Imploding the Diagnostic Statistical Manual: Mental Illness and Beyond

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The Diagnostic Statistical Manual (DSM) is widely used across North America. Established by the American Psychiatric Association, it was created to help mental health practitioners give clear cut diagnoses of mental illness (Kirk and Kutchins 1992; Mayers and Horwitz 2005). However, the DSM is not merely a tool used for diagnostic purposes. Currently on its fifth volume, the DSM is an active agent that helps legitimize and define psychiatry—a legitimizing force that is exasperated by its entanglement in many social institutions in North America. The DSM influences the boundaries and meanings of mental illness categories (Kirk and Kutchins 1992). It grants some people "legitimate" access to resources, while delegitimizing others (Fassin and Rechtman 2009). It shapes how people exist in the world and understand their reality (Mayers and Horwitz 2005). However, the DSM is also shaped and (re)produced by society. The meanings of mental illness as outlined in the DSM are challenged, resisted, and shaped by the very people placed into these categories. This research paper argues that the DSM is more than an object; it is a dynamic and active agent that exists in the world in many ways.

KEY WORDS Diagnostic Statistical Manual, mental illness, psychodiagnosis, professional legitimacy, boundaries, dialectics

The Diagnostic and Statistical Manual (DSM) is a diagnostic marvel that is used by psychologists, psychiatrists, policy makers, and mental health researchers (Cooper 2015). It was originally released in the United States by the American Psychiatric Association (APA) in 1952, with the most current fifth edition released in 2013. Since its third edition was released in 1980, the DSM has been a staple of mental illness diagnostic practices for psychiatrists and has been described as the "bible of psychiatry" (Schnittker 2017, 20). The DSM is an empirical, symptom-based manual that requires 5 or more symptoms to be met in order for an individual to receive a particular diagnosis (Kirk and Kutchins 1992). Now on its fifth edition, the DSM is still highly regarded, and psychiatrists and psychologists are required to know how to use this manual for diagnosis. The DSM is a document recognized worldwide, however it is mostly used in Canada and the USA, while European countries often opt for the closely related International Classifications of Diseases (ICD) (Whooley 2010). Despite its booming popularity in North America, many professionals, including anthropologists, psychiatrists and psychologists, have noted the

limitations of the DSM and have critiqued its symptom-based approach to diagnosis, its role in creating boundaries of mental illness, and the accompanying consequences of these boundaries (Kirk and Kutchins 1992; Mayers and Horwitz 2005). While most of these critiques are as old as the manual itself, the DSM continues to be a popular diagnostic tool in psychiatry and psychology.

However, the DSM is more than a sum of its critiques and praises. It is a document that exists in the world in many ways. It can be understood as a tool that works to distinguish and legitimize the profession of psychiatry through its adherence to scientific empiricism, a logic that can be traced back to the Enlightenment. The DSM is also a document that works to identify, validate and allow resources to be given to individuals who are labelled as having a mental disorder, while not addressing those experiences that do not fall within the DSM categories. Thus, it acts as a boundary maker between those who are recognized to be requiring additional resources and support, versus those who are not. The DSM expresses agency in that it not only is shaped by, but also shapes and alters the course of individuals within society. It is a travelling written document that shapes interpretations of life experiences and is consequently shaped by those placed within the DSM diagnoses. Informed by Joseph Dumit's (2014) object implosion methodological approach, in this article I unpack some of the ways the world exists in the DSM as an object and how the DSM exists in the world.

The DSM as Historic and Legitimizing

Before the release of the DSM I in 1952, there was no widely recognized standardized categorization for understanding mental illness. Due to the lack of standardized categorization, more mental health professionals such as social workers and crisis workers began claiming they were able to treat and diagnose mental illnesses just as effectively as psychiatrists (Kirk and Kutchins 1992; Fassin and Rechtman 2009; Mayers and Horwitz 2005). The DSM I and II were the APA's attempt to standardize the professional diagnostic practices of psychiatry and separate themselves from other mental health professionals (Fassin and Rechtman 2009). However, critiques of these manuals soon arose as professionals noted its low reliability, speculative etiology, and use of a psychoanalytic theoretical framework that was not based in scientific empiricism. Diagnosis and treatment mainly relied on psychiatrists' clinical judgements, and many noted that patients regularly received different diagnoses from different practitioners. This made psychiatry questionable as they positioned themselves as a part of medicine, a discipline that prides itself in having high diagnostic reliability (Schnittker 2017).

The APA wanted to establish themselves as experts in the field of mental health, and thus needed to adhere to the scientific concept of reliability. To do so, the DSM III task force was given the duty to create a more usable and reliable manual of mental illnesses and began to move away from etiology to focus on symptoms (Kirk and Kutchins 1992; Carta and Angermeyer 2015). This allowed the manual to be taken up by practitioners with varying theoretical orientations as it did not ascribe to one etiological understanding of mental illness (Schnittker 2017). The DSM III was an attempt to decrease clinical judgement and standardize mental illness categorization, which they believed was their ticket to solidifying their position as a credible part of the broader medical field (Rosenwald 1961).

By adhering to scientific medicalized ways of knowing, psychiatry solidified its professional legitimacy and its claims to expertise of the mind (Wand 1993). Since then, the DSM has been seen as the standard for mental illness diagnosis (George et al. 2011) and praised for its scientific, evidence-based structure (Mayers and Horwitz 2005).

The scientific foundations of the DSM can be traced back to the Enlightenment. The Enlightenment was a philosophical shift that happened in 17th century Europe that changed dominant ways of thinking and knowing about the world. The Enlightenment was a major milestone in current ways of thinking as it established empiricism and rationalism. Knowledge, as defined by the Enlightenment, is produced through systematic experimentation and asserts that facts about the world have observable evidence (Samson 1999). Since understandings of the world were based in systematic, observable, and quantifiable methodologies, science was viewed as being able to uncover ultimate, intrinsic truths about the world; this position assumes that facts are out in the world waiting to be discovered and are not connected to culture or context. Enlightenment science positioned itself on the basis of detached objectivity, which is the belief that scientific researchers can fully detach themselves from their work and find universal truths about the world and its inhabitants (Haraway 1988).

This empirical approach to science is currently embedded in Western medicine. Medicine is based in systematic observation of individuals to uncover traits about the patient that fit into a classification of diseases (Schnittker 2017). Western scientific medicine draws from Enlightenment ideologies by assuming that there is one truth about the body and illness that applies to everyone. Symptoms are understood as signs that there is an underlying disease present within the individual that is waiting to be diagnosed (Manning 2000). Diseases and patient experiences are not situated as practitioners focus on quantifying the physical body to uncover universal diseases (Kleinman 1995). In psychiatry, mental health disorders are rendered measurable and left un-positioned in the DSM. This manual acts as a practical taxonomy of mental illnesses that all psychiatrists could adhere to, creating a standard methodology. Thus, the DSM III portrayed mental illness as bounded, measurable and comprised of universal diseases that can only be uncovered by trained professionals—such as psychiatrists (Whooley 2010). In the introduction of the DSM III, it claimed to be based in nothing but "good, sound knowledge," framing their categorization of mental illness as unbiased and objectively detached (Cooper 2015, 133). This standardized categorization based on scientific medical empiricism helped unify and distinguish psychiatry, legitimizing them to the public and to the government.

In Ontario, the 1991 Regulated Health Professionals Act listed professions that are responsible for particular controlled acts that are deemed to be harmful to the public if used improperly. This sparked the creation of mandatory regulatory colleges that are responsible for registering, disciplining, and monitoring their members' practices. The act of communicating a formal diagnosis is a controlled act that is given to a handful of professions, including psychiatrists and psychologists (RHPA 1991). For making a formal diagnosis, mental health professionals in North America widely rely on the DSM or the closely related International Classification of Diseases (ICD) created by the World Health Organization (Manning 2000). Hence, the controlled act of communicating a formal diagnosis is largely based in the use of the DSM and ICD. Psychiatry is legitimized legally partly through the use of standardized diagnostic manuals like the DSM, which offers a

common language and understanding of mental illness among those in the mental health field (Lafrance and Makenzie-Mohr 2013).

The DSM's classification system and legitimizing force is alive today in part due to its continued adherence to scientific medical empiricism, which is still a valued and dominant way of knowing in Western ontologies. However, the ways in which scientific medical knowledges are used and understood are changing with context. For example, the introduction to the DSM V acknowledges the manuals limitations and notes that practitioners should use the manual as a guide and in tandem with clinical judgement and other sources of information. Additionally, despite using the same scientific medical logic by adhering to the same symptomatic structure of the DSM III, the DSM V includes sections that attempt to address common critiques. For instance, the Cultural Formulation Interview tries to make the DSM more inclusive and sensitive to diverse understandings of lived experiences rather than ignoring the individual's understanding of their lived reality (Cooper 2015). Nevertheless, psychiatry's history of gaining validity through scientific empirical methods is alive and present within the discipline albeit acknowledging of its limitations. The continued but slightly altered use of scientific medical reasoning in psychiatry shows that the past is not separate from the present or future, but these scales are entangled and embodied. Different aspects of the past shape, emerge, and fade in the present (Stoler 2008). Likewise, the past is interpreted differently based on the present context and situatedness (Roseberry 1989). This influences how the past exists and influences current affairs. The emergence of scientific empiricism as the dominant way of knowing during the Enlightenment period still shapes scientific medical knowledges and practices through the DSM today. However, the interpretation of scientific medical empiricism has changed throughout the years as more scholars critique the DSM's foundational assumptions of mental illness and as more professionals aim to address these concerns.

Addressing these critiques helps to ensure that the manual is up-to-date with current hegemonic ways of knowing, thus maintaining and reproducing its legitimacy. In addition to adding sections to the DSM to address common critiques and maintain psychiatry's legitimacy to the public and other professionals, mental health researchers and practitioners actively reinforce DSM categories by using the manual's classification system. Psychiatrists carry on rectifying continued concerns about the DSM's reliability and validity through more rigorous empirical methodology and standards, which further reinforces scientific medical ways of knowing (Kirk and Kutchins 1992; Horwitz and Wakefield 2007). Researchers use DSM categories and DSM based interviews and questionnaires to recruit people with particular psychodiagnoses. They then use these participants to generate more information on that particular psychodiagnostic category. Hence, researchers continue to support and reproduce DSM categories by using it and generating further knowledge, which reinforces the idea that the DSM is scientifically rigorous and empirically based (Cooper 2015). The DSM's continued adherence to scientific medical ways of knowing continues to shape, create and validate its categorical schema, thus adding to the legitimacy of the DSM and of the profession of psychiatry.

Researchers and practitioners are not alone in actively reinforcing the DSM classification system. The DSM is bureaucratically embedded in North America in many ways. Third party payers such as insurance companies rely on DSM diagnoses to determine if a claimant is eligible for disability status, treatment coverage and other financial benefits

(Cooper 2015). These diagnoses play a large role in developing and supporting the continued success of the psycho-pharmaceutical industry by creating and targeting particular medications to individuals with certain diagnoses (Kirk and Kutchins 1992, Horwitz and Wakefield 2007). It is also used heavily in policy making, the justice system, and advocacy. Due to the versatility of the DSM and number of various actors that use this mental illness classification system, the APA has received $5 to $6 million a year since the release of the DSM IV in 1994. Its deep embeddedness in North America continues to legitimize the DSM and the profession of psychiatry (Cooper 2015).

The DSM was originally a classification system meant to unify and legitimize psychiatry's claim to expertise over the mind through the use of scientific medical empiricism; however, today it is used as a dominant and hegemonic discourse legitimizing psychiatry's specific and medicalized ways of knowing. Despite this, the APA uses the DSM as a way of knowing that is not the same as it was 40 years ago. The APA acknowledges the limitations of the DSM and makes revisions in order to address concerns and critiques made by the public and fellow academics. Addressing the DSM's limitations helps to keep the classification system current and valid to the public. Furthermore, the use of the DSM by various industries such as pharmaceutical companies, insurance agencies and researchers, bureaucratically embeds the DSM as a mode of scientific medical classification in North America. Its institutional embeddedness continues to legitimize the DSM by using and reproducing its diagnostic categories and scientific medical logics. Reproducing the DSM also works to support the legitimacy of psychiatry legally (by regulatory bodies) and pedagogically by the use of the DSM.

DSM in Boundary Making

By situating psychiatrists as experts in mental health and encouraging the medicalization of mental illness, new forms of surveillance and state management emerge. Through the open recognition and discourse around mental health, authorities and the public are able to monitor mental wellbeing, creating common understandings of what is "normal" and "ill." This acts as a mode of discipline which decides what constitutes appropriate and "deserving" patients. The unequal power distribution allows authorities to create a "society of control" where bodies are policed by state expectations and the public who adopt and embody these standards (Deleuze 1992). Policing involves the monitoring and scrutiny of individuals and groups to ensure adherence to dominant values, behaviours, and ideologies. In terms of mental illness, the governing body and the public have deeply embodied ideologies of what constitutes a "deserving" patient, which creates and reinforces boundaries of inclusion and exclusion (Fassin and Rechtman 2009). These boundaries are reinforced through the DSM's adherence to scientific medical knowledges that standardize experiences of mental illness, positioning them as universal.

The belief that the DSM is based in universal facts resulted in its use cross-culturally to assess mental illness (Mayes and Horwitz 2005; Kirk and Kutchins 1992). However, the way we understand an object or phenomena—including mental illness—is shaped by a multitude of factors, including cultural systems, technologies, ecologies and social environments. Donna Haraway (1988), one of many scholars, disarticulates 'truth' as one, pure and pristine existence, but rather challenges it by making truth a situated and contextual

experience that can be ascribed to everyone slightly differently. There are different ways of knowing and understanding the world that are each situated in a larger context. Every way of knowing has its limitations, which gives us a partial truth that is influenced by one's positionality and the broader social, historical, economic, temporal and geographic context (Abu-Lughod 2006). For example, Annemarie Jutel (2010) argues that Female Hypoactive Sexual Desire Disorder in the DSM III-Revised, an issue of "abnormally low" female libido, reflects the North American media's increasing hypersexual portrayal of women in the late 20th century. She argues that overall societal conditions create an understanding that women want to be sexy, and if they do not then they are abnormal. This is a significant departure from societal beliefs of female sexuality decades prior, which vehemently opposed women expressing any sexual desire at all. Despite the APA priding themselves on the DSM's scientific and empirical basis, the psychodiagnostic categories of the DSM do not reflect a universal fact about human nature but reflect the societal norms and values of a particular context at a point in time.

Situating humans as the same, and having similar experiences of mental health and illness, allows for the generalization of mental illness across differences and diverse contexts, illuminated and ignoring significant variety in ontologies and knowledge systems. This depoliticizes inequalities created by mental illness categories and the DSM. By taking away the etiology of mental illness and focusing on the symptoms, the individual's unique experience with mental illness is hidden, which further allows for the generalization of mental illness categories (Fassin and Rechtman 2009).

Anthropologist Anna Tsing (2005) argues that generalization can lead to universalization via two interdependent processes. Firstly, there needs to be an "axiom of unity," which is a point where specificities of categories or knowledge converge. For example, bananas and oranges are different when thinking of their specific traits; however, by grouping them both a fruit, they can be seen as two of the same. Second, there needs to be "contingent collaborations among disparate knowledge seekers and their disparate forms of knowledge," which allows for the knowledge to be generalizable (89). Through collaboration, convergences between differences arise, which "bridges over unrecognizable difference" (89). Universals need to be able to travel across differences and be able to successfully converge with that context. The DSM works to create an axiom of unity by situating different people under the umbrella group of "humanity," with the same psychiatric and biological structure (Fassin and Rechtman 2009). This erases differences across groups and belief systems, hides inequalities, and depoliticizes these categories (Fassin and Rechtman 2009). Claiming universality masks who is included and who is excluded from these supposedly all-encompassing categories (Tsing 2005).

The universalization of the DSM and its related categories are very much politicized and create inclusion and exclusion criteria. Illness is quantified through standardized diagnostic tests and the DSM (Fassin and Rechtman 2009). Through measuring one's suffering, it legitimizes or delegitimizes people's claims to requiring assistance. Diagnosis works to confirm people's identity as patients and legitimize their experiences (Nettleton 2006). Individuals claiming to require assistance with their mental health are policed by doctors, insurance companies and the public to ensure that those claiming to be included within the bounded category of "mentally ill" are "authentic" in that they are adhering to the designated categorical boundaries. People who are allowed to lay claim to suffering

through the standards set by the state and embodied by the public are able to gain access to resources, such as treatment and monetary compensation (Lafrance and Makenzie-Mohr 2013).

Sociologist Sarah Nettleton (2006) explores the lives of individuals whose symptoms cannot be medically explained. People falling into this "diagnostic limbo" have trouble legitimizing their experiences and pains to their family, friends, medical institutions and sometimes themselves (1168). Individuals are left feeling not understood, not taken seriously, and disrespected. They are left fighting for useful resources that are denied to them due to a lack of a formal diagnosis. Nettleton's (2006) exploration of unexplained symptoms highlights the importance of formal diagnosis on legitimizing their experiences to themselves and others, thus granting them access to resources.

Even if one does not identify as suffering or having a mental illness, in order to have their voice heard and to get benefits from the state, they need to appeal to the socially appropriate patient narrative. People who cannot adhere to this specific narrative or people who are considered "too different" to help are ignored and excluded from being recognized as "deserving" of help (Fassin and Rechtman 2009). This can lead to members of society blaming individuals with a formal psychodiagnosis for their challenges. People who cannot adhere to a specific narrative of an individual "deserving" of care are blamed for their own misfortune, told that they are suffering not because of systemic inequalities, but because of their own inability to adhere to specific treatment methods or ways of knowing. This is rooted in hegemonic ideas that individuals are responsible for whatever happens to them and that people can do anything if they have the motivation to do so, despite the context and oppressions they face (Biehl 2007). For example, a woman diagnosed with Major Depressive Disorder through the DSM who does not take her medicine can lose her status as "deserving" of help because she is perceived to lack the drive to change her life and lack the discipline to adhere to medication. However, this (hypothetical) woman might not be taking medication for reasons outside her control, including issues such as poverty, inability to access pharmacies, gendered stigma against taking psychopharmaceuticals, negative side effects of the medication, and the list continues. Through generalizing mental health categories, mental health challenges are depoliticized and larger systematic violences are hidden; temporary solutions are applied to deeply rooted political issues (Redfield 2013). The scientific medical underpinnings of the DSM hides how the inclusion and exclusion criteria is made and universalized, and who is left out from these bounded categories.

The importance of the DSM as actively making boundaries of illness legitimacy is clear when noting the various activist groups and individuals who work to have their negative mental experiences recognized by the APA. In the revision of the DSM IV, the APA revision committee suggested grouping Asperger's disorder into a group with autism and pervasive developmental disorder—not otherwise specified (PDD-NOS). They suggested this because the category distinction was not reliably sound, meaning there were significant discrepancies in diagnosis between practitioners. Instead, they wanted to group all three diagnoses into one called autistic spectrum disorder (ASD). This change shifted the symptoms that qualified an individual for a formal diagnosis. Hence, the boundaries of the disorder were set to be slightly modified. This modification meant that some individuals diagnosed with Asperger's disorder from the DSM IV would no longer qualify as having a mental disorder under the new criteria. Consequently, this meant that individuals in

North America who relied on the diagnosis for insurance to cover costly therapies and to receive helpful resources would be at risk to lose their benefits. This sparked a huge push back from the public and Asperger's activist groups. Due to the immense backlash, the APA decided to compromise. While they omitted Asperger's disorder from the DSM V, they made edits to the new ASD criteria and made the exception that anyone previously diagnosed with Asperger's disorder or PDD-NOS from the DSM IV should be given a diagnosis of ASD (Cooper 2015). This case demonstrates the power the DSM has over creating inclusion/exclusion boundaries of those deemed as "legitimately" in need and "rightfully" getting access to resources. Additionally, it demonstrates the fluidity of psychodiagnostic categories and understandings of mental health as they shape and are shaped by various actors such as advocacy groups.

With this, we must also consider those who fight to have their experiences de-medicalized, such as gender dysphoria. Gender Dysphoria is outlined in the DSM V as "conflict between a person's physical or assigned gender and the gender with which he/she/they identify" (American Psychiatric Association 2016). Many transgender rights activists argue that being transgender should not be considered a mental disorder as it locates the "issue" within the individual instead of on societal oppression and discrimination (Grinker 2018). While they argue against its medicalization, having a diagnosis of gender dysphoria grants them access to resources such as hormone therapy, gender reassignment procedures, and counselling (American Psychiatric Association 2016). This diagnosis helps them navigate the bureaucratic system by giving them a billable code legible to insurance companies and professionals that can help them access resources. Unlike the APA, the World Health Organization cited gender incongruence as a physical health concern instead of a mental illness, which has its own billing code (Grinker 2018). This means that transgender individuals in Europe can gain access to resources without it being considered a mental disorder. However, transgender activists in North America that live under the APA system are now faced with the challenge of de-medicalizing their experiences while maintaining adequate access to resources.

Through the universalization and generalization of the DSM, mental illness categories are depoliticized and inequalities are tucked away. This masks the structural violence that shapes the experiences of those requiring further resources. It places immense responsibility on individuals as they are expected to be "good" patients that are responsible for adhering to the practitioner's instructions and fulfill the accepted narratives of having a mental illness. Those who cannot adequately adhere to particular narratives of having a psychological disorder are left unrecognized and do not get access to resources that may be beneficial. While there are activist groups that fight to have their experiences de-medicalized, having a formal diagnosis helps gain access to resources that would otherwise be inaccessible. These groups are now faced with the challenge of negotiating their experiences within the larger bureaucratic system so that their identity is not recognized as a mental disorder, yet they can get adequate access to helpful resources.

DSM as Active and Dialectic

The DSM can be understood as an active object that shapes people's identity. Just as how the DSM is shaped by society, society is shaped by the DSM. This relationship is dialectic

in that the actors involved are never fully independent of each other because they are constantly working together and in-the-making with each other (Clifford 1988). The DSM and identity are involved in a dialectic relationship as the DSM shapes identities, and existing, emerging, and fading identities shape DSM classifications. Alongside the creators of the DSM and the APA as an institution, the physical DSM itself is also an actor within this relationship. Actor network theory (ANT) acknowledges the influence of non-humans actors in shaping reality (Latour 2005). Non-human actors, such as the DSM, have great influence over people's lives and realities. Documents impact people in different ways and their influence changes based on context (Hull 2012). Not only does it act as a boundary enforcer, the DSM also actively shapes identity which is then embodied by the patient and members of society. For example, before the creation and recognition of post-traumatic stress disorder (PTSD) in 1980, people who had psychosomatic symptoms from trauma, especially soldiers who fought in battle, were seen as psychologically weak or morally flawed because they were understood as feigning illness to avoid going back to war. This understanding had serious consequences. For instance, in WWI 1800 soldiers who returned from war and refused to continue fighting for their country were accused of treason by the British Commonwealth military. Of those, 306 were executed. The DSM transformed this phenomenon into one that is medicalized and thus changed their identity to "sick" instead of "weak." This impacted how individuals diagnosed with PTSD were treated in society and understood (Lafrance and Makenzie-Mohr 2013). The diagnosis of PTSD has certainly garnered more sympathy and understanding of soldiers and other victims of trauma. It also changed how victims of trauma understood their experiences and identity. Instead of internalizing an identity of being cowardly or weak, individuals took on the identity of a patient in need of aid (Fassin and Rechtman 2009). Without the DSM the identities embodied by those currently diagnosed with mental illnesses would be drastically different. However, it is important to note that the history of stigmatization continues today as many veterans and traumatized individuals face challenges accessing financial, health, and community supports.

Documents such as the DSM are lively actors that are shaped by those placed within its classifications. As these individuals change, so does the document, and vice versa. People are in a constant state of becoming based on their current situatedness (Mattingly 2012). As times change and as different contextual forces come together to create new knowledges, technologies, and understandings, people's understandings of themselves and the categories they are placed into change. This process of self-creation is called autopoiesis (Faubion 2001). Through autopoiesis people dialectically engage with various forces, such as societal norms, medical classifications, and scientific knowledges, and must try to find meaning through the sometimes unpredictable relationships that emerge (Faubion 2001). People understand themselves through their interpretation of "facts" and their interpretation of the categories placed onto them via experts or societal beliefs (Dumit 2003). People begin to embody categories and work within their parameters as outlined by dominant social understandings (Hacking 1987; Dumit 2003). However, through embodying it, they are also actively working on that category, shifting the meaning of the category itself (Hacking 1987; Dumit 2003). This process is called objective self-fashioning (Dumit 2003).

Autopoiesis and object self-fashioning can be observed in mental illness activists push against psychiatric labelling, for example through the United Kingdom Mental Health

Survivor movement. These activist groups aim to reclaim derogatory words commonly used for people with mental illnesses, such as loonies and madness, redefining them to empower those labelled as mentally ill (Crossley 2004). Additionally, groups such as The Hearing Voices Network (HVN) work to redefine what it means to have reoccurring auditory hallucinations that are not drug induced. This network is comprised of friends, family, and individuals who "hear voices." They view hearing voices as a personal experience that can be interpreted as positively or negatively (Crosslet 2004). HVN encourages members to understand their auditory hallucinations as a positive experience instead of a mental illness or flaw in their being. They encourage individuals to become comfortable with the voices they hear and accept their experiences as a part of who they are instead of something that needs to be managed or fought against (Crossley 2004). The HVN is a prime example of how people placed in mental illness categories can work from within a label to redefine it and resist hegemonic ideologies surrounding its categorization. With that, they are also shifting what it means to be medically diagnosed with auditory hallucinations. Activist groups such as the HVN work within societal contexts to create new ways of being and existing that make sense to them and benefit their wellbeing, thus engaging in the process of self-creation. However, the HVN and associated activist movements emerge in response to the DSM and the power psychiatrists have in prescribing psychodiagnostic labels. Hence, the DSM plays a role in bringing about new forms of resistance, ways of knowing, and ways of being.

Critiques of the DSM and scientific empiricism work to alter this classification system by creating new ways of understanding that are taken up by activists, patients, and practitioners as well as other members of society. For example, Allen Horwitz and Jerome Wakefield (2007) critique the DSM for conflating normal sadness with clinical depression, thus giving rise to the staggering cases of depression in North America. The DSM-IV understands depression through a list of nine symptoms. If the patient meets five of those symptoms and they last for two weeks or longer, they are understood as being clinically depressed (Horwitz and Wakefield 2007). They argue that DSM does not account for the variety of circumstances of sadness and grievance outside of the loss of a love one, for which the grievance period is capped by the DSM at two months and afterwards is considered clinical depression. People experience an immense sense of loss and sadness over broken relationships, lost jobs and lost lifestyles, yet it is not considered by the DSM as a reasonable cause of distress that is outside clinical depression or related diagnoses.

This gives a very specific understanding of sadness and mental health, an understanding that is embodied by individuals. People now shy away from sadness and try to construct their reality upon the goal of being in constant bliss. Sadness's conflation with poor mental health results in people resisting feelings of despair to obtain the societal ideal of "positive mental health," which is understood as being constantly peppy, joyful and calm. People actively aspire to be constantly happy and relaxed by taking medications, doing yoga, adhering to self-help guides, and doing other activities deemed as "self-caring" (Horwitz and Wakefield 2007). While this aim for perpetual happiness is not solely shaped by the DSM's understanding of mental health, it does have an effect on how people understand their realities. As more scholars and mental health professionals recognize and voice the limitations of DSM diagnoses and cite alternatives to this current classification system,

more individuals will be aware of other possibilities for understandings their experiences. Based on which understanding best suits their context and makes sense to them, particular knowledges will be adopted that change their perception of their lived reality. This change in perception influences how they relate to and embody these categories, allowing them to shape the category from within.

However, the possibilities of self-creation and objective self-fashioning are limited by contextual circumstances, such as policies, available technologies, and deeply entrenched bureaucracies. The knowledges and resistance produced from critiques of the DSM not only shape how individuals understand their identity, but it can also have material effects on the manual itself. Homosexuality was listed as a disorder in the first DSM released in 1950s. The time the second DSM was due to be released was a time of revolutionary queer and feminist activism in North America. The APA was openly challenged by activists about their inclusion of homosexuality as a psychological disorder. The overwhelming backlash resulted in the omission of homosexuality in the 1973 DSM II (Kirk and Kutchins 1992). Public critiques and resistance towards the inclusion of homosexuality as a disorder shaped the DSM and consequently, aided in shaping public and professional understandings of homosexuality. It changed perceptions about the identity of being queer and worked to change how being gay was understood and embodied by individuals who identified as such.

Conclusion

Understanding the DSM through different lenses can offer many insights into its multi-faceted influences on society, and each angle allows for the exploration of different questions which further uncovers the complexity of this diagnostic document. The DSM exists in the world as a legitimizing force for the profession of psychiatry. Its adherence to scientific medical knowledges reinforced, and continues to support, psychiatry's legitimacy as a medical profession. While the DSM V acknowledges its limitations and notes that it should be used alongside other sources of client information, it still holds on to the medical scientific roots of the DSM III. The history of scientific medical empiricism still lives on today, albeit in a different form that allows it to exist in the current context. The use of the DSM by various social institutions, such as researchers, pharmaceutical companies, and insurance companies further embeds and legitimizes this classification system and with that, psychiatry's claim to expertise of the mind.

The DSM also exists in the world as a gatekeeper for claims to patient status and accessibility to resources. The DSM is situated and partial, thus it favours and includes certain lives and experiences while excluding others. If people are unable to embody a specific narrative of mental illness, then they are unable to establish themselves as "deserving" of aid. Through the DSM's claims to universality, individual experiences of mental illness or trauma are hidden. The DSM and associated mental illness categories are positioned as apolitical, which hides dominant authorities and ideologies that work in shaping the DSM and inclusivity/exclusivity criteria for aid. It also masks the systematic violence that result in experiences and symptoms that qualify as a mental illness. Through dominant ideologies that assert people are in control of their own fate despite their context, people who are excluded from the mental illness narrative are blamed for their hardship. The DSM's

generalized classification system aids in masking systematic violence that result in a psychodiagnosis, while reinforcing and creating inclusion/exclusion criteria for who should be recognized as "deserving" of aid.

The DSM exists in the world as an active non-human agent that shapes human experiences and identities. The physical document is a major actor in the discourse of mental health as it fuels resistance, and shapes identity possibilities and ways of being in the world. The DSM and identity are involved in a dialectic interaction and are constantly shaping one another. The DSM shapes people through prescribing labels to individuals, each label attached with particular sentiments that become embodied. However, through this categorization individuals who are given a psychodiagnosis work within this label to shape understandings of the diagnosis. Humans are actors in that they can accept, deny or reinterpret the labels place onto them. Hence, people also actively shape the DSM. Critiques of the DSM also work to produce knowledges, resistances, and identities that shape the DSM and people's embodiment of social identities. The DSM exists in the world in many ways that go beyond what is discussed here. The DSM is much more than a diagnostic assessment tool; it's a legitimizing force, it's a gatekeeper, and it shapes lived experiences. It is more than a mere object. It is an agent within the world that is dynamic and alive.

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