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Review Article: Everyday Sorrows are not Mental Disorders: The Clash between Psychiatry and Western Cultural Habits[1]

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The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder
Allen V. Horwitz and Jerome C. Wakefield
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This review article considers four issues, and some information gaps, in a literature broadly concerned with the definition of mental illnesses/disorders. The first issue is the relatively recent tendency towards the medicalisation of normal sorrows. The second is the widening of the diagnosis 'net' since a major innovation in psychiatric nosology, the *DSM-III*. A third issue is that the diffusion of this innovation improved psychiatric diagnosis but also spread some misconceptions associated with psychiatric illness. Finally, some issues about personal responsibility are considered and whether, in this era, 'evil' tends to be medicalised. Psychiatric nosology is important: its application to mental health problems is the economic scaffolding for the correspondence of mental health expenditures and mental health 'need'.

Introduction

The Loss of Sadness is a thought-provoking and important book. It is a slender volume, but in 11 chapters, the authors present some 'big ideas', which they support with over 600 references. Their ideas cover numerous issues and are drawn from several disciplines. The authors are two American academics who have been 'tilling the field' of psychiatric nosology for decades. Horwitz is a professor of sociology at Rutgers University; and Wakefield is a professor of social work, and a professor of the conceptual foundations of psychiatry, in the School of Medicine at New York University. Their book, published in 2007, is about critical issues which have informational characteristics: psychiatric diagnosis, the conception of a mental disorder itself, the sciences underlying psychiatry and psychology, and some puzzles about current Western culture. These issues involve forces being observed at a societal level, external to everyday clinical diagnosis for depression (although some would argue that the issues here are intimately entwined in the diagnostic process).

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Arguably, Horwitz and Wakefield are implicitly alluding to a tangle that has developed in the web of knowledge about mental illness, which has occurred despite the new scientific understandings of mental illness in the latter half of the twentieth century.

It is hardly coincidental that, also in 2007, two of Australia's leading psychiatrists (both in the specialty of affective disorders) were posed the following question: 'Is depression overdiagnosed?' One of the psychiatrists, Professor Gordon Parker, presented the affirmative case, and the other, Professor Ian Hickie, argued the negative case. Parker argued a case that current criteria for mental illness are medicalising sadness; Hickie pointed out that many people are still not accessing treatment, either not at all or not enough, and that failure to do so is sometimes life-threatening. Their replies are in two incisive one-page articles in the *BMJ* (the former *British Medical Journal*).[2] Their opposing views represent an underlying concern over diagnostic processes. Interestingly, Parker concludes his case with the quip: 'As the American journalist Ed Murrow observed in another context: "Anyone who isn't confused doesn't really understand the situation"'. This review article seeks to clarify some of the informational issues underlying what will be called here 'The Loss of Sadness' proposition.

The debate is, in part, about current or contemporary definitions of mental disorder. Thus, to investigate the topics of concern requires reference here to psychiatric nosology, illness nomenclature and the widely used diagnostic manual, the *DSM*. Such topics are not the subject of everyday conversation. Often debates over the accuracy of a manual, dictionary, encyclopaedia or nomenclature on any topic can seem cloaked in profundity, and 'someone else's worry'. Psychiatric nosology certainly has some rarefied sense to it. However, to think that this topic is 'someone else's worry' misses something pervasive in all populations: opinions about depression, and about mental illnesses more generally, are widespread, tending to involve notions that readily can become well entrenched in popular and folk beliefs, and even in the practices of the providers of professional services. The histories of mental illness and of psychiatry are replete with examples of folklore about mental illness.[3]

Thus, the topic is one of general interest and concern. Issues concerning the treatments provided for mental illness, its prevention, research into the aetiology of mental disorders and who has access to services, all originate, in some part, in the relevance of the diagnostic schema, and the influence that it has on activity in the mental health sector. Several interest groups stand to benefit from a diagnosis of a mental illness, or from the process of diagnosing it. These groups include service users (and those service non-users who, despite the fact that they have a mental illness for which treatment is beneficial and available, refrain from treatment), service providers, and also payers of mental health services (whether taxpayers or private insurers), and various users and providers of legal/judicial processes.

The wider relevance of this essay is reflected in the newsworthy nature of its themes. At the time of writing, Professor Hickie was interviewed on Australian national radio by Philip Adams. One of the two authors of *The Loss of Sadness*, Professor Jerome Wakefield, was also interviewed by Philip Adams.[4] Clearly, then, there is much to suggest that this topic is important enough not to leave it just to *patricians*, *literati* and *dilettanti*.

Before proceeding, some terminology needs to be clarified. Although many people use the terms 'mental disorder' and 'mental illness' interchangeably, there is a non-specific international convention whereby 'disorder' is used when a

pathological process or the aetiology is unknown (which is nearly always the case with mental conditions), in contrast to 'illness' or disease, which generally implies a known aetiology. 'Mental disorder' is also subject to an international clinical convention. However, 'illness' can be applied to episodic or acute events of sickness. For severe and chronic conditions, the term 'serious mental illness' is often heard, whereas 'mental health problems' can be used for mild or acute conditions. 'Mental illness' is also applied to an episode in a chronic mental (as opposed to physical) condition, irrespective of the degree of severity. Note also that, with the tendency for psychiatric diagnoses to involve co-morbidity, these co-morbid conditions can be one disorder with several illnesses, or one illness incorporating several disorders. Terminology aside, a critically important distinction to keep in mind in the present discussions is that mental health conditions or states range from serious to mild, and that this distinction exists in an objective sense, i.e. irrespective of how a person views his/her own mental state, as well as there being the subjective experience.

The reader needs also to be aware of two different uses of 'the loss of sadness' in this review. One of these uses is *The Loss of Sadness*, which is the title of the book under review here. The other is denoted 'The Loss of Sadness' proposition. This is a reference to a loosely linked set of ideas about 'normal sorrow' having become 'medicalised' or 'pathologised'. These ideas are contained in the book of the same title, and other authors have discussed other perspectives on this topic. The next section will start by examining 'The Loss of Sadness' proposition presented in *The Loss of Sadness* by Horwitz and Wakefield.

The Loss of Sadness

The first chapter of *The Loss of Sadness* is entitled 'The Concept of Depression'. Here, the authors outline the growth of depressive disorder in, as the authors say, 'The Age of Depression'.[5] They present some conventional measures of this trend reported in the literature, including: the results of the epidemiological studies that show more depression in the community; the increase in the numbers of people seeking treatment and pharmaceutical prescriptions; the growth in research publications; and media attention.[6] Such trends have generally received wide publicity.

The authors then explain why it is important to distinguish between 'normal sorrow' and 'depression'. The interested reader may wish to read this chapter in conjunction with Frank Furedi's introductory chapter of his *Therapy Culture*.[7] Furedi provides a fascinating empirical insight into the media input into The Age of Depression. He does this via five, time-series graphs of a count measure of the number of citations (using *Factiva*[8]) in British newspapers from 1980 to 2001 of the following terms: 'self-esteem'; 'stress'; 'syndrome'; 'counselling'; and 'trauma'. The graphs presented by Furedi show some phenomenal rates of increase. For example, 'self-esteem', which had three citations in 1986, and 103 citations in 1990, was cited 3,329 times in 2000. The usage of 'stress' rose from approximately 1,000 citations in 1993 to around 24,000 citations in 2000. This same phenomenon is noted by Sommers and Satel who, in *One Nation under Therapy: How the Helping Culture is Eroding Self-Reliance*, refer to this age as 'an age when talking about one's feelings has become a mark of personal authenticity'.[9]

The second chapter 'The Anatomy of Normal Sadness' is a scholarly and insightful discussion of sadness. The opening paragraph encapsulates the thrust of the chapter, gracing that purpose with evocative nuances in expressive language:

> Sadness traditionally has been viewed as humanity's natural response to deaths of intimates, losses in love, reversals of fortunes, and the like. It arises, as Shelley says, because 'the world's wrong!' And when the losses and strains that evoke the sadness are profound, the resulting emotions can also be severe, seeming to defy expression. In Samuel Coleridge's words:
>
> A grief with a pang, void, dark, drear,
> A stifled, drowsy, unimpassioned grief,
> Which finds no natural outlet, no relief,
> In word, or sigh, or tear.
>
> The potential intensity of what appears to be normal sadness poses some difficult questions for psychiatric diagnosis … (p. 27).[10]

Horwitz and Wakefield suggest in this chapter that normal sadness can be characterised by three features or components: it is context-specific, roughly proportionate in intensity to the loss, and ends (more or less) when the cause stops. The second component indicates that the 'sorrow response' is the consequence of some 'real' external factor to which a person is 'legitimately' responding.[11] The authors also provide useful examples of normal sadness (e.g. bereavement, other relational loss, other significant loss such as job loss, health loss, material loss and disasters, chronic stress, etc.) and they consider the various possible causes of normal sadness. They also consider several issues arising with cultural differences over normal sadness.

In Chapter 3, 'Sadness With and Without Cause', the authors provide a brief account of depression in various literatures through history. They point out the omnipresence of depression as an experience of humanity, although explanations of depression have varied through time. In reference to Ancient Greek and Roman times, the authors comment that depression was conceived of at that time in an 'essentialist' frame of mind. Putting this idea most simply, depression was regarded as being 'sadness without cause'. This conception arose again in the Renaissance. In other words, there is already a long-standing tradition of perspectives about depression that distinguishes those depressive disorders that are a form of 'madness' (with no pejorative meaning) from 'nondisordered' sorrow. The authors then note that a significant change in perspective occurred in the 1980s: despite some 'admirable scientific aspirations' (details discussed next), the 'critical traditional distinction' (between normal sorrow and depressive disorder) was 'inadvertently abandoned' (p. 53).

The remainder of the book turns to investigate the post-1980s era in further detail. Chapter 4, 'Depression in the Twentieth Century', is a scholarly account of the conceptions of depression that occurred in the latter half of last century in particular, an era of great changes, almost lurches, in conceptual developments in psychiatry. (There is insufficient space here to record their discussions of the roles of such figures as Kraepelin, Freud, Meyer, etc. in the earlier part of the twentieth century.) Let us instead focus on Horwitz and Wakefield's discussion of the particular innovation (although they do not use this word) in psychiatric nosology that occurred in 1980. This innovation was the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* ('the *DSM-III*') by the American Psychiatric Association.

The *DSM-III* can be seen as a breakthrough in several ways, largely due to the dedication of Robert Spitzer.[12] It certainly was heralded at the time as an advance,

being regarded overall as a more scientific approach to psychiatric classification. The importance of the *DSM-III* as an innovation cannot be underestimated. For example, in *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, Edward Shorter carefully demonstrates the scientific importance of the basic task undertaken in the preparation of 'the *DSM-III*' of data gathering about psychiatric conditions. The extensive listing of symptoms and conditions in the *DSM-III* fostered this process. The significance of this edition of the *DSM* is further understood by Shorter's record of the ethos at the time in psychiatry with respect to diagnosis. This ethos can be appreciated by Spitzer's reference to the American Psychiatric Association's meetings in the 1960s, on which Shorter records the following observation: 'The academic psychiatrists interested in presenting their work on descriptive diagnosis would be scheduled for the final day in the late afternoon. No one would attend. Psychiatrists simply were not interested in diagnosis'.[13] It is now widely acknowledged that 'the *DSM-III*' improved diagnostic reliability for many mental disorders. It also was thought to have lowered the 'false negative' rate.

However, Horwitz and Wakefield point to some severe problems in that approach to classifying depression. The source of the problem, they argue, is the criterion-based approach that had been developed by John Feighner and his group at Washington University, St Louis in 1972. Their purpose was that of 'tightening up' diagnostic practices at that time.[14] This first criteria set was formed specifically for depression (since referred to as 'the Feighner criteria').[15] Spitzer then generalised criteria for other conditions in the *DSM-III*, and he called this the 'Research Diagnostic Criteria' (RDC). The purpose of Feighner *et al.* was to propose a set of criteria that based classification not on 'best clinical judgement and experience'[16] but on fixed criteria that had to be met in order that a patient be classified with a diagnosis. The research community heralded the Feighner criteria and in 1989, the article 'was the single most cited article in the history of psychiatry' (p. 95). It was further welcomed because it was, in a sense, the response for its time, i.e. to some other challenges confronting psychiatry.[17] There is a lovely account of this in Chapter 4. For an extensive historical account of psychiatry, other than Shorter's, see Stone.[18]

If one adopts the perspective that the *DSM-III* was an innovation in psychiatry, then it can be argued that the RDC approach underwent diffusion. This occurred easily and widely, first through Spitzer's own drive to improve psychiatric nosology. The avenue for the diffusion was the incorporation of an 'RDC approach' into the *DSM* (thus freeing the *DSM* from its former Freudian, and other, binds). Thus, the RDC approach became disseminated via the *DSM* itself.

Such a chain of events might be thought to be 'a good thing' for promoting scientifically-based diagnosis amongst mental health professionals; but Horwitz and Wakefield argue that the *DSM-III*, in one fell swoop, 'inadvertently rejected the previous 2,500 years of clinical diagnosis tradition that explored the context and meaning of symptoms in deciding whether someone is suffering from intense normal sadness or a depressive disorder' (p. 103). In an ironic twist for the advances in the correct diagnosis and treatment of mental illness, some of the traditions of folklore had perhaps also served a place in understanding mental illness. The implication is that the diffusion of the *DSM-III* worsened the false positive rate for several types of diagnoses.

Moreover, since the *DSM-III*, depression has become a far more heterogeneous diagnostic category. Shorter also makes reference to another phenomenon associated with this process of diffusion, in terms of what forces shaped the *DSM*. Some

other forces are apparent in the clash of political interest groups that have been recorded, and the resultant squabbling:

> Politics represented a final pothole on the high road of science for the *DSM-III* drafters. Even though they were struggling to cling to 'the data', they were buffeted by ideological lobbies and forced to make a series of concessions. All this negotiating left the impression that what the drafters had created was as much a political document as a scientific one.[19]

For example, the state of homosexuality and its practice were fiercely debated for exclusion and (since *DSM-III*) homosexuality and its practice is no longer automatically assigned a psychiatric diagnostic category.[20] The point here is not to enter into the issue but to note that, contrastingly, sexual addiction (including pornography addiction) is not assigned a separate diagnostic category in *DSM-IV*, and is managed by subsuming it under various disorders. However, it is regarded analogously to other addictive disorders, such as the substance abuse disorders that *are* listed separately in the *DSM*.[21] Sexual addiction has not been hotly debated in the public domain for inclusion in the *DSM*.

The authors' arguments are developed further in several chapters. In the first of these chapters, which they call Chapter 5, 'Depression in the *DSM-IV*', they show that the Feighner criteria and the *DSM* were not the only factors driving the trend. In Chapter 6, 'Importing Pathology into the Community', Horwitz and Wakefield outline the stages by which this subtle transformation of society occurred: this chapter highlights how the fallacies expanded and the rate of false positive diagnoses grew. In the next chapter, 'The Surveillance of Sadness', the trend in routine screening for depression that overtook American society is examined. In Chapter 8, 'The *DSM* and Biological Research about Depression', the authors examine some evidence about the brain states of normal sadness and depression. They argue that

> people experiencing sadness may have some of the same biological markers as the truly depressed. Thus, showing a biological substrate to a condition of intense sadness symptoms that satisfy *DSM* criteria is not enough to indicate whether that substrate … is normal or disorder (pp. 177–8).

The context in which sadness develops 'matters'. The chapter called 'The Rise of Antidepressant Drug Treatments' (Chapter 9) investigates an underlying bias in pharmacological research with respect to normal sorrow being treated with medication at all. Chapter 10, 'The Failure of the Social Sciences to Distinguish Sadness from Depressive Disorder', involves an argument by Horwitz and Wakefield that some recent faddish tendencies in the research agenda of anthropology and sociology (such as political correctness, post-modernism etc.) have caused these disciplines to overlook useful knowledge for the aforementioned debate. This point will be elaborated below. The book concludes in Chapter 11. Its conclusion will be discussed below.

This section concludes by returning to a comment made by Robert Spitzer, the psychiatrist who headed the APA's taskforce that created the *DSM-III*. It is particularly noteworthy that Spitzer, that remarkable force behind the *DSM-III*, wrote the foreword to *The Loss of Sadness*. Spitzer regards *The Loss of Sadness* as 'the most cogent and compelling "inside" challenge to date to the diagnostic revolution that began 30 years ago in the field of psychiatry' (p. *vii*).

Having outlined the book's contents, this review will proceed directly with a discussion of The Loss of Sadness proposition. Doing so poses some difficulty in the space limitation here because meaningful discussion is predicated upon knowledge of some very important information about diagnosis *per se*, the processes of psychiatric diagnosis, and the deficiencies, and various technical details about psychiatric nosology. A discussion of these matters is available in the working paper version of this article in a section entitled 'The Information Bases of Mental Diagnoses'.[22]

The 'Medicalisation of Sorrows': a 'False Positive' Argument

This essay considers the Loss of Sadness proposition specifically from the perspective that medicalising sorrow can lead to an increase in the number of false positives being treated in mental health settings. It is also suggested that there is some likelihood that two of the key sources of this trend involve psychiatric nosology (and its application in the clinical setting) and some attitudes and habits presently in Western culture. These two sources continue to be discussed in this section. The point is made that diffusion (the process by which new technology is adopted) can occur not just for good ideas but misconceptions. Incorrect notions can be subject to diffusion. 'Bad ideas' can be 'catchy' when the conditions are right for them to be received into the 'channels and repositories' of the knowledge shared by people.

Few people would debate the notion that unpleasant emotional or psychological experiences are a common occurrence in humanity's 'daily grind'. However, *The Loss of Sadness* is part of a larger academic literature about various aspects of this phenomenon, which entails the so-called Age of Depression. This broader literature often mentions a term 'medicalisation', which is some terminology used largely in reference to mental health states that are at the milder end of a spectrum of severity. A definition of medicalisation is provided by Peter Conrad, who sees this phenomenon as 'a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses and disorders'.[23] Some of Conrad's examples include post-traumatic stress disorder and attention-deficit hyperactivity disorder. Human conditions once commonly considered 'normal' have been transformed into medical ailments and treatable disorders.[24] Conrad also cites the arguments of Clarke *et al.* about medicalisation as 'one of the most potent transformations of the last half of the twentieth century in the West'.[25]

There is now a plethora of other, thought-provoking books with titles like *The Loss of Sadness*, including *Shyness: How Normal Behaviour Became a Sickness*; *The Worried Well*; *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*; *Creating Mental Illness*; *Against Happiness: In Praise of Melancholy*; *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression*; *Prescriptions for* the *Mind: A Critical View of Contemporary Psychiatry*; *The Age of Melancholy: Major Depression and its Social Origins*; *Comfortably Numb: How Psychiatry is Medicating a Nation*; *One Nation under Therapy: How the Helping Culture is Eroding Self-Reliance*, and so forth. Most of these titles are not the works of popular journalism but serious academic studies concerned with the content of psychiatric diagnosis and classification. Not only do psychiatrists puzzle over the definition of mental disorder, and appropriate diagnostic and classification schema, but also philosophers, sociologists, psychologists, social workers, psychiatric nurses, counsellors, lawyers, epidemiologists, biostatisticians, service users themselves, and the occasional economist.

Medicalisation was first discussed by a medical sociologist and scholar of disability, Irving Zola in the early 1970s.[26] Shortly after, Ivan Illich also wrote on medicalisation, in his much-quoted 1975 book, *Limits to Medicine*.[27] According to Illich, the medical establishment ought to be seen as a 'threat to health', not only because it tends to produce clinical, social, and cultural iatrogenesis, but also because there is the Western tendency to medicalise life, death and dying. This trend causes individuals and societies to be less able to deal personally with those 'natural' processes. Thereafter, the notion of medicalisation became commonplace in the various literatures. Note that Illich applied his argument in broad terms, i.e. to general health, not to specific mental health issues.

In more recent times, it has been suggested with respect to mental health issues that the original 'engines of medicalisation' have now shifted: 'the availability of new pharmaceutical and potential genetic treatments is [sic] increasingly drivers for new medical categories'.[28] This observation has been examined carefully in a book-length treatment of the pharmaceutical industry by Healy, a Reader in Psychological Medicine at Cardiff University. Healy documents an 'unhealthy relationship', which he has observed first-hand between the pharmaceutical industry and depression.[29] A similar phenomenon is now documented regarding the history of amphetamine.[30]

An earlier influential, though contrasting, 'engine' was the 'anti-psychiatry movement' of the 1960s (Szasz,[31] Laing[32] etc.). This view maintained that psychiatry does not exist in a political or cultural vacuum. These scholars went so far as to contend that the classifications of sickness by psychiatry were arbitrary. Anti-psychiatrists argued that diagnoses were far too dependent upon opinion, given the unavailability of definitive diagnostic testing; the context in which symptoms were reported and interpreted had become too dominant. At that time, there was also Kesey's (1962) novel, *One Flew over the Cuckoo's Nest*, later a film, which also influenced public perceptions. It appears that the ideological environment of the 1960s–70s, like the availability of anti-psychotic medications, became one of the 'enabling factors' in deinstitutionalisation (referred to by Doessel[33]). This, in turn, enabled the acculturation of a 'comfort zone' for mental illness *per se* in 'the community'. Thus, mental illness was transported from the edges of cities, where the asylums had been located, to inner-city ghettoes, and to suburban lifestyles, a cultural setting of relatively lesser stigma. Szasz (who is still alive at the time of writing, October 2008) once argued strongly that socio-political viewpoints continue to determine 'appropriate' and 'inappropriate' behaviours. He also maintains a strong stand that 'mental illness' is largely a fictitious construct having no 'true' medical basis. That view is now challenged by new knowledge.[34] The manner in which Wakefield and Horwitz, and others, address some of these concerns about psychiatry will now be discussed.

In a separate article, Wakefield refers to there being a lack of distinction between mental disorder and 'nondisorder problems of living'. Wakefield is quite specific in what he regards to be some examples of 'nondisorders': 'normal intense emotional reactions, social deviance, conflict between an individual and social institutions, personal unhappiness, lack of fit between an individual and a specific social role or relationship or environment, and socially disapproved or negatively evaluated behavior'.[35] He comments also that blurriness in this distinction is not a new phenomenon, but has 'evolved into a new form' (i.e. the anti-psychiatry movement is 'no longer a potent force').[36]

Another scholar who discusses a practical implication of the conflation of 'normal sadness' and 'depressive disorder' is Kirk whose argument can be understood by the following:

> The same intense sadness that satisfies *DSM* criteria for the diagnosis of major depressive disorder could be indicative of genuine depressive disorder in which something is wrong with one's sadness-response mechanisms, or it could result from a normal response to a serious loss; the same antisocial conduct that satisfies *DSM* criteria for the diagnosis of conduct disorder or antisocial personality disorder could be indicative of a genuine mental disorder resulting from a dysfunction in, for example, the sense of empathy, or it could be the result of a normal response to adverse, deprived, or otherwise criminogenic environments; and the same intense anxiety that satisfies *DSM* criteria for a diagnosis of generalised anxiety disorder could be indicative of a genuine anxiety disorder that involves inappropriate triggering of anxiety response mechanisms or it could indicate a normal response to overwhelming environmental demands.[37]

However, it should be noted that 'the *DSM*' does make some very clear distinctions that the grief due to loss of a loved one is 'normal sadness' and is not, or not necessarily, clinical depression.

Wakefield argues that the definition of mental disorder provided by the *DSM-III* has attempted to distinguish 'mental disorders in the medical sense from social deviance and other kinds of personal and social problems'.[38] However, it then created categories for 'nondisorders' too. This category, Wakefield argues, is found in the 'V-Codes', i.e. 'Conditions not Attributable to a Mental Disorder that are a Focus of Attention or Treatment'. Examples of the phenomena found in the V-Codes are Partner Relational Problem (V61.10), Sibling Relational Problem (V61.8), Academic Problem (V62.3), Occupational Problem (V62.2), Acculturation Problem (V62.4), and a Phase of Life Problem (V62.89), among others.

This is not to suggest that Wakefield regards the *DSM-III* as of no use. To the contrary, the fact that the *DSM-III* provided theory-neutral definitions of each disorder was an enormously important advance: '[It] improved reliability and contributed to valid differentiation'.[39] This is not trivial. It is a key factor in improving the evidence about the aetiology of mental illness which can be observed by a biological basis.

However, the key point of Wakefield's focus ought not to be, as he puts it, 'on whether mental disorders exist at all but rather on whether mental health professions, using *DSM* criteria, are overdiagnosing in such a way that many kinds of human problems are deemed pathological'.[40] While his challenge seems as if the social control and mislabelling arguments of the old anti-psychiatry movement have re-emerged, it is 'much more subtle and targeted, and is not inherently antagonistic to the broader goals and conceptual approach of psychiatry'.[41] In fact, Wakefield goes so far as to describe this tendency to over-inclusiveness as 'the false positive problem'.[42]

It is relevant to give further consideration to some of the sources of 'medicalisation'. Let us first return to Horwitz and Wakefield's book because, in Chapters 2, 8 and 10, there is a discussion of the place of cultural values. They undertake this discussion by considering what is known about the mechanisms underlying human responses to loss. They contend that there is a lack of scholarship about the universal loss responses of humanity, and those that are culturally unique. They argue that knowledge about the universal responses to loss is very useful data for clarifying the distinction between normal sadness and depressive disorders;[43] this knowledge base is very underdeveloped. They provide two areas where gaps

have emerged. One gap lies in the discipline of anthropology, a discipline that is well-equipped for examining the distinctions of culturally specific loss-responses from those that are 'typical functionings'. According to Horwitz and Wakefield, anthropology has narrowed its focus since the 1980s and has tended to become parochial in studying normality and pathology. In this process, anthropology has neglected the study of 'generalisations that apply across cultures to all humanity' (p. 201). It has missed the importance of the accumulation of such knowledge; this knowledge would have provided some needed universal statements to psychiatry and psychology, but it is not available.

The authors make similar observations about some recent emphases in the discipline of sociology. Horwitz and Wakefield observe a dominant sociological paradigm in respect to mental health studies. One example of this tendency is in the study of 'the sociology of stress'. Such studies ought to involve sociological investigation into the psychological consequences of social arrangements that are stressful. However, according to Horwitz and Wakefield, several relevant topics are being overlooked: 'any delineation of disorder and distress' is lacking in studies, and 'sociologists have failed to appreciate that current studies in sociology conflate two different domains of research … the consequences of normal distress of various stressors and positions with the social system … (and) genuine mental disorders that severe social stressors can cause or trigger' (p. 205). In all, Horwitz and Wakefield conclude that '(a)nthropological and sociological studies have helped perpetrate the conflation of normal sadness and depressive disorder and have been "enablers" of psychiatry's own overinclusive definitions of disorders' (p. 194).

Sometimes in scholarly literatures, a few 'creative writers' approach a subject from a humorous angle. This has been exemplified from time to time in those academics who engage in the art of the spoof to convey their message (as is the case with the so-called 'Sokal affair'[44]). Another example (not a spoof) is mentioned by Sommers and Satel. In their Preface,[45] they refer to an entertaining, but provocative, 'neurodevelopmental analysis', using *DSM* criteria, of the children's tale, *Winnie the Pooh*, by A. A. Milne.[46] It seems poor Pooh has a few disorders, not to mention having Very Little Brain; and Pooh is *not the only one* in The Hundred Acre Wood with problems.[47] The *Canadian Medical Association Journal* published this article under a heading 'Research of a Holiday Kind' for the December 2000 issue. Mentioning this article here is not to trivialise the scientific bases in mental health diagnoses but to note that these children's characters of A. A. Milne's creation are 'rich in personality', and the stories revolve around problem-solving and very personalised 'helping out' of one other in their community.

Let us now examine some further forces relevant to the medicalisation of sorrow. Conrad has suggested two. First, he comments that there are now many more diagnoses available: 'a wide range of new medical categories' which, he says, have emerged in the past four decades.[48] These include attention-deficit/hyperactivity disorder, anorexia and eating disorders, chronic fatigue syndrome, repetitive strain injury, fibromyalgia, premenstrual syndrome, and multiple chemical sensitivity disorder. His second point is that

> there are numerous reasons for seeking new medical diagnoses. Life's troubles are often confusing, distressing, debilitating, and difficult to understand … and a medical diagnosis transforms … an agglomeration of complaints and symptoms … into an entity that is more understandable … In some instances a

> diagnosis can be a kind of self-labeling [*sic*] that provides a new public identity … In other cases, it may facilitate treatment …

The outcome of these forces, according to Conrad, is 'hardly surprising to see individuals embracing medicalisation'.[49]

Another force that is relevant is a setting where public perceptions develop, *viz.* the Arts. The Arts is a long-standing cultural setting for the portrayal of both contemporary and enduring perspectives about the mental states of humanity. For example, of Shakespeare's tragedies, Bloom notes that Shakespeare invented 'ways of representing human changes, alterations not only caused by flaws and by decay but effected by the will as well, and by the will's temporal vulnerabilities'.[50] Now in the present era, two quite opposing perspectives can be observed. On the one hand, one can find performance works for which the mental illness is a vehicle, and one can also find works where mental illness *per se* is portrayed. An example of the former is Jenny Kemp's 'Kitten'. In 'Kitten', mental illness is marketed. Kemp markets 'Kitten' as a 'bi-polar soap opera', a 'psychiatric fable'.[51] Also in this genre is Kemp's 'Madeline' (still in development), which she advertises as a 'schizophrenic tragedy'. In the modern era, the theatre can be seen as portraying mental illness as something that gives a person legitimacy: this view is not the 'reality' of mental illness. On the other hand, there is Neil Cole's 'Alive at Williamstown Pier' and 'Topo the Play',[52] both of which are examples of the second type, in which mental illness *per se* in portrayed. Also in this genre is a play by lawyer-playwright, Suzy Miller. She is currently writing 'Truth', which examines what leads children to commit acts of murder.[53]

It is relevant now to comment on yet another phenomenon, i.e. stress. Stress is one of the terms which was mentioned in the Introduction (above), on which Furedi undertook newspaper searches using *Factiva* and found its usage in language has flourished in the short space of 20 years. Whilst 'stress' is known to be associated with mental health problems,[54] whether or not it is a causal or precipitating factor in mental illness is still debated in scholarly circles. The biological basis of stress in mental illness is not yet well understood. Stress itself lacks consistent definition.[55] Concurrent with the biological limitation to knowledge of this subject, the definition of stress is much influenced by public perception.[56]

Stress as a phenomenon in mental health gained prominence after 1967 when Graham Goddard (cited by Stone[57]) first presented, in another setting, *viz.* epilepsy, what soon became known as the 'kindling' theory. He observed that stress leads to structural changes in the sufferer's brain. This happens via feedback effects. The brain then re-forms and behaviour changes in response to that.[58] With epilepsy, the feedback theory seemed to explain the build-up mechanism that occurs prior to a seizure. Ballenger and Post subsequently postulated a similar mechanism for kindling in regards to mood disorders, particularly bipolar disorder;[59] for a non-technical account, see Kramer.[60] If there is a scientific basis to kindling, it is still debatable; and it certainly is not fully known, as many of the parameters and mechanisms are presently elusive. However, the relevance here is that stress now has a folk interpretation. Post's idea is metaphorically powerful: the folk perception of stress was initially an innovative explanation for some processes that are understandable in folk perceptions, and has undergone diffusion throughout the places where lay interpretations of illness form. Despite the fact that kindling has as yet unproven aetiology, it is stated as a truism in self-help web-sites etc. about bipolar disorder.[61]

Clearly, the spread of folk understanding of mental illness has played a critical part in the development of some recent Western cultural 'habits' about mental health services. For a further account of the tendency, in psychology, for the diffusion of suggestions and hypotheses to occur as those thoughts were axiomatic, see Burnham's *How Superstition Won and Science Lost: Popularising Science and Health in the US*.[62] Note also Zachar's comment about the problem of folk taxonomies, as follows:

> it biases thinkers to believe that they have discovered a final God's-eye view of their subject matter, encourages them to adopt beliefs about the fixed inherent structure of a category, and allows them to maintain that those beliefs are supposed to be true in all possible worlds.[63]

A related social process which can be observed is a notion which Wakefield has developed (prior to his book with Horwitz) which Wakefield refers to as harmful dysfunction.[64] In several articles, Wakefield suggests that mental disorders can be conceived of as two distinct components: the component of 'dysfunction' represents the failure of a mechanism in a person to perform its natural function, which is the mechanism designed by natural selection; and the 'harmful' descriptor which involves a value judgment about the dysfunction being undesirable. For a critical view of Wakefield's argument, see Murphy and Woolfolk.[65]

Mental illness will now be placed in a broader context.

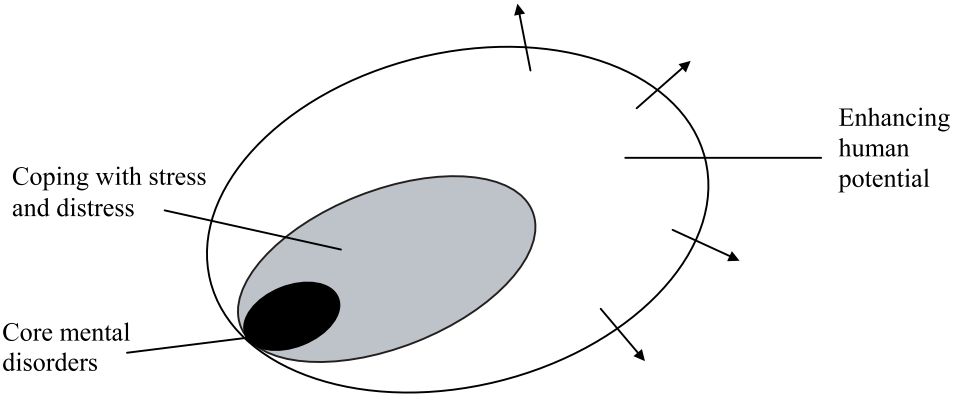
The Spectrum of Mental Conditions and 'Structural Imbalance'

It is instructive to place The Loss of Sadness proposition into an economic framework. One can proceed by posing the following question: does it really matter in a democratic country if some people who have no diagnosis or a mild diagnosis seek professional help for their sorrows? This question can be answered by considering some trends across the broad spectrum of disorders in recent decades. These trends are influenced by books, newspapers, the arts and the media. They have economic implications.

One trend has been described above, *viz.* that normal phenomena (disappointments, stresses of daily life, everyday sorrows, etc.) have become 'medicalised'. As described above, a 'depression culture' has developed. The outcome is that mental health services are being sought for 'normal sorrows' and the general stresses of everyday life. Alongside this trend is another: the expansion of a 'growth and potential' market, where a concern has developed to attain one's maximum personal human potential.[66] A third, related, trend is the growth in service providers whose interest is in mental health phenomena other than mental illness. Some mental health professionals take an interest in these phenomena, examples of which are performance in sport[67] and bureaucratic executive life,[68] as well as those 'worried well'[69] who are subject to the forces of The Loss of Sadness proposition.

These related phenomena can be considered as a continuum: from mental illness, mental health to human potential. Figure 1 is one approach to illustrating this continuum.[70] The enlargement of the area of 'core mental disorders' can occur as a result of medicalising and pathologising various behaviours through time; and the expansion through time of the boundaries of human potential can also occur due to the trend in performance enhancement.

This figure also illustrates another long-standing issue in the mental health sector, which is often referred to as 'unmet need'. It is detailed in numerous



Source: G. Klerman and G. Schecher, 'Ethical aspects of drug treatment', in S. Bloch and P. Chodoff (eds), *Psychiatric Ethics*, Oxford University Press, Oxford, 1981, pp. 117-30.

Figure 1. The diagnostic spectrum.

reports, in Australia for example, which document the inadequacy of facilities for the provision of mental health services.[71] 'Unmet need' is used in reference to specific sub-groups, such as people with schizophrenia, those who have attempted suicide, Aboriginal and Torres Strait Islander, low-income countries etc.,[72] and also in more general analyses of data from national, population-based representative sample surveys to determine prevalence and service utilisation of people with mental illness. For example, with respect to the United States, the two most important studies were the Epidemiologic Catchment Area (ECA) study[73] and the National Comorbidity Study,[74] both of which have been mentioned above.

Other evidence can be seen in the various Australian government reforms in the mental health sector, such as the National Mental Health Strategy,[75] and the more recent Council of Australian Government (COAG) reforms,[76] which are attempts by governments to respond to 'unmet need' in this country. The 2005 report by the Mental Health Council of Australia, captures the situation regarding mental health resources by the following point: despite 12 years of mental health reform 'any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected'.[77] See also Hickie *et al.*[78]

Some general discussions of 'unmet need' have also been provided by Andrews and Whiteford.[79] Andrews provides some useful definitions: unmet need refers to people 'who meet criteria for a [mental] disorder and do not see a clinician'; met need relates to 'people with a [mental] disorder who see a health professional', and 'met non-need' applies to 'people who have no current mental disorder and yet are consulting clinicians for mental problems'. A fourth category *viz.* 'unmet non-need' (not defined by Andrews) is those people with no mental illness who do not use mental health services. These definitions have been given some empirical specification by Doessel, Williams and Nolan, via data from the national survey of *Mental Health and Wellbeing*.[80]

The point of this discussion is that there is not just the problem of resource shortage (in an absolute sense) in the mental health sector, but another problem, which elsewhere is described as structural imbalance.[81] Structural imbalance in the mental health sector occurs when unmet need (people with a mental health

diagnosis not using mental health services) exists alongside met non-need (some consumers of mental health services having no mental health diagnosis). Structural imbalance is a manifestation of the economic concept of resource misallocation. In the context of this review article, *The Loss of Sadness* sheds further light on what Andrews and Whiteford (above) both mean when they refer to 'met non-need' in the mental health sector: it is further indication of the existence of structural imbalance in the mental health sector.

Attention will turn now to a likely factor that has caused the middle area in Figure 1 above, depicted to represent the general stresses of everyday life, to expand.

The Expansion of the Diagnosis 'Net'

Generally speaking, the purpose of medical nomenclature is clinical. That is, nomenclature exists for communication purposes between service providers, treatment decision-making, data recording purposes and so forth. It is interesting to note, however, that nomenclature in new areas of discovery is not necessarily stable. Definitions and classifications change as knowledge is discovered. In regard to psychiatric nomenclature, the number of diagnoses has increased enormously during the twentieth century. At the start of that century, the conditions recognised as being a psychiatric disorder were few. Depending on what time period, and country, there were diagnoses which included mania, melancholia, monomania, paresis, dementia and epilepsy. 'Madness' or 'insanity' are words that have been applied both pejoratively and compassionately in the past, but as a classification, these words were reserved only for inappropriately disruptive, withdrawn or very strange behaviour. Other forms of distress, of the milder kind, were different, and were classified as 'nerves', 'hysteria', 'lovesickness' or 'neurasthenia'. Stone gives a careful historical account of pre-twentieth century definitions and diagnosticians.[82]

During the twentieth century, the 'net' of diagnostic categories of mental disorders expanded. The first *DSM* in 1952 listed 106 disorders contained in a manual of 130 pages. By 1994 *DSM-IV* listed 297 conditions in a manual of 886 pages, as detailed in Table 1. For an account of the widening process, see Spiegal.[83]

Some will argue that the increase in the number of diagnostic categories suggests an improvement in psychiatry's practices because it indicates careful recording of all the possible different ways in which mental illness manifests. Others might wish to argue that this widening is an example of medicalisation.

Table 1. The number of pages and number of diagnoses contained in sequential versions of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, various)

Basis of nomenclature	Year	Total no. of diagnoses	Notes
ICD-6	1949		A section on mental disorders is included for the first time in the *ICD*
DSM-I	1952	106	130 page manual
DSM-II	1968	182	134 pages manual
DSM-III	1980	265	494 pages manual
DSM-III-R	1987	292	567 pages manual
DSM-IV	1994	297	886 pages manual

It is instructive now to ask ourselves about what perspective the law adopts in regards to what can be 'admitted' as a mental disorder in a criminal matter. A useful discussion of this topic is contained in a *Discussion Paper* of the recent Review undertaken in the State of Queensland. (Each State and Territory of Australia has a Criminal Code, and each differs from any other in some details; the Code for the State of Queensland is employed here for the purpose of illustration.)

The Queensland *Mental Health Act* applies the following definition of mental illness, which is given in Section 27 of the Criminal Code: a person

> is not criminally responsible for an offence if, at the time of the offence, the person was in such a state of mental disease or natural mental infirmity that they were deprived of the capacity to understand what they were doing; or to control their actions; or to know that they should not do the act or make the omission constituting the offence. 'Mental disease or natural mental infirmity' does not include a personality disorder or a situation where the mental disorder was caused by rage, jealousy or intoxication.

This definition involves long-standing concepts: English law 'accepted insanity as a defence to a criminal charge nearly two hundred years ago'; and that concept 'was enshrined in the Queensland Criminal Code at the beginning of last century'. In other words, the Law has not shifted its goalpost on this aspect of mental illness. Note also that the above approach 'does not ignore the nature and seriousness of the act committed by the person but focuses on treatment of their condition and protection of the person and others, rather than on punishment'.[84] In the state of Victoria, there is the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. This has replaced the common law defence of insanity with a statutory defence of mental impairment. The *Act* applies the following definition:

> A person is unfit to stand trial for an offence if, because the person's mental processes are disordered or impaired, the person is or, at some time during the trial, will be—(a) unable to understand the nature of the charge; or (b) unable to enter a plea to the charge and to exercise the right to challenge jurors or the jury; or (c) unable to understand the nature of the trial (namely that it is an inquiry as to whether the person committed the offence); or (d) unable to follow the course of the trial; or (e) unable to understand the substantial effect of any evidence that may be given in support of the prosecution; or (f) unable to give instructions to his or her legal practitioner. (2) A person is not unfit to stand trial only because he or she is suffering from memory loss.[85]

Clearly, there is no continuum in the above conceptions of mental impairment in a person. In such a case, this is 'the core' of the core mental disorders of Figure 1. For example, in Queensland, 'rage, jealousy or intoxication' involves choice, understanding and responsibility prior to an event, according to the Queensland Criminal Code.

The purpose of stating the content of the legal definition of mental disorder is in order to contrast that definition to the content of the definitions in the *DSM-IV* and the *ICD-10*. The medical definition or 'characterisation' of mental disorder in those documents is broader than it is for those who deliver services for the Criminal Code. This seems largely related to the provision of health services for mental conditions which entail concepts that 'widen the net' considerably.

Whilst it is generally acknowledged that the widening of the diagnostic net was important for scientific reasons, not all agree as to the healthiness of its impact. Furedi takes a critical position about some of the new definitions: 'Today's cultural elite may lack confidence in telling people what to believe but it feels quite comfortable about instructing people how and what to feel' and 'It is truly a regrettable state of affairs when so many of us seek solace and affirmation through a diagnosis'.[86] Furedi suggests also that 'the therapeutic imperative is not so much towards the realisation of self as the promotion of self-limitation' and 'not so much the promotion but the distancing of the self from others'.[87] He notes that there is also a dominating trend:

> Although in competition with other currents, therapeutic culture has acquired a powerful influence over the conduct of individual behaviour. It has no monopoly over the way society gains meaning over life, but it is arguably the most important signifier of meaning for the everyday life of the individual

and 'From the perspective of today's therapeutic ethos, therapy is much more of an instrument of survival than a means through which enlightenment is gained'.[88] In this context, see also Doessel's review article on happiness.[89]

It is also important to note in this context that each point along the continuum in Figure 1 has some basis in definitions, distinctions and classifications of mental disorders. The previous sections have highlighted some present-day informational tangles about mental illness. It is appropriate now to re-examine the fundamentals of the information bases of mental diagnoses.

The Diffusion of Misconception (Again)

A theme in this review article is the argument that despite scientific advances in knowledge about mental illness, and although mental illness is now less stigmatised, considerable evidence of misconception about mental illness still exists. It is also argued that both the advance in knowledge (of mental illness), and misconception too, are subject to the forces of diffusion. It is re-iterated that the focus of discussion of these forces in *The Loss of Sadness* is on just one mental illness (depression), but this essay clearly has paid attention to all mental illnesses. This is because the forces causing the misconceptions over depression seem to be pervasive: analogous phenomena are being reported for mental disorders other than depression. Some authors suggest that 'medicalisation' is an indicator of the problem. There has developed in Western society a set of expansive and blurred beliefs about the definition of mental illness.

A final focus for the arguments above can be provided by recourse to the effects of the phenomena that have been described. If there is any substance to these arguments, then two testable hypotheses would be verified, as follows. First, despite the lacunae of medical knowledge of mental illness (with a full armamentarium of efficacious therapies not available, and the alleviation of symptoms often being the best available outcome), a rising temporal utilisation of per capita psychiatric services would be found. (Note, the occurrence of a rising trend in per capita service utilisation may also arise in the allied mental health services, such as the services of psychologists, counsellors etc. However, depending on the types of mental conditions that all the various mental health service providers treat, such a trend may complement that for per capita psychiatric services, or it may replace

those services.) A related testable hypothesis is as follows: despite the existence of some efficacious therapies for core mental illnesses, the unmet need does not decline, i.e. there is no negative trend in the per capita utilisation of psychiatric services. Testing these hypotheses requires data on both underlying prevalence and service utilisation.

Let us turn now to some other final matters. Horwitz and Wakefield make an important point in their concluding chapter, which they make in the light of their 'Loss of Sadness' proposition. They state in this chapter that much of the underlying confusion can be found in the scientific conception of 'disorder'. They point out that an objective concept such as 'disorder' has its opposite (non-disorder) and that these two states can actually be clearly conceived and defined. Whilst there may be some fuzziness in the boundaries of the definition, that fuzziness does not preclude the existence of a definition. Horwitz and Wakefield suggest that it is quite correct to conceive of objective concepts (the essential definitions) alongside continuous distributions. A range of 'fuzziness' around the essential phenomenon:

> Continuous distributions in nature are completely compatible with objective concepts, although it is true that the fuzziness of the concept means that fixing an exact boundary for practical purposes will indeed be more likely to depend on social values and conventions than objective facts. For example, there are real differences, rooted in biological facts, between children and adults, between being asleep and being awake, between normal and high blood pressure, and between the colours black and white … (p. 218).

This fuzziness seems similar to the notion of 'zones of rarity' mentioned by some psychiatric epidemiologists in the working paper version of this article.[90] The *DSM* adopted the Feighner criterion for diagnostic purposes. Fuzziness in symptoms at the boundaries of a range of 'mental types of illness/syndromes' needs to be recorded in order for the scientific basis of psychiatric nosology to be strengthened. However, some the objective core concepts underlying a mental illness nosological category also became fuzzier in the *DSM-III*. It seems that the Feighner criterion caused some fuzziness in the core concepts of some diagnostic categories.

Let us now re-consider the widening of the 'diagnostic net' of illness, alongside the tendency to resource misallocation described above regarding the mental health sector. These trends have several consequences. Two further examples will now be provided. First, it is instructive to review here the perceived widening of the incidence of post-traumatic stress disorder (PTSD). This trend was due to a belief that developed that a type of therapy, Critical Incident Stress Intervention, ought to be applied obligatorily and indiscriminately after a traumatic event. For example, this occurred in some parts of the world, such as after the World Trade Center attacks in New York. That approach to response is now subject to criticism. There are now some arguments that this approach to intervention has quite adverse results: it can undermine natural resilience to trauma stress; at best, some types of intervention are ineffective and, at worst, they actually cause psychological harm.[91] It has recently been argued that the appropriate approach to post-trauma intervention is found in terms of principles of 'psychological first aid', an effective, evidence-based response to a traumatic event.[92]

Second, it is useful to consider briefly an anecdote told by the reviewer of a book, *The 21st Century Brain: Explaining, Mending and Manipulating the Mind*, by Steven Rose (who is a Professor of Biology and Neurobiology at the Open University and University

of London).[93] The reviewer, John Cornwall, commences with an anecdote about the prosecution of Dan White in San Francisco in 1978 for the murders of George Moscoine and Harvey Milk. Shortly before the action that resulted in the deaths of these two people, White had over-indulged on 'sugar-ice Twinkie cakes'. White was found guilty of involuntary manslaughter, not murder. (Since that case, when some factor is thought to cause an accused person to be subject to 'automation', then this is known as a 'Twinkie Defence'.) Cornwall uses this anecdote to illustrate a theme in Rose's book:

> At the heart of Rose's concern is the battle being fought between philosophers, sociologists and psychologists over neuroscientific descriptions of human nature. Rose's timely book warns of the self-fulfilling prophecies of reductionist explanations of human nature for future policy in mental-health … In order to behave freely and responsibly, he argues, it is crucial we believe we are free …

Rose suggests that, despite some remarkable breakthroughs which have occurred in brain research during the 1980s–90s, some vitally important conceptions of human nature have been discounted or overlooked during the latter decades of the twentieth century. The recent review article of 'happiness' in this journal indicates some of the missing ideas relevant to happiness.[94] Richard Bentall's book, *Madness Explained: Psychosies and Human Nature*, provides yet another perspective on this matter.

Philip Zimbardo, emeritus professor of psychology at Stanford University, has written a detailed psychological investigation of the causes of evil, which he wrote subsequent to his ill-famed Stanford Prison Experiment.[95] In that experiment some 30 years ago, psychology student volunteers were screened for suitability and then placed in a mock prison, half randomly being assigned to the role of prisoners and the other half assigned to the role of 'guard'. In less than a week, sadistic behaviour emerged amongst the guards, serious depressive conditions were apparent among some of the prisoners and Zimbardo himself now states that he is shocked at his slowness in discontinuing the experiment. His book, published in 2007, *The Lucifer Effect: How Good People Turn Evil*, has only now re-examined that experiment. Zimbardo's book explores the power over human nature of situational, and societal, influences and conditions.[96]

Another way to clarify some of the misconception is in the explanations of the meaning of current times. One source of some insights can be found in *A Secular Age* by Professor Charles Taylor, Professor Emeritus of Philosophy at McGill University. Taylor's book involves the massive, scholarly effort of describing the transformation in Western society over the last few centuries from a culture in which it was virtually impossible not to believe in God, to 'something else'. (Perhaps 'ethos of modernity' is one phrase for what now exists, with apologies to Michel Foucault). In one of Taylor's chapters, he discusses the notion that the source of emotional pain is not only mental illness: how people treat each other and live life can be another major source of inner pain, heartache, anxiety etc. He suggests that secular society offers little help in dealing with the problem of evil and the meaning of the struggles of everyday life: 'Evil tends to be seen as exogenous, as brought on by society, history, patriarchy, capitalism, the "system" in one form or another …'.[97] Taylor is not suggesting that exogenous forces are non-existent but rather he seeks to suggest that one consequence of acculturation towards secularism has been 'the transfer of so many issues which used to be considered moral into a therapeutic register. What was formerly sin is now sickness …'. He then argues that freeing society from the notion

of 'sin' may not have enhanced human dignity at all: '[It] can actually end up abasing it [because] in the spiritual register, the "normal", everyday, beginning situation of the soul is to be partly in the grip of evil …'.[98] It is impossible here to do justice to *A Secular Age*. However, if there is any validity in Rose's proposition, Zimbardo's perspective from psychology and Taylor's arguments (and if anyone can stop long enough to reflect upon life in contemporary secular society), then is it any surprise that 'modernity' has no framework to distinguish which of one's sorrows, anxieties and stresses are 'normal' and what to do about the situation? But that is another story.

Conclusion

The Loss of Sadness is a well-communicated, scholarly critique of the current 'overexpansive' (the authors' word choice) definition of depression. Their key message is that 'normal' mental distress ('legitimate' reactions to the vicissitudes of life) and 'abnormal' (illness) have become confused.

Some readers may wonder whether the confusion examined in this book is any concern of modern, democratic society: after all, whether or not one consumes mental health services is surely one's own business. However, in practical terms, there are consequences that do matter. It is shown here that poor validity in the application of the 'Major Depressive Disorder' diagnosis in the *DSM* (and its *ICD* equivalent) impacts upon access to mental health services: unmet need among people with mental illness is not trivial.[99] This sector of the health system is already stretched to its resource limits. The 'situation in which psychiatry and the social sciences find themselves' indeed matters (p. 232); it is not self-correcting. Moreover, it is instructive to note, in Chapter 11 of *The Loss of Sadness*, that the authors are aware that interest groups sustain the situation: 'a number of constituencies have found a symptom-based concept of depression that generates high rates of pathology to be advantageous' (p. 213).

In their own words, the authors state their purpose is fulfilled when a change in professional attitudes and practices is provoked:

> We can only adequately confront the complex and important concerns involved if we clearly differentiate normal sadness from mental disorder. We hope that by examining the consequences of the current failure to adequately [*sic*] draw such a distinction, this book may encourage mental health professionals to embrace the needed distinction and to start talking to each other and to their patients in a more nuanced way that yields improved understanding and treatment (p. 225).

Another clear implication of Horwitz and Wakefield's arguments is that much attention needs to be devoted to the diagnostic information about mental illness (the quality, structure and application of that information).

To foster professional self-correction is very important but, of itself, it is not sufficient to overcome the problems when vested self-interest is self-sustaining. Such situations usually are not self-correcting and appropriate mixes of market forces and government action on several policy fronts will help. *The Loss of Sadness* is not intended to be a discussion of the economic implications of the pervasive misconceptions over mental illness. However, political will needs the knowledge base that not just motivates, but also informs government in effective action. It is clear from the breadth of this review, that attention is needed to the problem on

various fronts. Although this book is very useful for removing the informational blinkers denying attention to the issue, it will not be the last that addresses the plethora of scientific, ethical and economic etc. issues that surround mental illness. Watch this space …

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42. Wakefield's reference to 'false positives' is diagnostic terminology. There are four possible outcomes from a diagnostic test: the true positive, the true negative, the false positive, and the false negative. Important and relevant material is in Williams, *op. cit.*
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45. Sommers and Satel, *op. cit.*
46. A. A. Milne, *Winnie-the-Pooh*, Methuen, London, 1926; A. A. Milne, *The House at Pooh Corner*, Metheun, London, 1928.
47. In their Table 1 these authors present further symptomatic analyses of the nine characters, by applying criteria under four of the *DSM-IV* axes, of course undertaken for the article. Piglet has Generalised Anxiety Disorder, Eeyore has Dysthymic disorder and Traumatic amputation of the tail under Axis III, Rabbit has Narcissistic Personality disorder, Owl clearly has a reading disorder and Axis IV housing problems, Tigger has ADHD hyperactivity impulsivity subtype.

Kanga and Roo do not have Axis I clinical disorders but psychosocial/environmental problems under Axis IV, and they give a provisional diagnosis on Christopher Robin of Gender identity disorder of childhood due to Axis IV lack of parental supervision.

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58. This is an apt metaphor for a phenomenon similar to small burning twigs ultimately lighting a fire. Goddard proposed that recurring sub-threshold convulsive stimulation of the brain of rats, initially by electrical current but subsequently by pharmacological agents, produces through multiple neurotransmitter systems seizure behaviour. This behaviour gradually increases in intensity, and results in a full seizure. Through time, the threshold lowers.
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62. J. C. Burnham, *How Superstition Won and Science Lost: Popularising Science and Health in the US*, Rutgers University Press, New Brunswick, 1987.
63. P. Zachar. 'Folk taxonomies should not have essences, either: a response to the commentary', *Philosophy, Psychiatry, and Psychology*, 7, 3, 2000, pp. 191–4.
64. There are several articles, including J. C. Wakefield, 'The concept of mental disorder: on the boundary between biological facts and social values', *American Psychologist*, 4, 7, 1992a, pp. 373–88; J. C. Wakefield, 'Disorder as harmful dysfunction: a conceptual critique of DSM-III-R's definition of mental disorder', *Psychological Review*, 99, 1992b, pp. 232–47; J. C. Wakefield, 'When is development disordered? Developmental psychopathology and the harmful dysfunction analysis of mental disorder', *Development and Psychopathology*, 9, 1997, pp. 269–90; J. C. Wakefield, 'Personality disorder as harmful dysfunction: DSM's cultural deviance criterion reconsidered', *Journal of Personality Disorders*, 20, 2, 2006, pp. 157–69.
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66. See Kramer, *op. cit.*, which occurred as a result of Kramer's observation that some patients, when treated with antidepressants, reported feeling 'better than well'. Kramer considers the feasibility of 'cosmetic pharmacology' as a practice. This practice involves the prescription of pharmaceuticals to healthy people in order to induce personality traits that either are desired or socially rewarded such as energy and assertiveness. This activity now has a society: http://www.circuitblue.com/psypharm/. Kramer has been mistakenly criticised as a proponent of the use of medication for such purposes: his book is concerned with the ethics of this

practice. If say, Australian governments were subsidising these practices under an umbrella of 'need', then one would surely question such a use of funds.

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69. G. Bell, *The Worried Well: The Depression Epidemic and the Medicalisation of our Sorrows*, *Quarterly Essay No. 18*, Black, Melbourne, 2005.
70. This figure has also appeared in *Prometheus* previously, in the following recent article: D. P. Doessel, 'The rise of studying happiness, but what of the shadow of unhappiness from mental illness?', *Prometheus*, 25, 4, 2007, pp. 435–54.
71. See, for example, A. Stoller, *Report on Mental Health Facilities and Needs in Australia*, Government Printing Office, Canberra, 1955; and E. C. Dax, *Asylum to Community: The Development of the Mental Hygiene Service in Victoria, Australia*, Cheshire, Melbourne, 1961. There is also a book devoted to the general issue, *viz.*, G. Andrews and S. Henderson (eds), *Unmet Need in Psychiatry: Problems, Resources, Responses,* Cambridge University Press, Cambridge, 2000.
72. See, for example, the following: G. Thornicroft, S. Johnson, M. Leese and M. Slade, 'The unmet needs of people suffering from schizophrenia', in Andrews and Henderson (eds), *op.cit.*, pp. 197–217; A. Beautrais, P. Joyce and R. Mulder, 'Unmet need following serious suicide attempt: follow-up of 302 individuals for 30 months', in Andrews and Henderson (eds), *op. cit.*, pp. 245–25; and E. Hunter, *Aboriginal Health and History: Power and Prejudice in Remote Australia*, Cambridge University Press, Cambridge, 1993.
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81. *Ibid.*
82. Stone, *op. cit.*, Chapters 3–10.
83. Spiegel, *op. cit.*
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88. *Ibid*, p. 204.
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