THE FINANCIALISATION OF THE MENTAL

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Since its inception in 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered the standard for the definition, classification and characterisation of mental health. Its impact extends beyond the discipline of psychiatry and psychology, to policy-making, research funding, health insurance, medical training and the psychopharmacological industry. It emerged from the U.S. Bureau of the Census' need to gather uniform statistics on mental disorders and the demand to have a standard guide for the diagnosis of military personnel during World War II. Currently in its fifth version the manual has increasingly affirmed a biologically driven classification of mental health, bolstered by the progressive incorporation of techno-scientific evidence from the medical- and neurosciences.

An examination of the history of the various editions of the DSM reveals how the mental has become a disputed and financialised object, constant prey to quantification, mapping and measurement. Such tendency walks hand in hand with the privatisation, medicalisation and individualisation of health care.

Early psychiatric taxonomies were primarily statistical. The first DSM was largely reflective of the psychodynamic tradition and merged conflicting diagnostic terms being used by psychiatrists, namely in civilian and military psychiatry.

The second DSM, published in 1968, was developed with the aim of standardisation with the World Health Organization's International Classification of Diseases (ICD) and articulation with other biomedical specialties. The new edition avoided terms that denounced theoretical etiologies (such as Freudian psychoanalytic theories) and terms implying causal mechanisms for disorders (eg. 'reaction'), so that the taxonomy might be accepted by professionals with distinct etiological philosophies. The descriptions of individual disorders in DSM-I and DSM-II were typically one paragraph per disorder, offering a description of clinical conditions. They were not yet lists of specific symptoms or criteria as they would become in the DSM III.

The DSM III (1980) pushed for a research based model of mental illness, increasingly reliant on data as the basis for diagnosis. It was the first to introduce explicit diagnostic criteria that would be more generalisable. Controversy about the utility of the DSM-II, the mounting loss of legitimacy of the prevalent psychodynamic tradition in psychiatry, and the antipsychiatry movement contributed in part to the shift toward more discrete and biologically rooted diagnostic criteria and to a pharmacologically oriented specialty. More discrete and

explicit classifications allowed for more effective psychiatric medications and ensured the validity of participant sampling for clinical trials of different psychiatric drugs. It is commonly accepted that the developments in psychopharmacology are linked with legitimation of the DSM-III. Newly developed psychiatric drugs in the '80s were trialled as specific treatments for the novel DSM-III diagnoses and results of such studies widely disseminated in psychiatric events. The increasing pharmaceutical industry required a better-defined system of classification. In addition, as coverage of mental healthcare increased, the vague description of conditions did not fit an insurance logic, which required clinicians to treat a distinct disease and a greater measurement of outcomes of specific therapies. Nonetheless, disparities found in the diagnostic criteria in both research and clinical practice led to the development of a new edition of the DSM, the fourth, released in 1994.

The DSM IV attempted to resolve inconsistencies between DSM criteria and clinical symptoms observed in patients. The number of diagnoses grew from 182 to 261. The many categories were carefully distinguished from each other on the basis of their explicit symptoms, rather than being understood as signs of some broader underlying condition. It is not without importance, that it was also the first edition to list disorders caused by psychopharmaceutical treatments of physical illnesses, known as psychiatric side effects (PSEs) (eg. 'persisting dementia induced by sedatives, hypnotics or anxiolytics').

The last and current edition of the DSM was released in 2013 (DSM-V). The first clear change is the wide increase in number of the diagnostic categories. The scope of the diagnosis of mental disorders is wider and criteria for having a given a diagnosis has been loosened. This increases the probability of a mental disorder diagnosis. A series of previously perceived normal reactions to a given situation are now being seen through a pathological eye. One example is grief which in the new version can easily be diagnosed as Major Depressive Disorder. The DSM IV contained a 'bereavement exclusion' aimed at differentiating depressive syndromes following grief, that could be seen as normal, from what might suggest mental illness. Previously, it was advised not to diagnose individuals if symptoms began two months following the death of a loved one. However, the DSM V removed this criteria. This reclassification of what were once viewed as natural reactions to experiences, into pathological conditions, is an example of the widening range of mental illness diagnosis. A statement released by the British Psychological Society expressed concern over the predominant focus on the individual, missing 'the relational context of problems and the undeniable social causation of many problems,' adding that 'a classification system should begin from the bottom-up starting with specific experiences, problems or symptoms'. Studies have pointed out several reasons for the increasing scope of DSM diagnostic criteria. One reason for this is related to insurance payments which often require a diagnosis. Another reason is that diagnoses dictate who will received support from health and social services. The other one is the pharmaceutical industry. When numbers of individuals diagnosed with a specific disorder increase, or when the DSM adds a new disorder, use of medication for treatment of such disorders grows.

The DSM history is that of a development which is guided by the progressive incorporation of scientific evidence from the neurosciences and brain imaging techniques, the evolving medicalisation of psychiatry, interests of psychopharmacological therapeutics, as well as government and private insurance logics. The mental has become a space of financial dispute of which we have been excluded. This has contributed to its progressive deterritorialisation from spaces of existence and life practices, and its mounting pathologisation and medicalisation. What is worse, people suffering from mental disorders are ever more isolated as the wider community and the environment are not given any substantial role to play. It is ironic that the DSM is presented as an effort to create a common language of mental disorders while there is very little of that production of language that is for the people. We are often left with the impression that the mental is an individual problem, with its psychological-physical dimensions, when in fact it is collective from the start.

Despite all its problems, the history of the DSM has the usefulness of providing an archive of the different processes by which mental health became an object of power. Furthermore, it highlights the centrality of language as the mechanism through which disputes over mental health take place. However, if currently language is the vehicle of a progressive financialisation of the mental, it could also be made to serve very different projects. I am referring for instance to the importance of collective practices of care – each with its 'minor' or local practices of language – and to the binding of mental health concepts to concrete social pragmatics and contexts. While the DSM has become a global tool, we should be looking to the multitude of other forms of practicing and thinking mental health diagnostics that exist across the world. In particular, practices in which language is not reduced to an axiomatic calculation, but exists as a collective tool, both critical and clinical.

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