This reasoning can be divided into two misconceptions: a DSM label can explain someone's behavior and also adequately define someone's identity.

When people consider a DSM label a disease that acts on behavior, they commit the same fallacy as the researchers mentioned earlier; a description of behavior is interpreted as the cause of the behavior it describes. Since most DSM categories do not refer to diseases that act on behavior (Barlow & Durand, 2011), but form global descriptions of behavior, the explanation of behavior by referring to a DSM label is invalid.

When a DSM label is reified, it also defines someone's identity in several ways. People consider DSM diagnoses as providing accurate and definitive statements about the nature of those diagnosed, because they *have* something that other people do not have. This deprives the diagnosed person's ability to define him or herself, or redefine him or herself in the future (Grover, 2005; Susko, 1994). The DSM diagnosis is reified into something core and persistently latent within the individual (Grover, 2005, p. 80), and the story told about the DSM category, is the same story told about the diagnosed individuals (Susko, 1994). When the essence of DSM categories was considered earlier, the conclusion was that DSM categories may definitely not be interpreted in this way. Firstly, one cannot really *have* something that is highly artificial, because artificial "things" mainly exist in our minds instead of reality. Secondly, DSM categories do not provide much information about diagnosed individuals. Of course, people within one DSM category will be different *on average* than others; if this wasn't the case, the relevance and value of the categories would reduce to zero. But the great *variability* of individuals within these categories makes them inappropriate to act as valid statements about the identity of individuals. This principle of variability within groups logically also applies for biological differences. When researchers claim that people diagnosed with ADHD possess more of a certain neurotransmitter in a certain brain region than other people, they only mean that this difference occurs on average. Due to the artificiality of the category they cannot say anything specific about the concentration of this neurotransmitter in an ADHD diagnosed individual's brain (Dehue, *n.d.*; Willcutt, Doyle, Nigg, Faraone & Pennington, 2005).

When people meet DSM's criteria for a particular "disorder", and also reify the describing concept into a real disease, they consequently think that they are diseased or abnormal persons, because they *have a disease*. However, when their "symptomatic" behavior is considered in its unique and complex *context* (i.e. personal history, personal values, family situation, etc.), it may quite possibly be seen as normal adaptive behavior (Carson, 1991; Dehue, *n.d.*). One could argue that psychiatrists do not entirely rely on DSM's standardized criteria; they also make observations and patients must really suffer from their behavior in order to be diagnosed. However, due to an endless desire for reliable and objective diagnoses, psychiatrists seem to overestimate the value, and thereby elevate the use of DSM's defining criteria in their diagnoses, whereby they consider behavior in isolation from its context

(Barlow & Durand, 2012, p. 93; Carson, 1991; Dehue, *n.d.*). This ultimately interferes with the validity of their diagnoses; "are they really abnormal and disordered persons?" (Barlow & Durand, 2012; Carson, 1991; Dehue, *n.d.*; Frances, 2009, 2010). Also, because all the defining criteria of DSM categories can be found on the internet, people diagnose themselves (and others), and they may not be aware that the behavior needs to be placed in its context, or may not have the ability to do this. Furthermore, DSM categories shouldn't be seen as undesirable and negative *per se*, at least, not all categories should. Because most DSM classifications are highly artificial, they are primarily defined by humans, and therefore arbitrary and culture-dependent. What is considered desirable and undesirable, or normal and abnormal, depends on norms and values, and these vary considerably across cultures and time. For example, one could imagine that a desire for physical activity or mental arousal is valued quite different in Western culture than in a hunting and gathering culture; "Attention Deficit Hyperactivity Disorder" is considered a disorder in the former, but may be the norm in the latter.

Conclusion

DSM categories, as part of a psychiatric system, should be interpreted and used as heuristically valuable constructs in describing behavior of patients. However, due to the artificiality of most of its categories, they should not be interpreted as things that explain behavior, or capture some essential characteristics of diagnosed individuals. On an individual level, people should therefore try to define themselves and others in personal terms and stories, by placing their experiences and behavior in its unique and complex context, and evaluating them on the basis of their own norms and values. This will provide person-centered identities that capture the essence of individuals more adequately than do DSM labels.

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