

dals that followed confirmed that American culture was still suffering from '68 syndrome. It all connected.

Of course, there were Americans of every ideological stripe—not just members of the professional counter-establishment—who supported the war to topple Saddam. Most of them had no fantasies of restoring “national greatness,” they just thought that Saddam had the weapons and that we had no better option. Fine. But even that is not the whole story. For it turned out that the liberal hawks who became so prominent after September 11, including here at *THE NEW REPUBLIC*, were indeed interested in restoring “national greatness,” though in a new, more left-leaning form. They have been accused of succumbing to neoconservatism themselves, but that is backwards. In retrospect, what seems to have motivated them was the desire to displace the neocons from their dominant perch in Washington by proving that liberalism could be a fighting faith at home and abroad. Clinton’s intervention in Kosovo confirmed that was possible, so why not continue the march all the way to Baghdad? Why leave the promotion of human rights and democracy—not to mention the protection of dissidents such as Ayaan Hirsi Ali—to the madmen at AEI, whose domestic policies were loathsome? As Heilbrunn’s pages show, though he does not quite put it this way, the temptation to beat the neocons at their own game was hard to resist—which meant, of course, that the liberal hawks also found themselves playing the old reactionary game, which is to use a foreign war to reform society at home.

Poor Iraq! And poor America! The dénouement we all know, but Heilbrunn’s book, for all its superficiality, still shows how depressingly predictable it all was. By leaving the reality-based community and creating their own Team-B approach to every issue—and stocking that team with reliable soldiers who happened not to know what the hell they were talking about (trivia question: who was Laurie Mylroie?)—the neoconservatives had become the very last people you’d want leading you to war. They knew how everything connected but not how anything worked—the Army, the United Nations, the Sunni-Shiite quarrel, the balance of power, human culture in the face of occupation and humiliation. And what they used to know about the unintended consequences of political action they seem to have willfully forgotten. Reactionaries are like that—because in the end, contrary to Heilbrunn’s title, they really don’t care whether they are right.

What they care most about is reconfirming their picture of the world.

Heilbrunn ends by asserting that the neocons “aren’t going away” and he may be right, though fitting the scream of Iraq into their mental picture will take all the artistry of Edvard Munch. Still, there’s always World War IV to look forward to.

And while we’re basking in the twilight of Western civilization, maybe we can all take time out and light a candle for an older, nobler idea of the intellectual’s task in politics, which was “to help all of us, when we discuss issues of public policy, to know a little better what we are talking about.” Whose idea was that, anyway? ♦

Sally Satel

SCIENCE AND SORROW

THE LOSS OF SADNESS: HOW PSYCHIATRY TRANSFORMED NORMAL SORROW INTO DEPRESSIVE DISORDER

By Allan V. Horwitz
and Jerome C. Wakefield
(Oxford University Press,
287 pp., \$29.95)

IN THE EARLY 1970S, annual meetings of the American Psychiatric Association (APA) were home to angry showdowns between the gay rights lobby and organized psychiatry. Activists picketed convention sites, shouted down speakers, and waged ad hominem attacks on psychiatrists who sincerely believed that homosexuality was a sickness. The goal of their flamboyant campaign against the APA—an impressive display of “guerrilla theater,” as one psychiatrist put it—was to force the association to take homosexuality out of its official handbook, the Diagnostic and Statistical Manual of Mental Disorders, second edition, popularly known as the DSM-II.

In December 1973, they won. A decisive majority of the APA board of trustees voted to remove homosexuality from the professional nomenclature. “Doctors Rule Homosexuals Not Abnormal,” read the headline in the next day’s *Washington Post*. It was a major victory both for gay people and for the enlightened wing of the psychiatric establishment. But rather than calm the critics of psychiatry, the APA’s acknowledgment that homosexuality was not a mental illness only inflamed them. They took this as further evidence that the profession was a sham, and asked in outrage how psychiatry could claim to be a legitimate, scientific branch of medicine if its members determined the very existence of an illness by vote.

Frustration with the profession had already been simmering for about a decade. With the liberationist ethos of the 1960s heavy in the air, many academics

and social critics were edgily attuned to the complexities of wielding the authority to declare someone mentally ill. Behavioral scientists bemoaned the lack of a systematic method for designating people mentally ill. Physicians who cared for the seriously mentally ill were fed up with the uselessness of talk therapy. And private insurers complained about the cost of long-term psychotherapy, sometimes lasting for years, for neurotics who had no obvious mental illness.

Large-scale evidence pointed to diagnostic disarray. In 1971 a seminal study found that the definition of schizophrenia employed by American psychiatrists led them to diagnose the condition several times as often as their counterparts in Great Britain. American doctors were using an overly broad description that led them to misidentify people in the excited phase of manic-depressive disorder as having schizophrenia. The error was especially significant because the Food and Drug Administration had just approved lithium carbonate as a treatment for mania. If a patient were misdiagnosed, he would not be properly treated. In 1973, in *Science* magazine, a smaller but no less powerful study by the Stanford University psychologist David L. Rosenhan, called “On Being Sane in Insane Places,” described how eight normal people got themselves admitted to a psychiatric hospital by simply claiming they were hearing voices that said “empty,” “hollow,” and “thud.” Though these pseudo-patients said their symptoms disappeared upon admission, it still took an average of three weeks before they were considered well enough for discharge.

Damning stuff. If the integrity of a medical specialty turns on its ability to make meaningful diagnoses and to distinguish

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the sick from the well, then psychiatry was in a deep crisis of credibility. To be sure, removing homosexuality from the nosology was a good first step; but, diagnostically speaking, it was low-hanging fruit. The truly arduous work of creating a coherent classification scheme demanded a thorough re-examination of other, more plausible diagnoses, such as depression, anxiety, schizophrenia, and so on.

That became the mission of the APA's Task Force on Nomenclature and Statistics, assembled in 1974, shortly after the controversy over homosexuality was resolved. For the next six years, the tireless group undertook a massive overhaul of the DSM-II, which described diagnoses in brief narrative paragraphs containing vague phrases such as "impaired reality testing," "mood swings," and "anxious over-concern." In order to rehabilitate the tarnished image of psychiatry and to align it with the rest of medicine, the task force would create a symptom-based classification system of mental disorders.

The grandiose vision of the DSM planners did not faze most psychiatrists. As it was, they paid little attention to the DSM-II and assumed its successor would be similarly disregarded. Psychoanalytic theory, the dominant conceptual framework in American psychiatry since World War II, still held sway. This perspective cast psychopathology as the result of unconscious processes gone awry or of development trajectories stalled out before age six. Symptoms were of little intrinsic interest, regarded as superficial and interchangeable markers of these psychodynamic mishaps. Neither were bounded categories of illness. After all, psychoanalytic theory held that mental states are fluid, and thus sick people merely suffer from extreme versions of the anxieties that all of us harbor.

The architects of the new nosology would have none of this. They vehemently rejected the Freudian model, with its impressionistic approach to diagnosis. Their vision was of a purely descriptive system—"atheoretical," as they called it. Psychiatry would be organized around a catalog of reliable diagnoses identified by specific sets of symptoms that indicated a particular illness. Only then could practitioners have a common language with which to discuss patients; and researchers would at last have a shared blueprint to guide systematic inquiry and to repeat and confirm others' work.

When the DSM-III was unveiled in 1980—

ushering in what is often called the "diagnostic revolution"—it was a blockbuster of a manual. At almost 500 pages long, it was more than three times the length of its forerunner, and it contained 265 diagnoses, one-third more than the DSM-II. The manual sold more than half a million copies in the United States and was translated into fourteen languages. It quickly became the indispensable text of residency training programs, its near-memorization required for specialty certification. Insurance companies used the DSM-III to guide reimbursement, social service agencies relied upon it to assess disabilities, and the courts turned to it in resolving questions of criminal culpability, competence to stand trial, and insanity. The FDA tied its approval of new medications to DSM diagnoses. With a standardized, agreed-upon definition of mental disorders, epidemiological research blossomed at the National Institute of Mental Health.

WITHOUT QUESTION, the DSM-III signaled a new era in psychiatry, a new way of classifying and studying mental disease based on a new way of understanding it. But the DSM-III was not without its discontents. Among its most respected critics are Allan V. Horwitz and Jerome C. Wakefield, who have produced a nuanced, scholarly, and provocative book that offers both a conceptual analysis of depression as a medical disorder and a thoughtful critique of the cultural implications of psychiatric diagnosis.

What worries Horwitz and Wakefield most about the DSM-III, and its subsequent editions (the latest was published in 1994), is what could be called the validity problem. Just because two examiners concur that a person qualifies for a particular diagnosis does not mean that he has an authentic mental illness. In scientific terms, the diagnosis may lack validity. How do we know, for example, that a person diagnosed with major depressive disorder (the DSM's formal designation for pathological depression) is not actually suffering from a bout of natural sadness brought on by a shattering loss, a grave disappointment, or a scathing betrayal? Unfortunately, twenty-eight years after the publication of the DSM-III, there are circumstances in which we still cannot know. The DSM, Horwitz and Wakefield charge, sacrificed validity on the altar of inter-rater agreement. As



a result, they contend, the manual inadvertently primes practitioners to find pathology where it does not exist.

To be fair, Horwitz and Wakefield give psychiatry credit for adopting the standardization regime introduced by the DSM-III. But "even a justified revolution has some unwarranted casualties," they say. "Virtually all discussions ... ignore the critical question of when depressive symptoms indicate a mental disorder and when they are a non-disordered response to loss." The price of such oblivion is steep, they charge. It "affect[s] our understanding of how many people have mental disorders, to what degree we can prevent depression, whom we should treat, and what sort of policies we should develop."

How many people have depression? The answer starts with the way it is diagnosed. Consider the current formula for diagnosing major depressive disorder, the formal term for a mood disturbance that requires professional help and likely medication. The criteria below are taken from the DSM-IV, the most recent edition released in 1994 (and updated in 2000). To the extent that psychiatry transformed normal sorrow into depressive disorder—creating a false-positive problem—this is where it happened.

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure....
- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)...
 - (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 - (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day...
 - (4) insomnia or hypersomnia nearly every day
 - (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - (6) fatigue or loss of energy nearly every day
 - (7) feelings of worthlessness or excessive or inappropriate guilt (which may

be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode (both manic and depressive symptoms at the same time).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Surely, any person who meets the criteria above is suffering mightily, as Horwitz and Wakefield are quick to accept. What they question is whether such suffering necessarily means that person has a mental illness. The persistence of symptoms for more than two weeks, for example, tells us nothing—such a threshold seems purely arbitrary. Someone reeling from the devastating shock of a breast-cancer diagnosis, desertion by a spouse, or loss of a business will often be profoundly distraught for more than two weeks. Also, he will likely experience the same symptoms as someone with major depressive disorder. As many of us know firsthand, disrupted sleep, and a loss of concentration, appetite, energy, and libido are all too common—and entirely normal—byproducts of an acute psychological blow.

The DSM concedes the outward similarities between expectable sadness and pathological depression. This is why it excludes from the diagnosis of major depressive disorder people who are in a state of bereavement, the prototypical sadness response. Horwitz and Wakefield would extend that exemption to individuals who are reacting to losses of any kind, not just to the death of a loved

one. In a recent study that they published with two others in the *Archives of General Psychiatry*, the authors estimated that such a stipulation would exempt one out of every four people currently diagnosed as clinically depressed. That adds up to a lot of people in a country where about fourteen million people a year—or at least three-quarters of them—are afflicted with major depression.

Does this mean that one in four people who feel depressed should forgo psychiatric care—or be refused it? Not at all. Intensely sad people who want professional help should get it, the authors say, and it is perfectly reasonable for insurers to cover their care. Medication may be in order as well, even if the symptoms are proportionate to the precipitant. But Horwitz and Wakefield are concerned that mistaking a normal reaction for a pathological one can “prejudice” the clinician into prescribing an antidepressant as if he were treating a true disorder “for which medication is the optimal treatment when evidence suggests that [for sorrow] other interventions may offer equal or better relief.”

How, then, to distinguish a true disorder from a non-disorder? The first indicator, the authors contend, is the situational context in which the symptoms are grounded. If they emerge in response to a cause—a great loss or disappointment—they are more likely to be natural. Also, normal sorrow is proportional to the nature of the crisis experienced, and; it is time-limited. By contrast, pathological, or clinical, depression, would present the mirror image. (The term “biological depression” is misleading because even normal sadness is associated with neurochemical changes.) In the classic form of uncaused depression—referred to in the pre-DSM-III days as endogenous depression or melancholia—symptoms arise mysteriously out of the blue when life is otherwise good. It seems clear that whatever biological mechanism that regulates mood has gone badly awry.

Yet clinical depression need not always have a spontaneous onset; it can also arise in the aftermath of loss. The important distinction between normal sorrow and major depression, the authors say, is that in the latter the symptoms triggered by circumstances eventually lose their contextual moorings. Either they persist long beyond the resolution of the stressful situation, or the point at which an otherwise healthy person would have adapted to a new condition; or they mutate into overt psychosis, suicidal impulses or actions, or physical immobilization. A patient in the pathological

realm is beset by self-reproach and ruminations. He does not brighten when, say, a beloved grandchild visits, and he cannot imagine anything ever making him happy again.

In emphasizing the “caused” versus “non-caused” aspect of depression, Horwitz and Wakefield seek to revive a once-vital concept. As they document in rewarding detail, the importance of context as a key to whether a condition is abnormal was appreciated throughout the ages. Hippocrates and Aristotle distinguished melancholic states—considered a surfeit of black bile in those days—according to whether they arose with or without cause, associating only the latter with disease. Roman physicians also assented to this distinction. In the Renaissance, even greater emphasis was placed on cause. In 1621, Robert Burton, the author of the great *Anatomy of Melancholy*, identified today’s equivalent of depressive sickness as “sorrow ... without any evident cause ... grieving still, but why they cannot tell.”

In the eighteenth century, Benjamin Rush, known as the father of American psychiatry (his likeness is on the seal of the APA), continued to embrace the contextual tradition, as did the Anglo-European psychiatrists. Even psychoanalytic attempts to explain depression were based on the traditional assumption that depressed moods in the wake of emotional upheavals were fundamentally different from those emerging on their own. In “Mourning and Melancholia,” Freud distinguished between depressions with cause (mourning) and those unbidden (melancholia). Finally, the DSM I and II recognized a dichotomy between precipitated (“reactive”) and unprompted (“endogenous”) forms of depression as well.

Enter the DSM-III. “In the urgent quest for reliability ... [the manual] rejected the previous 2,500 years of clinical diagnostic tradition that explored the context and meaning of symptoms in deciding whether someone is suffering from intense normal sadness or a depressive disorder,” write Horwitz and Wakefield. “The unwitting result of this effort ... was to be a massive pathologization of normal sadness that, ironically, can be argued to have made depressive diagnosis less rather than more scientifically valid.”

II.

IN 1992, PLUTO, the diminutive ninth planet, was plunged into an identity crisis. The discovery of a belt of small cosmic objects in its vicinity caused astronomers to ask whether Pluto was really a planet after all or just the largest

object in the belt. But first, what was a planet? Before the so-called planetary status controversy arose, the International Astronomical Union had never defined planethood. In 2006, it voted on the first-ever definition—and Pluto was undone. Apparently, the heavenly underdog failed to meet one of the three newly devised criteria (its orbit overlapped the path of another large celestial body, Neptune). To the consternation of millions, Pluto was demoted to the status of dwarf planet.

As far as status controversies go, psychiatry has a few of its own. For starters, until the DSM-III, the profession had never explicitly defined “mental disorder.” Accordingly, the manual’s architects enshrined it as follows: “a behavioral, psychological or biological dysfunction” that is “typically associated with either a painful symptom (distress) or impairment in one of more important areas of functioning (disability.)” Not bad, but like the definition of a planet—like all definitions—it was one devised by humans. And because despair and dysfunction exist along a continuum, judgment is required to draw the line between normal-range problems and pathological levels of distress and impairment.

A second status controversy dealt with distinguishing variants of normalcy from pathology (say, shyness from social phobia). In 1994, the DSM-IV task force addressed this by incorporating an “impairment criterion” to its edition. This meant that a diagnosis could be assigned to an individual only if he were rendered dysfunctional in some way by his symptoms. Unfortunately, after September 11, 2001, the impairment criterion was discarded and hundreds of thousands of New Yorkers who were experiencing perfectly rational distress following the most cataclysmic man-made disaster in this country’s history were proclaimed by epidemiologists to be suffering from post-traumatic stress disorder.

ANOTHER STATUS controversy revolves around how many disorders there really are. The DSM-IV has identified 374 different kinds of disorders (up from 180 in the DSM-II and 265 in the DSM-III). What to make of the multiplication of diagnoses over the years? Are we constantly discovering new mental illnesses the way a field biologist might find a new species of poison dart frog?

That is unlikely. Most psychiatric nosologists hail from the so-called splitter school of taxonomy. As such they emphasize differences between clinical syndromes, while their ideological opponents—the lumpers—group them broadly,

according to signature similarities. Splitting is illustrated by the dismantling of the diagnosis of “phobic neurosis” in the DSM-II into five discrete diagnoses in the DSM-III: agoraphobia (fear of places from which escape is difficult), simple phobia (e.g., fear of dogs), social phobia (e.g., fear of public speaking), separation anxiety (for children), and panic attacks with agoraphobia. In the future, however, the trend toward expanding the number of diagnostic categories may reverse. As brain-based etiologies of classic serious mental illnesses, such as schizophrenia and bipolar illness, are uncovered, psychiatry will probably lose those diagnoses to neurology. Perhaps one day psychiatry will cater only to patients suffering from existential crises. But not anytime soon.

A word about the politics of diagnosis-making is in order. Over the years, DSM task forces have had to contend with bids, pro and con, for diagnoses such as masochistic personality disorder, sadistic personality disorder, pathological (racial) bias, and premenstrual dysphoric disorder (a.k.a. PMS). Soon, planners of the next edition, the DSM-V, tentatively scheduled for publication in 2012, will hear appeals to create categories for shopping and food addictions. Internet addiction will surely come up too—as it did this summer at a meeting of the American Medical Association. Pro-life advocates hope to get the DSM to adopt “post-abortion syndrome” (indicating pathological regret after terminating a pregnancy). Meanwhile, there is a battle over gender identity disorder, with some members of the transsexual community wanting it evicted, while others wanting it to stay in so that insurance companies will pay for sex-reassignment surgery.

ALL REPARATIVE enterprises, from medicine to car mechanics, prefer to have their nosologies organized according to etiology (the cause of disease) or pathogenesis (the process of disease). In this way, the classification can offer guidance in fixing the underlying problem, or at least suggest productive avenues of research to develop new remedies. Nosologies based on symptoms are less desirable. The DSM-III framers were keenly aware of this, but it was impossible for them to construct their scheme otherwise. Still, they were optimistic. It was the end of the 1970s, a time of great (but misplaced) enthusiasm about the rapidity with which neuroscience would clarify whether the 265 conditions did indeed differ from one another and from normalcy on the basis of underlying unitary pathophysiology or other root eti-

ology. Until then, even if they did not know what a disorder such as schizophrenia truly was, at least they could agree on a certain cluster of symptoms that would go by the name.

In this manner, the DSM architects found themselves transported back to an earlier era in medicine. Over the centuries, as medicine progressed, diagnostic formulations shifted from superficial descriptions of conditions—which, at best, allowed physicians to render a prognosis—to identification of a verifiable mechanism of disease, which ideally would enable targeted treatment and prevention. Before the twentieth century, for example, schizophrenia and the insanity of tertiary syphilis were regarded as the same disease, because they were both characterized by psychosis. Yet when the cause of syphilis was found to be a spirochete bacterium, it was no longer classified as a mental disorder but an infectious one.

A similar trajectory characterized Tourette’s disease, a condition of vocal tics and uncontrollable explosive cursing. When first described by the French neurologist Gilles de la Tourette in 1885, the so-called *maladie des tics convulsifs* was understood to be the result of excessive alcohol and immoral activity in previous generations. Later, in the 1920s, Tourette’s was attributed to repressed masturbatory desire and bad parenting. By the 1960s and 1970s, however, psychiatrists began to accept a physiological origin for Tourette’s once it was shown that tics often responded well to medication.

Psychiatry, alas, has a long way to go. “Although the past two decades have produced a great deal of progress in neurobiological investigations,” notes a recent paper written to guide preparation of the forthcoming DSM-V, “the field has thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacological treatment.” Indeed, almost all of the recent genetic findings are not specific. A particular gene associated with bipolar illness was later discovered to occur in people with schizophrenia. The same goes for almost every other major finding—leading to the current hypothesis that these various genes confer risk for psychopathology, but not for any specific kind.

Indeed, we still make diagnoses the old-fashioned way: by observing patients and talking to them. Andrea Yates, the Houston mother who drowned her five children in 2001, had one of the most severe biological mental illnesses known to medicine—postpartum psychosis—

and yet no brain scan or other objective, physical test could illuminate the clinical picture further, let alone diagnosis her. Something had gone tragically wrong in Yates's brain. For Horwitz and Wakefield, such "wrongness" is central to their concept of a disorder.

In a series of papers that Wakefield published beginning in 1992, he developed a theory of mental illness called "harmful dysfunction" (HD). The HD theory holds that disorders are genuine when they meet two criteria: they produce distress or impairment in the afflicted, and they are the result of a failure in a brain mechanism that prevents it from performing its natural function—that is, the function for which it was biologically designed by natural selection. Thus, when a person experiences "normal" sadness, according to the HD model, nothing is broken, except perhaps his heart. Conversely, authentic depression (major depressive disorder) is the product of mechanistic failure. What might such failures be? One hypothesis regarding depression, for example, is that it is caused by a defect in the behavioral activation system. This could account for apathy, dampened interest in both the seeking of pleasure and the person's capacity to respond to it. What we call panic disorder may have origins in a damaged threat-response mechanism. And some speculate that perhaps schizophrenia is a developmental failure of cognitive processing.

If the specific nature of the dysfunction element of "harmful dysfunction" seems vague, that's because it is. The simplest scenario would posit an errant gene behind the pathology, but that is not how psychiatric conditions work. Mental illnesses are the product of numerous genes that interact with one another, with the environment, and also with experience. A recent study by the National Institute of Mental Health found that eighty genes could be associated with bipolar disorder, eight of which influence how the brain responds to neurotransmitters such as dopamine. Add to this the miasma of social and personal encounters that impinge upon the genetically vulnerable individual—stress, impoverishment, family instability, drug or alcohol use, and so forth—and the "cause" of mental illness becomes staggeringly complex and elusive.

For more than a decade, the Wakefield HD theory has sparked vigorous debate among philosophers, psychologists, and evolutionary theorists. If dis-

order is a disturbance in an evolved function "intended" by nature, how can we know what nature intended? Must these defects necessarily impair reproductive fitness to count as a dysfunction? Is it appropriate to rely upon standards of evolutionary fitness that developed under conditions that existed hundreds of thousands of years ago? Such questions are fascinating to academics—but less so to those who treat patients.

In 1997, the psychiatrist Robert Spitzer published an essay in an obscure psychology journal with the disarming title "Brief Comments from a Psychiatric Nosologist Weary From His Own Attempts to Define Mental Disorder." Weary, indeed. Spitzer, a professor of psychiatry at Columbia University, was literally present at the creation. He had chaired the APA Task Force on Nomenclature and Statistics that developed the DSM-III. And earlier, as a junior member of the same task force, he advised the board of trustees that homosexuality did not qualify as a mental disorder; he also wrote the position paper explaining the vote. Few people on this planet have spent more time wrestling with such questions.

Yet in his essay the weary Dr. Spitzer admitted that, "I doubt that clinicians will ever be very concerned with what illness itself is.... Concerns with defining medical or psychiatric illness or disorder are generally left to sociologists, psychologists, philosophers of science, and members of the legal profession." This is deeply true. Front-line clinicians will not be joining the fray anytime soon. The academic debate over the evolutionary history of their patients' woes is irrelevant to everyday practice.

III.

IN *The Noonday Demon*, his sweeping memoir of depression, Andrew Solomon expressed dismay over the DSM's definition of depression. "There's no particular reason to qualify five symptoms as constituting depression; four symptoms are more or less depression ... having slight versions of all the symptoms may be less of a problem than having severe versions of two symptoms." Solomon is right. Psychic pain often refuses to obey the procrustean demands of official classification schemes.

A wise colleague of mine warns trainees at his medical school, "If you come to rounds and present a patient who fits the DSM criteria perfectly, I'll know you haven't really talked

to him." The "psychopathological pie," he says, is rarely divided up as cleanly as the manual implies. Patients often have symptoms that sprawl across several diagnostic categories at once. For example, 50 percent of kids who receive the trendy diagnosis of bipolar disorder also have ADHD. Over half of all patients with major depression also meet the criteria for an anxiety disorder. Does this mean that they suffer from more than one fundamental condition, or do they just appear to have multiple disorders because of the way the DSM has drawn boundaries around psychiatric symptoms? It is often impossible to know, because psychiatrists are not yet sure that the various named disorders signify distinctly abnormal brain mechanisms. That is why good psychiatrists do not rely too heavily on the DSM.

I do not mean to say that it is clinically irrelevant, however. As mentioned earlier, the distinction between schizophrenia and manic-depressive (bipolar) illness is important, given the role of lithium in the latter. Separating the depression of bipolar illness from major depressive disorder is important, too, given the risk of precipitating mania by treating a bipolar patient with an antidepressant. It is also important to distinguish severe immobilizing depression (the so-called melancholic subtype) from other forms of depression, because electroconvulsive therapy (ECT) is extremely effective for that subtype. Another example is catatonia (extremes of movement, from hyperactivity to passive mutism), which responds best to a Valium-type drug and to ECT.

But more often than not, treatment is not very specific. Consider depression. A psychiatrist will almost surely prescribe an antidepressant for a patient with major depressive disorder—this is obvious—yet the very same drug can be helpful in obsessive-compulsive disorder, eating disorders, and panic attacks. Perhaps this is because the drug's psychopharmacological properties are broad enough to affect multiple forms of pathology. Or perhaps it is because depression and the other disorders share a common defect far upstream in the causal chain. Moreover, just as a single medication may ameliorate several different mental conditions, the converse is also true: a single condition may require more than one medication. The manic phase of bipolar disorder, for example, often requires a mood stabilizer and a sedating antipsychotic to control the excursions of mood, to combat accompanying paranoia, and to quell the agitation. So drug treatment is often guided less by diagnosis as such than by symptoms.



In the end, the most we can say about mental illnesses is that they are the result of various interrelated causes unfolding at different levels of explanation: biological (genetic or cellular), cognitive (information processing), and psychological (the generation of meanings in contexts). Medications, talk therapies, and guided behavioral regimens bring their virtues to bear at these different levels. In this way, the full armamentarium of therapeutics can often be deployed with only a nod toward the DSM (except to use its coding system for reimbursement, of course).

Still, there is no denying the worrisome inroads made by a checklist mentality, especially in this era of rushed clinical encounters and the looming specter of the insurance form that requires listing a diagnosis. The “DSM has had a dehumanizing impact on the practice of psychiatry,” wrote a member of the DSM-III task force last year in the *Schizophrenia Bulletin*. “History taking—the central evaluation tool in psychiatry—has frequently been reduced to the use of DSM checklists.” This, sadly, is often the case, but the blame should go to the deterioration of residency education, not to the DSM.

In training programs across America, wise senior academic psychiatrists are reaching the end of their careers and retiring from teaching. This cohort is well versed in the psychodynamic tradition, yet enthusiastic about new medications and biological discoveries. As teachers, mentors, and department chairmen, they ensured that residents were trained in an eclectic fashion that combined descriptive, psychodynamic, and biological perspectives; that they learned how to listen and how to observe. The masters gently pried the DSM from our anxious fingers when, as residents, the manual was our beacon of orderliness in a roiling sea of desperately ill and sometimes frightening patients. Now newer generations of psychiatrists have suffered as these seasoned men and women leave the field.

The architects of the DSM were well aware of the potential for misuse. They cautioned against applying the manual mechanically and warned that it had to be complemented by clinical judgment, context, and patient history. They shunned any pretense of fixed essentialism and acknowledged that criteria chosen by group consensus to represent the diagnoses were based on clinical judgment and not yet fully validated. Similarly, they cautioned against manual users taking too literally the sharp boundaries drawn between disorders and between disorder and health. “This final version

of DSM-III,” the manual says, “is only one still frame in the ongoing process of attempting to better understand mental disorders.” The DSM, it is clear, was meant to be a living document.

SO WHO’S AFRAID OF the DSM? Not psychiatrists. Their primary goal is to relieve patients’ suffering, and, with some important exceptions, it is symptoms, not formal diagnoses, that direct the clinician. In contrast, the DSM has had a powerful influence beyond the clinic. The impact has been felt, Horwitz and Wakefield observe,

in marketing of antidepressant medications, in preventive efforts in schools, in screening [for depression] in general medical practice, in court proceedings, and in many other settings. In effect, these DSM definitions have become the authoritative arbiter of what is and is not considered mental disorder throughout our society. What might seem like abstract, distant, technical issues concerning these definitions in fact have important consequences for individuals and how their suffering is understood and addressed.

While clinicians can often make subtle, case-by-case assessments of their patients, many other social institutions demand more cut-and-dried approaches. Take the National Comorbidity Survey Replication, a \$20 million survey of more than 9,000 citizens conducted by the National Institute of Mental Health and designed to paint a picture of America’s general mental health. Results published in 2005 revealed that 26 percent of all American adults qualified as having a mental illness within a given year. This sounds ominous, but a closer look shows that almost half had “mild” cases, often representing garden-variety anxieties and despair associated with problems in living—“emotional hangnails,” as the lead author of the study called them. Horwitz and Wakefield devote a persuasive chapter, called “The Surveillance of Sadness,” to describing efforts to gauge the amount of depression within the general population. The implications of sweeping mild cases into the wide net of epidemiological investigation are indeed worrisome.

Clearly, investigators who survey broad populations need to guard against setting thresholds so low that they detect non-disorders and count them as real. Unless they do, the estimates of mental illness make the problem look bigger than it is, thus ushering in intrusive new “tool[s] of emotional surveillance and potential

misdiagnosis for each and every one of us.” As Horwitz and Wakefield note, “It was decided that if people would not come in for [psychiatric] diagnosis, then diagnosis must go to the people.” Screening takes place in the offices of primary-care doctors and in schools, the venue of most concern to the authors.

With suicide the third most common cause of death in fifteen- to twenty-four-year-olds (about 4,400 annually), and with more than half a million adolescents making an attempt serious enough to warrant medical attention, screening would indeed appear to be an important public health mission. Columbia University’s TeenScreen is one popular program. Screening is conducted in two stages: teens voluntarily fill out a short questionnaire and are then interviewed by a social worker or a clinical psychologist, who verifies that a positive result means that the teen is truly struggling. If so, then the teen, with his parents’ knowledge, is encouraged to undergo a more thorough evaluation.

In 2005, the program screened 55,000 young people in forty-two states. About one-third of them screened positive on the questionnaire, and half of those—about 17 percent of all those screened—were referred for further evaluation after the clinical interview. The unintended result, Horwitz and Wakefield claim, is an “immense number of individuals who test positive on the pre-screen ... but who have no disorder.” Horwitz and Wakefield are not opposed to these efforts in principle, but they urge that screening pay attention to both the context in which symptoms occur and to their duration. They worry that teen screening is a social program that is proceeding apace despite uncertain financial and societal trade-offs.

The dangers of over-inclusiveness for both children and adults are obvious: needless prescribing of medications and gratuitous exposure to their side effects; wasting money on superfluous therapy and illegitimate disability claims; diverting physicians’ services from the truly needy; creating bogus personal-injury lawsuits. Granted, individuals seeking disability entitlements and redress for injury undergo detailed examination, not merely screening; but normal variants and mild versions of disorders can fit categories and count as official disorders nonetheless. These are problems in their own right, but the blurring of the distinction between normality and disorder has even wider societal implications. “The way in which people interpret their emotions is changing,” Horwitz told a reporter, “People are starting to think

that any sort of negative emotion is unnatural, that they can take medication and feel better. What that can also do is ... make it less likely for people to make real changes in their lives that might be better than medications.”

This is a great concern, particularly for parents. Over the last decade, the numbers of children with bipolar illness and ADHD have exploded—or, more precisely, the rates of diagnoses for these diseases have skyrocketed. Yet how many of these children truly have a disorder? How many are simply exuberant kids who find themselves pushed over a diagnostic threshold by reacting normally to deprivation and chaos in their homes? As with depressed adults, misdiagnosing normal kids as disordered means they are needlessly medicated while precious mental health resources are diverted from children with genuine clinical needs. In the end, diagnosing a population is a balancing act. Setting a threshold too low makes sick people out of normal ones, but compensatory efforts to raise the bar threaten to exclude people who truly are ill.

The *Loss of Sadness* comes at a fortuitous time for American psychiatry. The APA has just selected the hundreds of clinicians and scientists who will develop the DSM-V. They would be wise to consider the work of Horwitz and Wakefield, and their demand that we avoid pathologizing normal reactions to the vicissitudes of life. Normal reactions to timeless human heartache are not the same as mental disorders. Horwitz and Wakefield call for changes to major depressive disorder that would exempt patients whose depression is triggered by a serious loss, just as bereaved patients are ineligible for the diagnosis. This is certainly worth considering.

But salvation does not lie within the DSM. It never did. As historians of psychiatry have pointed out, none of the four versions of the DSM issued between 1980 and 2000 came into being because front-line practitioners clamored for them. Why would they? A compendium of diagnoses in which only a minority is directly linked with treatment will be of limited use to clinicians. Nor will changes in the manual enlighten the doctor-patient relationship. Any psychiatrist who sees his patients as symptoms on legs does so because he is a hack, and no modification of the DSM will change that—though better education in medical schools and residency training could.

There is another reason to read Horwitz and Wakefield. This book is a hum-

bling reminder of how much more we need to learn—of how fundamental the validity problem is. “Clinical diagnosis is a quite different task from conceptual analysis of the defining criteria that separate disorder from normality,” the authors observe. So different, in fact, that theoreticians such as Horwitz and Wakefield practically inhabit another universe from the one in which clinicians toil. The authors are concerned with nothing less than the nature of reality, with the manifold problems of how knowledge is created and organized.

Charles Larmore BEHIND THE VEIL

LECTURES ON THE HISTORY OF POLITICAL PHILOSOPHY

By John Rawls

Edited by Samuel Freeman

(Harvard University Press, 476 pp., \$35)

EVER SINCE ancient times, philosophers have sought to define the proper goals of political life. Yet in the age of modern democracy, when citizens themselves are held to decide through the various institutions of government the laws and the norms under which they will live together, political philosophy can look profoundly undemocratic. In claiming to settle the fundamental questions of politics, don't philosophers attribute to their own views about justice and the common good a special authority they deny to the opinions of ordinary citizens? Don't they really hope to bring politics to an end, to replace the rough-and-tumble of public debate, coalition-building, and voting with the finality of truth as they have discerned it? Plato dreamed of a state in which philosophers alone would rule. Isn't that the dream of every philosopher who theorizes about politics? Can philosophy be democratic?

The relation between philosophy and democracy is the topic with which John Rawls began his lectures at Harvard on the history of political philosophy, now available in this posthumous volume. Rawls, who died in 2002, was the greatest political philosopher of the twentieth century. His landmark work, *A Theory of Justice*, changed the way the idea of so-

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Practitioners, however, have another purpose. They wish to know how to make their patients better. But until we can organize a compendium of mental illnesses according to a better working knowledge of the brain, the therapeutic revolution in psychiatry will have to wait. Neuroscientists and psychiatrists have certainly made prodigious strides—and yet we are far from grasping how those swirling galaxies of neurons and molecules make us who we are, both in sickness and in mental health. Even as we gather light, we are still struggling in the dark. ♦

cial justice is understood, and provided the starting point for almost everything of note that has come afterward in political philosophy. Rawls was also a great teacher—not particularly charismatic, perhaps, but committed to his students and adept at showing how much there was to learn from the classics of moral and political thought. His lecture courses were famous, and transcripts circulated well beyond the world of Harvard Square. The lectures on the history of moral philosophy were published in 2000. Now Samuel Freeman, aided by Rawls's wife and daughter, has welded together the manuscripts of more than two decades to produce a definitive and magnificent version of Rawls's teachings on the history of political philosophy.

How, then, does Rawls deal with the charge that political philosophy has become a dangerous anachronism, aiming “to render unnecessary the everyday politics of democracy—the great game of politics”? Philosophers, he admits, can claim no higher authority than the authority of reason, which every citizen can invoke who argues carefully and conscientiously for some political position. But this point is far from trivial, since Rawls understands it as cutting both ways. Though philosophers do not constitute an intellectual elite to whom political deference is due, all citizens should be like philosophers in holding themselves responsible to the requirements of good argument. Everyone ought to understand political debate as the effort to justify to others the principles or the policies one favors, and not as a tool to bully or dupe them into submission. Citizens should not only argue “rationally” for their views, explaining how certain decisions would best advance the