**Understanding the Mental Disorder Shopping Catalogue**

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Imagine that you look upset. Is it very remarkable that I can "diagnose" that you are upset? After all, you are clearly upset. What expert thing did I accomplish by noticing that you were upset? Have I added anything meaningful by saying "I diagnose that you are upset" instead of "You seem upset"? "You look upset" is the simple, truthful thing to say and "I diagnose that you look upset" is a piece of chicanery.

By adopting that circumlocution, I've tried to turn an ordinary observation into a pseudo-scientific marvel. By contrast, let's say that you explain to me that you've been having hallucinations. You describe the look of your hallucination and you also describe to me your recent history, other physical symptoms, and so on. Taking that information together, I have a strong hunch that you're suffering from early Parkinson's. I then run tests to confirm or disconfirm my hypothesis. I didn't "diagnose" your hallucination—you handed me that. What I did was diagnose your Parkinson's.

We seem to have a lot of trouble understanding this fundamental difference: the difference between "diagnosing a symptom" and "diagnosing a cause." The second is what medicine legitimately does. The first is what the mental health establishment illegitimately does. It is not real diagnosis for me to "diagnose you with an anxiety disorder" because you told me you were anxious. That is not diagnosis.

You don't diagnose symptoms. You diagnose causes. To diagnose a symptom is only to say, "Yes, I agree, you have a rash." Everyone who looks at you knows that you have a rash! What we want to know is what sort of rash is it? What's causing it? You make use of a symptom as part of your efforts at diagnosis. But the symptom isn't the diagnosis. You observe a symptom and then you diagnose a cause. *You don't observe anxiety and then diagnose anxiety*. It isn't okay to call this "diagnosing."

Here, for example, are some of the questions whose positive answer will get you an "anxiety disorder" diagnosis:

+ “Are you feeling keyed up or on edge?” That is, are you feeling anxious?

+ “Do you have feelings of panic, fear, or uneasiness?” That is, are you feeling anxious?

+ “Are you constantly worrying about small or large concerns?” That is, are you feeling anxious?

+ “Are you constantly tense” That is, are you feeling anxious?

+ “Does your anxiety interfere with your work, school, or family responsibilities?” That is, are you feeling anxious?

+ “Are you plagued by fears that you know are irrational, but can’t shake?” That is, are you feeling anxious?

+ “Do you avoid everyday situations or activities because they cause you anxiety?” That is, are you feeling anxious?

+ “Do you watch for signs of danger?” That is, are you feeling anxious?

If you answer yes to these questions, you are acknowledging in these different-but-same ways that you are feeling anxious. But what you get from the mental health establishment is not, “Yes, you are clearly feeling anxious. Let’s see if we can figure out why.” What you get is the “diagnosis” of an “anxiety disorder.” In our current system, you appear to have “ten symptoms” of an “anxiety disorder.” You come in looking anxious, acting anxious, and saying that you are anxious. What sort of diagnostic acumen does it take for me to say, “You’re anxious”?

A diagnosis should be a *conclusion* about cause and effect. “You need new spark plugs” is a conclusion about cause and effect. “You say you are anxious so I will say that you are anxious” is not a conclusion about cause and effect. It just doesn’t seem possible that the whole mental health industry could collude in adopting a way of looking at mental health that makes no sense whatsoever. It sounds like some nutty conspiracy theory to suggest that so many smart, educated people—psychiatrists, psychologists, psychotherapists, academics,

judges, etc.—would agree to perpetrate what amounts to a complete fraud. It just doesn't sound possible. However, that is exactly what is going on.

The fraud goes as follows. When we see certain things going together (and we will pick and choose which things we see and which things we refuse to see), and *independent of any understanding of why these things go together or whether they really go together*, we will give these things a name and call them a syndrome, a mental disorder, a mental disease, and/or a mental illness. We have no idea whatsoever what is actually going on but by virtue of the "fact," which is no fact at all but a decision to "see these things together," we will feel entitled to call them this or that mental disorder. *We will base our whole mental health apparatus on this particular naming game*.

Mental health professionals do not focus on causes (or concern themselves at all about causes) because they currently have no understanding of the fundamental causes of or connections between the "mental health" things they observe. It is completely Orwellian that the bible used by the mental health establishment to "diagnose and treat mental disorders," the DSM-5 (the Diagnostic and Statistical Manual of the American Psychiatric Association, 5th Edition), would call itself a diagnostic manual when it does not diagnose and is not a manual. It should rightly be called a shopping catalogue for mental health professionals looking to make a profit.

The DSM names putative "mental disorders" and describes how you can "diagnose" those mental disorders based on what are called symptom pictures. It is silent on the causes of the "mental disorders" it names and it is silent on how to treat the mental disorders it names. No doubt its producers can provide all sorts of reasons as to why they decided to fall silent on both causes and treatments but the real reason is the following one: they are silent because the things they are describing do not exist.

Suffering exists. Mental pain exists. But to be so callously and carelessly ignorant as to collect "symptoms" and to then combine those "symptoms" into "syndromes" just because an array of putative symptoms occurs together is unconscionable.
Here is Thomas Insel, former director of the National Institute of Mental Health, on the subject. As part of his public announcement that the NIMH was

withdrawing its support for the DSM, Insel explained: "The weakness of the manual is its lack of validity. Unlike our definitions of heart disease, lymphoma, or AIDS, the *DSM* diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. While the *DSM* has been described as a 'Bible' for the field, it is at best a dictionary, creating a set of labels and then defining each."

Most people, if they have an opinion at all, believe that the "mental disorders" described in the DSM must actually exist. How could there not be things like "depression" or "schizophrenia"? How could they not exist when tens of millions of people are "diagnosed with a mental disorder" every year—including millions upon millions of children? Those "things" just must exist, mustn't they?

Ah, but they don't. Human suffering exists. The consequences of human suffering, like being too anxious to perform, too sad to get up and go to work, or too agitated to sleep through the night, exist. Behaviors that a parent might not like, like his child not sitting still in school, exist. Behaviors whose causes we do not understand exist by the bushel load. But the existence of all of that is not the same as the existence of "mental disorders diagnosed on the basis of symptom pictures." Why not believe the director of the National Institute of Mental Health on that score? Or at least take his opinion seriously?

It is very hard for someone not schooled in this debate to get their head around this idea, that the current practice of the mental health establishment to "diagnose and treat mental disorders based on symptom pictures" is a completely illegitimate activity. *To diagnose means to understand, not to observe*. Many mental health professionals are currently debating whether the criteria for this or that "mental disorder" ought to be tweaked, whether this or that "mental disorder" category is reliable or valid, and so on. But these debates are fundamentally beside the point. The fundamental problem is that the whole enterprise is fraudulent.

The Merck Manual used by physicians to diagnose two thousand diseases and disorders addresses what causes those diseases and disorders, how to treat them, and how to prevent them. The DSM does none of that. Not a word about causes, treatment, or prevention. What does that suggest about its legitimacy? What are the implications of the fact that the DSM is silent on the causes of the disorders it

names? What are the implications of the fact that the DSM is silent on how to treat the disorders it names? What are the implications of the fact that it calls itself a diagnostic manual but says "inside" that it is not really diagnosing but rather naming syndromes based on symptom pictures? The implications are that we must abandon this charade.

For more than fifty years the Hungarian psychiatrist Thomas Szasz argued tirelessly that "mental illness" was a harmful myth and a self-serving metaphor employed by the psychiatric industry to drum up business. He wrote in *The Myth of Mental Illness*: "My aim is to suggest that the phenomena now called mental illnesses be looked at afresh and more simply, that they be removed from the category of illnesses, and that they be regarded as the expressions of man's struggle with the problem of how he should live. Since medical interventions are designed to remedy only medical problems, it is logically absurd to expect that they will help solve problems whose very existence has been defined and established on non-medical grounds."

Defining a mental disorder does not make a mental disorder exist. There is nothing easier than defining things: defining is child's play. That something appears in a dictionary because it can be defined does not make that thing real. No one doubts the phenomena of sadness, worry, agitation, rage, confusion, and so on. But to call these phenomena symptoms of mental disorders amounts to turning real things into a made-up thing. By illegitimately using real phenomena as "proof" of the existence of non-existing things, "mental disorders" come into existence.

Part of the joy and ease of this fraudulent creating is that you can define the non-existing thing any way you like. Who is to say if a mental disorder is the same or different from a brain disorder, the same or different for a Jungian, a Freudian, or a chemical dispenser, the same or different from unwanted thoughts or behaviors, if there is no real thing involved? It ought to be the case that those making the claim for a non-existing thing should have to prove its existence; but in real life the burden always falls on the whistle-blower.

See how blissfully easy the definers of non-existing mental disorders have it. First, they define "mental disorder" one way, as they did in the DSM-4: "A mental disorder is a clinically significant behavioral or psychological syndrome or pattern

that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." If you pay attention and spend the time, you will discern that this says nothing in particular. But our interest for the moment is in the following funny event: the ease with which they ditched this definition and replaced it with another one in the DSM-5.

Under pressure by skeptics as to the whether this definition made any sense whatsoever, the American Psychiatric Association redefined non-existing mental disorders a new way in the DSM-5: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, 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 behavior (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."

Forget for a moment what this definition seems to be saying. The very idea that you can radically change the definition of something without anything in the real world changing and with no new increases in knowledge or understanding is at first glance remarkable, remarkable until you realize that the thing being defined does not exist. It is completely easy—effortless, really—to change the definition of something that does not exist to suit your current purposes. In fact, there is hardly any better proof of the non-existence of a non-existing thing than that you can define it one way today, another way tomorrow, and a third way on Sunday.

If you had the patience and the interest you might want to scrutinize the changes made to the definition of a "mental disorder" and come to your own personal understanding of how language has been employed here to cover all bases, support societal goals, and say absolutely nothing about human reality. A mental disorder is a psychological thing—or maybe it isn't. A mental disorder is a biological thing—or maybe it isn't. You can rail against your society unless you have a "dysfunction," at which point your railing is a mental disorder. You can

disagree with your politicians unless you have a “dysfunction,” at which point you are a mental deviant. One could go on making such observations and yet making such observations actually plays into the hands of the creators of non-existing things, who love it if you play their game.

They can slip about with impunity, adding, qualifying, and shifting, while you waste your breath being reasonable and thoughtful. The question is not, “What is the best definition of a mental disorder?” The question is not, “Is the DSM-5 definition of a mental disorder better than the DSM-4 definition of a mental disorder?” The first and only question is, “Do mental disorders exist?” The phenomena of sadness, worry, pain, distress, angst, and so on exist. Just as the birds and bees exist, pain and suffering exist. But birds and bees do not prove the existence of gods and pain does not prove the existence of mental disorders as portrayed in the DSM.

Once you illegitimately define something like a “mental disorder” into existence, you then need to operationalize that definition so that you have a way of further “recognizing” this non-existing thing. If you invent a unicorn you then have to announce how many horns it has. In our current system, having turned genuine human distress into “mental disorders” by definition, the next step is to “describe” these “mental disorders.” This is done via what is known as “symptom pictures,” a lovely phrase pulled from the world of medicine to make this illegitimate naming gaming sound more scientific, medical, and believable.

Our current mental health system is organized around the idea of symptoms and the related idea of collections of symptoms called symptom pictures. This is its fundamental orientation. All the mental disorders that the DSM catalogues are described in terms of symptom pictures and not in terms of possible causes or sources of the “disorder” or in terms of any underlying logic. You are never told why this collection of “symptoms” should be called this “disorder.” The unstated premise is that each “symptom picture” is an accurate description of a real thing and somehow amounts to that real thing. No reasons are given for this assumption, though something about the title of DSM—the “statistical” part—is supposed to suggest that this is somehow a “statistical matter.”

That symptom pictures alone are used to “diagnose mental disorders” should cause you to jump out of your chair and exclaim, “Wow, that *is* alarming!” *To*

*repeat one of our headlines: a symptom picture is not an explanation*. Let's say that you find yourself sitting inert for hours at a time in front of your television set eating potato chips, not speaking to the people around you, refusing to clean your apartment, and barely dragging yourself to work. A psychiatrist looks at that "symptom picture" and says that you're obviously depressed and that you ought to go on an antidepressant right now. But what if what is actually going on is that you received some scathing criticism at work that sent your world reeling and your self-image plummeting and that you haven't begun to recover from that blow yet?

The symptom picture without an accurate explanation only got you chemicals called "medication." The appropriate explanation makes sense of your unhappiness and alerts you as to what you might need to do to recover: change your job, rebuild your self-confidence, and so on. When you rely on symptom pictures rather than explanations to "diagnose" human challenges and when you create "treatments" intended to reduce or eliminate the "symptoms" rather than addressing the human issues involved, then one day the clerk at your local big box store will be empowered to scan a laundry list of "symptoms," check them off, and send you to a counter at the back where a busy pharmacist will dispense the chemical of the month.

"Symptom" is a medical word and should be reserved for medicine. Your low energy might be a symptom of a thyroid condition or an indicator that you aren't getting enough sleep. If it happened to be the latter, you would go to bed earlier and see what happened. If it happened to be the former, you would seek medical attention. This is a difference that matters! It matters whether something we observe is a symptom of a medical condition or an indicator of a life situation.

To repeat: *The Diagnostic and Statistical Manual of Mental Disorders* provides no diagnoses and isn't a manual. A manual tells you how to do something. The DSM tells you how to do nothing except put a label on a picture. That is what catalogues do: they provide you with a picture of a sofa, give the sofa a name (like "craftsman sectional"), and add some details so that you can make a purchase. In this regard, the DSM is precisely a catalogue that allows mental health practitioners to make sales and not a manual that tells them how to do something. A genuine manual of mental disorder would tell you how to treat

those mental disorders. A pretty catalogue of pictures and labels need do no such thing.

A manual has utility. The logic of a manual is that you get instructions for doing something. These instructions go beyond just naming things. An engine manual not only names the parts of an engine but tells you what to do when a certain red light comes on or when you hear a certain grinding noise as you drive. A manual of any sort does more than just name, it instructs and explains. A catalogue, on the other hand, just names and describes things. It may put the named and described things into categories, like glassware, silverware, and small appliances, it may even make some connections among items, as for example presenting how a living room ensemble might come together from items in the sofa section, the table section, and the lamp section. But its goal is to sell you things and not to instruct you.

A manual is for understanding and a catalogue is for shopping. The DSM is a shopping catalogue for mental health professionals and not a manual of instruction. A genuine mental health manual would do the following sort of thing. It would present various hypotheses or best guesses about the sources of emotional distress. This hypothesizing might sound like, “Anxiety is a normal feature of our species. It is an aspect of our warning system against danger. It appears that some people suffer from more anxiety than other people do. Here are some thoughts on why that might be the case.”

A genuine manual would then continue with treatment options and present the rationale for its suggestions. It would indicate when and why you would want to use chemicals, when and why you would want to use one form of talk therapy versus another form of talk therapy, and when and why you would want to make other sorts of suggestions and try other sorts of things. If it were possible to do so, it would continue in the following vein: “With a cognitive approach you might expect the following positive effects, the following negative effects, and also no effects in certain instances. You should expect a cognitive approach to have limited or no effect on excessive anxiety if the source of that anxiety is genetic but significant effect if it is learned.” And so on.

Might there ever be a genuine “mental health manual”? There are good reasons to suppose that no such manual could ever be created, given the welter of human

experiences it would be tasked with covering. But whether or not that effort is sensible, what is clear is that the DSM is certainly not that sort of manual. It ought to be discarded so that we can get on with the business of better understanding human distress, both its causes and its remedies.