

Constructing normality: a discourse analysis of the DSM-IV

M. CROWE RPN PhD

Senior Lecturer, Department of Psychological Medicine, Christchurch School of Medicine, PO Box 4345, Christchurch, New Zealand

Correspondence:

Marie Crowe

Department of Psychological

Medicine

Christchurch School of

Medicine, PO Box 4345

Christchurch

New Zealand

CROWE M. (2000) *Journal of Psychiatric and Mental Health Nursing* 7, 69–77

Constructing normality: a discourse analysis of the DSM-IV

The purpose of this research was to explore how the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) 1994, (American Psychiatric Association, 1994) defines mental disorder and the theoretical assumptions upon which this is based. The analysis examines how the current definition has been constructed and what the criteria for specific mental disorders suggest about what is regarded as normal. The method employed for the research was a critical discourse analysis. This critical approach to research is primarily concerned with analysis of the use of language and the reproduction of dominant belief systems in discourse. It involves systematic and repeated readings of the DSM-IV (1994) to examine what evidence was employed by the text to substantiate its definition of mental disorder and how in the process some assumptions are made about what constitutes normality. This study challenges a central assumption in the DSM-IV's (1994) definition: that it is a pattern or syndrome 'that occurs in an individual'. The proposal that it occurs in an individual implies that it is a consequence of faulty individual functioning. This effectively excludes the social and cultural context in which experiences occur and ignores the role of discourse in shaping subjectivity and social relations. This study proposes that the definition and criteria for mental disorder are based on assumptions about normal behaviour that relate to productivity, unity, moderation and rationality. The influence of this authoritative image of normality pervades many areas of social life and pathologises experiences that could be regarded as responses to life events.

Keywords: discourse analysis, DSM-IV, mental disorder, moderation, productivity, rationality

Accepted for publication: 12 November 1999

Introduction

The most authoritative text on mental disorder in contemporary western society is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) developed by the American Psychiatric Association which is currently in its fourth edition (1994). This centrality positions it as a representation of psychiatry's 'clinical jurisdiction' (Wilson 1993).

The DSM-IV (APA 1994) aims to be 'practical and useful for clinicians by striving for brevity of criteria sets, clarity of language and explicit statements of constructs

embodied in the diagnostic criteria' (1994, xv). It is basically a classificatory system which aims to see, to isolate features, to recognize those that are identical and those that are different, to regroup them, to classify them by species or families (Foucault 1977). As a classificatory system its purpose could be regarded as the translation of particular observed behaviours into symptoms. These symptoms are attributed with considerable significance – anaemic, diagnostic and prognostic (Foucault 1973). The meaning that is attributed says something about the individual's past and present and to a certain extent determines their future. The discourse which determines this

meaning has significant power over the individual's life therefore.

This paper proposes that the way in which the DSM-IV (APA 1994) constructs mental disorder effectively constructs normality. This has some major implications for mental health nursing practice. Mental health nursing practice is strongly influenced by the process of psychiatric diagnosis. It is frequently incorporated into nursing discourse often without critical examination of its implications for nurses and more significantly the implications for those who receive a diagnosis.

Mental health nursing practice has largely co-opted psychiatric discourse as the basis of practice. It could be argued that by accepting the psychiatric model mental health nurses constructed a limited and dependent role for themselves and have failed to explore other possibilities for those that they nurse. The psychiatric construction of mental distress regards it as a mental disorder caused by some internal, probably biochemical fault that can be treated by biochemical intervention authorised by the psychiatrist. If mental health nurses continue to endorse this view it would seem an inevitable consequence that nursing care consists of dispensing medication, controlling the behaviour associated with mental distress until the medication takes effect and helping the individual to adapt their life to the inevitable disability of a biochemical dysfunction (Crowe & Alavi 1999). Mental health nursing has more to offer than this and involves skilled interventions to facilitate the individual's potential and skills in moving through their mental distress.

Methodology

The analysis of the DSM-IV (APA 1994) was conducted from a discourse analysis perspective which regards language as a form of social practice, rather than purely an individual activity or a reflex of situational variables (Fairclough 1992). Language constructs how we think about and experience ourselves and our relationships with others. Discourses are regarded as patterns of ways of representing such phenomena in language (Lupton 1998, p. 8). They shape the meaning by which relationships and behaviours are understood. From this discourse analysis perspective mental disorder is regarded as a product of the meaning established by discourses. It is not something that 'just exists' or 'just is' independent of social and cultural processes. Discourses do not simply reflect or describe reality, knowledge, experience, identity, social relations, social institutions and practices, rather they play an integral part in constituting them (Lupton 1998, p. 24).

Discourse analysis is concerned not simply with the text itself but how it is produced by certain types of knowledge

and power and how in turn it reproduces this knowledge and power through language. This methodology recognizes that a text is not necessarily the only representation or explanation of the subject matter but that it is one of a number of possible ways of understanding it. However, texts which align themselves with authoritative discourses are like to have more authority. The analysis assumes that discourse is constructed for particular purposes and serves the interests of particular groups. The language of authority is reproduced by a process in which individuals in society participate by adopting the same language to exhibit an alignment with the values of authority (Crowe 1998).

Because psychiatry shapes beliefs about mental disorder it also shapes the knowledge of others who work in the field including mental health nurses. The reality of mental distress experienced by consumers of mental health services is constructed by psychiatric discourse. The DSM-IV (APA 1994) is representative of this discourse. Other explanations of the reality of mental distress are effectively marginalized in favor of a psychiatric diagnosis. It is the focus of discourse analysis to explore the power relations inherent in particular discourses and the strategies used to maintain those relations. Power relations are embedded in discourse through claims to possess the most expert knowledge.

Relationships between consumers and mental health nurses inevitably reflect these power relations which are maintained by claims to possess this expertise. Mental health nurses use their professional knowledge to determine what consumers need and define what is needed in terms of what is regarded as normal. This professional knowledge is often based on psychiatric discourse. Consumers' behaviors and life styles are observed to ascertain whether they can be regarded as normal or symptomatic of mental disorder. Consumers and their families often want an explanation for the mental distress or abnormal behaviour that is occurring. They seek professional help to determine the cause of the abnormality. What the mental distress is classified as shapes how the individual experiences her/his self in relation to others. The authority to name what is happening carries with it considerable power. This research is not proposing that naming and classifying are inherently wrong but rather that it is necessary to examine the assumptions which underpin this process in order to provide mental health care that best meets the needs of consumers. The DSM-IV (APA 1994) operates as a tool for separating out abnormal behaviour from normal behaviour and in the process shapes what is regarded as normal in society.

Discourse analysis is primarily concerned with analysis of the use of language and how dominant belief systems

are reproduced in discourse. It is concerned with the way in which theories of reality and relations of power are encoded in discourse (Lupton 1992). As a research method for health sciences it is gaining increasing recognition (Lupton & McLean 1998, Allen & Nairn 1997, Seidel 1993, Hepworth 1994, Harper 1994, Hazelton 1997, Nessa & Malterud 1990). The research potential of discourse analysis lies in its exploration of the power relations that underpin psychiatric knowledge and practice, and the strategies that are utilized to maintain this.

This approach takes influential texts as the object of inquiry and this research focused on the DSM-IV (APA 1994) because of its position as an authoritative text in psychiatric practice. The object of the research was to explore how the DSM-IV (APA 1994) constructed mental disorder and the implications this had for how normality is constructed. The research process involved examining how the DSM-IV (APA 1994) defined mental disorder and what behaviors or experiences were regarded as criteria of specific mental disorders.

The analysis examined what evidence was employed by the text to substantiate its definition of mental disorder and diagnostic criteria and the values and knowledge which underpinned this. There were no predetermined analytic categories but the analysis involved a thematic analysis of the criteria for specific mental disorders. It became apparent in the examination of the criteria for particular mental disorders that behaviours associated with poor social or occupational functioning, poor ego boundaries, excess or lack of certain behaviours, and unrealistic thinking and speech were the main descriptors of mental disorder. For the purpose of the research these behaviours were translated into themes relating to productivity, unitary, moderation and rationality. These categories were chosen to reflect the individual's social participation and emerged as an alternative way of grouping behaviours that were listed as criteria for specific mental disorders.

Mental disorder

The DSM-IV (APA 1994) defines mental disorder as:

'A clinically significant behavioural or psychological syndrome that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased likelihood of suffering death, pain, disability or an important loss of freedom.' (1994, xxii)

There appears to be an assumption in the definition of mental disorder that biochemical and physiological causes 'constitute the deep structure of life and so are universal, adhere to regular patterns and provide reliable markers for

predictable behaviour' (Pardeck & Murphy 1993). It is assumed the fault lies within the individual. Bourdieu (1977) proposes that every established order tends to produce the naturalization of its own arbitrariness so that what appears to emanate from the individual action is in fact determined by submersion in the 'habitus' – traditional cultural practices. This suggests that situating the individual as the cause of mental disorder ignores how behaviors are shaped by culture and the social context in which they occur. Bourdieu (1977) proposes that cultures develop a consensus of meaning for certain actions which individuals within the culture take for granted as the common sense way of interpreting the world and the actions of others. Cultures establish normative criteria for what is acceptable behaviour within that culture. These cultural norms are internalized as constructions of reality by individuals within the culture. Discourses that have the power to categorize behavior as within or outside the norms tend to do this by situating the individual as faulty if they do not adhere to these norms.

The process for deciding what constitutes mental disorder in the DSM (APA 1994) involves the establishment of criteria consisting of groups of behaviors regarded as symptomatic of specific disorders. Each mental disorder listed is supported by a list of criteria that describe particular behaviors and experiences. These behaviors and experiences are regarded as symptoms of the disorder. The DSM-IV (APA 1994) includes a broad range of such behaviours and experiences which assumes that they are caused by a syndrome occurring in the individual and ignores the possibility that they may be caused by other factors.

Kutchins & Kirk (1997) have identified three areas in the definition of mental disorder that indicate its weakness in relation to establishing validity. They propose that the definition's emphasis on 'impairment' is an insufficient criterion of disorder; and that 'dysfunction' assumes knowledge of the functions of mental processes when no such knowledge is available. They suggest also that there is a lack of precision in diagnostic criteria to clearly demarcate one diagnosis from another and mental disorder from mental distress. It is not clear how all the behaviors and experiences cited in the diagnostic criteria can be legitimately regarded as evidence of mental disorder as distinct from responses to life events.

'The manual has no consistent requirement that the everyday behaviors used as diagnostic criteria actually be the result of mental disorder and not the result of other life experiences.' (Kutchins & Kirk 1997, p. 37)

A key premise in the definition of mental disorder is that a syndrome *occurs in an individual* which suggests that it is caused by some fault within the individual. It excludes

the possibility that it may be a response to external events. The definition of mental disorder assumes that identification of disorder is determined by a subjective experience of distress and that this subjective experience of distress is a symptom of some disorder. This is a self-referential process dependent upon classifications of disorder and then a pursuit of signs that could be interpreted as symptoms in order to validate a subjective appraisal of disorder.

'This reification of the disorder is supported by a process of circular reasoning which begins by considering individual's experiences in isolation from other aspects of their lives. These detached experiences are then reconceptualized as 'symptoms' of an underlying (and unobservable) disorder, one that can be detected only by means of the very experiences on which the initial diagnosis was based.' (Stoppard 1997, p. 22)

A search for naming the disorder takes precedence over understanding the experience or distress in the context of the individual's life and interactions with their social world. Mental disorder, however, is not observable in the same way that a diagnosis of a fracture is. It is inferred from the observation of behaviours. A range of inferences could be drawn from any behaviours observed. The DSM-IV (APA 1994) assumes underlying pathology is creating the disorder but there is a lack of refutable proof that such pathology exists. As the text points out, most disorders are of 'unknown aetiology'. There is an assumption that mental disorder occurs within the individual without diagnostic evidence to support this, e.g.

'No laboratory findings have been identified that are diagnostic of Schizophrenia's (1994, p. 280);

'No laboratory findings that are diagnostic of a Major Depressive Episode have been identified' (1994, p. 323).

Symptoms are read as signs of a pathological condition but if there is no evidence of pathology what is the symptom a sign of?

'Clinical significance' is positioned as crucial to the diagnostic process by the DSM-IV (APA 1994). This clinical significance is determined by clinical judgment that must be regarded as subjective in the absence of conclusive scientific evidence. The clinician's beliefs and values could therefore be regarded as major influences in the diagnostic process. These beliefs and values are shaped by discourse and the most authoritative discourse has the most influence in this process. Particular discourses are authorized within the clinical environment thus authorizing what can be regarded as a mental disorder. Professional acculturation processes and professional regulation act to ensure that only those knowledge and skills that reflect the dominant discourse are endorsed as competent clinical practice.

The norms of the professional culture are internalized by the clinician during their acculturation into the profession and the clinical culture and these act to shape the individual's behavior and attitudes (Crowe 1997). Clinical significance as determined by clinical judgment could thus be regarded as determined by discourse. This process of discursive determination does not necessarily constitute a problem but it does need to be openly acknowledged rather than be veiled in a cloak of scientific objectivity. A significant effect of this is that psychiatric meaning is attached to some behaviors and not to others. This effectively constructs some behaviors as abnormal and colleagues as normal.

Constructing normality

The DSM-IV (APA 1994) measures the likeness of behaviors observed in a clinical context to certain categories from which theoretical generalizations can be made. Behaviors are given meaning by the clinician who ascertains how similar or different they are to the behaviors described as criteria for mental disorders. The meaning attached to these behaviors by the DSM-IV (APA 1994) constructs them as not normal. The DSM-IV (APA 1994) requires that the clinician observe for behaviors that fit certain diagnostic criteria with the possibility that other behaviors which may cloud the picture are ignored.

In its construction of mental disorder the DSM-IV (APA 1994) validates particular behaviours as normal by invoking the status of science. By defining mental disorder and its categories, the DSM-IV (APA 1994) establishes a privileged meaning for particular signs which are interpreted as symptoms. The analysis of diagnostic criteria in the DSM-IV (APA 1994) revealed clusters of particular behavioral and speech attributes that were regarded as abnormal rather than consistent characteristics of disorder: poor social or occupational functioning, poor ego boundaries, excess or lack of certain behaviors, and unrealistic thinking and speech.

'Diagnosis locates the parameters of normality and abnormality, demarcates the professional and institutional boundaries of the social control and treatment system, and authorizes medicine to label and deal with people on behalf of society at large.' (Brown 1995, p. 34)

The diagnostic criteria of the DSM-IV (APA 1994) sets the parameters for what can be regarded as abnormal or normal behavior within society. This discourse analysis revealed that this classificatory system evaluated where these parameters should be set in relation to the following behavioral attributes: productivity, unity, moderation and rationality.

Productivity

The DSM-IV (APA 1994) reinforces a normative expectation that individuals function productively within society. The predominant neo liberal and rational economic ethos, which permeates most contemporary western cultures, requires individuals who can contribute to the economic wealth of that society. When the success of societies is evaluated on purely economic criteria it becomes critical that individuals can participate in enterprises of production and reproduction.

‘Productivity can be regarded as a matter of practical efficiency in ‘the attainment of goals generally accepted as reasonable’ (Sass 1992, p. 2)

Although productivity is a highly valued attribute it is not necessarily available to all members of any society. Social conditions often ensure that this opportunity is primarily available to particular privileged groups thus validating this privilege while disadvantaging others groups. As a behavioral attribute productivity could be defined as the use of time and space in culturally sanctioned ways in order to meet culturally determined goals. Productive use of time and space requires consistency (the individual is expected to act in similar ways across different periods of time); instrumentality (the individual is expected to demonstrate that their behavior is goal directed); and amenability to rational explanation (the individual is expected to provide a rational interpretation and justification for their behaviour).

There is an assumption that particular patterns of sleep, appetite, decision making, interactions with others, speech production, energy levels and goal oriented behaviors should be maintained consistently to ensure productivity despite their social and environmental context. The DSM-IV (APA 1994) marginalizes the context within which ‘unproductive’ behaviors may occur: traumatic life and developmental events, altered relations with significant others, an unsafe or unstable living environment and the expectations of others. When an individual fails to demonstrate goal directedness, efficiency, rational sequencing and occupation of space in particular ways, their behavior may be constructed as a symptom of mental disorder e.g.

- ‘dysfunction in the productivity of thought and speech’ (1994, p. 275);
- ‘poor concentration or difficulty in making decision’ (1994, p. 349);
- ‘markedly diminished interest or participation in significant activities’ (1994, p. 428);
- ‘compulsions that are severe enough to be time consuming’ (1994, p. 417);
- ‘decreased energy, tiredness and fatigue are common’ (1994, p. 321);

- ‘inability to engage in goal directed behavior’ (1994, p. 275);
- ‘irresponsible work behavior may be indicated’ (1994, p. 646);
- ‘failure to fulfil social obligation’ (1994, p. 182).

Unitariness

The DSM-IV (APA 1994) perpetuates a western construction of normal subjectivity which emphasizes individuality and requires an ability to distinguish self from others; interiority from exteriority. The concept of unitariness is based on an understanding of the self as discrete from others. In order to be recognized as a normal subject, the individual is required to demonstrate a stable, unitary and consistent identity separate from other subjects. This is a culturally biased understanding of subjectivity which disregards other cultures, such as Maori culture, that do not have the same regard for individuality and unitariness but rather attach value to connection with others and one’s environment (Durie 1996).

This western understanding of unitariness as fundamental to an individual’s behavior has a long tradition but demonstrates a cultural bias in expectations of normal behavior. Smith (1993) proposes that this understanding of western selfhood is based on a concept of the self as a universal phenomenon with well defined, stable and impermeable boundaries that delineated an exteriority from an interiority. Subjectivity from a western frame of reference lies as a discrete core abstracted from society. This construct of the self privileges it with a consciousness which can exert will and determination in maintaining its boundaries and separateness from others through the invocation of the concept of ego boundaries.

Because the demonstration of unitariness is given such predominance, relationships with others are not held in such high regard. This has implications for women in particular who are required to attend to the needs of others rather than their own. Individual achievement is more likely to attain social recognition than behaviors that facilitate community responsibility or responsibilities attached to child rearing or managing the home.

If the individual fails to demonstrate socially acceptable levels of stability, unity and consistency or they fail to demonstrate appropriate differentiation between themselves and colleagues, their behavior may be interpreted by the discourse of the DSM-IV (APA 1994) as a symptom of a mental disorder:

- ‘a loss of ego boundaries’s’ (1994, p. 273);
- ‘persistently unstable self-image or sense of self’ (1994, p. 651);

- 'a pattern of intense or unstable relations' (1994, p. 650);
- 'confusion about personal identity' (1994, p. 481);
- 'failure to integrate various aspects of identity' (1994, p.484);
- 'memory and consciousness' (1994, p. 484);
- 'a sensation of being an outside observer of one's mental processes' (1994, p. 489);
- 'one's body or parts of one's body' (1994, p. 489);
- 'a distinct change from the usual self' (1994, p. 274).

Moderation

Having established a sense of self as unitary, the individual is expected to demonstrate control over its performance in particular subject positions. The subject positions of individuals are determined by their identification as either man or woman and require culturally determined performances (Gatens 1996). The DSM-IV (APA 1994) establishes the parameters of moderate behavior by subjective evaluations of activity levels, speech production and regard for self and colleagues. What this means for those defined as either male or female is that behavior and speech are interpreted in relation to the sex of the subject. The very same behaviors have quite different personal and social significance when acted out by either a male or a female subject. This has been highlighted by Busfield (1996) who explores the intersection between the way we think about gender and the way we think about mental disorder.

The DSM-IV (APA 1994) construction of mental disorder places a requirement on displays of moderation. Cultural processes for ensuring moderation could be regarded as disciplinary procedures (Foucault 1977): coercions that act upon the body in a calculated manipulation of its elements, gestures and behaviors. Foucault proposes that it is through these disciplinary procedures that the body becomes more docile and therefore more obedient and useful. In this context moderation could be regarded as displays of docility, utility and obedience through the demonstration of self-control, predicability and behavior congruent with one's place in the social hierarchy. Rose (1996) describes such requirements for moderation as a means of self government for the regulation of populations without the need for overt force. His argument is that psychiatry and the psychological sciences have played a significant role in government and legitimizing power by forging new alignments between rationales and techniques of power and the values and ethics of democratic societies.

When individuals fail to display this moderation, those behaviors may be interpreted as symptoms of mental disorder:

- 'uncritical self-confidence' (1994, p. 336);
- 'enthusiasm for social, interpersonal or occupational interaction' (1994, p. 336);
- 'inflated self-esteem or grandiosity and increased involvement in goal-directed activities' (1994, p. 335);
- 'excessive involvement in pleasurable activities' (1994, p. 332);
- 'the individual may become theatrical, with dramatic mannerisms and singing' (1994, p. 328);
- 'psychomotor agitation or retardation' (1994, p. 327);
- 'shows exaggerated expression of emotion' (1994, p. 658).
- 'failure to conform to social norms' (1994, p. 649).

Rationality

Individuals are constructed by and expected to demonstrate allegiance to cultural interpretations of reality that demonstrate rationality. There is a cultural assumption that there is only one authorized version of reality or framework for interpreting experiences. Sass (1992, p. 1) proposes that madness and irrationality are synonymous because the essential feature in what has historically been considered madness involves 'the decline or even disappearance of the role of rational factors in the organisation of human conduct and experience'. Rationality, as determined by scientific discourse, requires empirical evidence and reasoned calculation. To be acknowledged as real an experience must also be amenable to linguistic expression which demonstrates literalness, objectivity and fixity. This expectation of language production is based on a belief in an objective reality and one authorized version of the truth which can be captured linguistically.

This is a limited view of speech and language to assume that it is always literal. Frow (1996) proposes that in language there are no formal markers, which permit discrimination between metaphor and nonmetaphor, and that there can be no purely literal language but rather, all language moves between the literal and the figurative. In most contexts language consists of floating signifiers whose meaning can be interpreted from a number of discursive positions. In situations and experiences of vulnerability individuals may construct their speech as 'coded metaphors that speak to contradictory aspects of social life, expressing feelings, sentiments and ideas that might otherwise be hidden' (Scheper-Hughes & Locke 1987). Figurative speech provides a means of expressing what may be too painful or unacceptable in a literal form by establishing ambiguity; creating an instability of meaning and shifting and uncertainty of boundaries.

Poole (1990) has identified the principles of rationality as being of three pervasive modes: instrumental or

means/end rationality; juridical rationality; and cognitive rationality. He suggests that the common features of these modes are impersonality, consistency and objectivity, and a penchant for the mathematical. In order to be attributed with rationality an individual's perception of reality must be consistent with these features.

If individuals do not perceive reality in a manner that is consistent with cultural norms or their speech pattern lacks the requisite literalness, or they have beliefs and experiences that fall outside the criteria for normal experience, these may be regraded as symptoms of mental disorder:

- 'gross impairment in reality testing' (1994, p. 273);
- 'ideas of reference;
- odd beliefs or magical thinking' (1994, p. 645);
- 'unusual perceptual experiences;
- including bodily illusions' (1994, p. 645);
- 'suspects without sufficient basis, that others are exploiting;
- harming or deceiving him or her' (1994, p. 637);
- 'worry about everyday, routine life circumstances such as possible job responsibilities, finances, the health of family members, misfortune to their children' (1994, p. 433);
- 'feelings of excessive or inappropriate guilt' (1994, p. 327);
- 'distortions or exaggerations of perception (hallucinations)' (1994, p. 275).

Discussion

This analysis was an interpretation of the text and sought to examine core assumptions about mental disorder as they were constructed by the DSM-IV (APA 1994). One method of validating these findings involves reviewing literature to identify whether they were supported by others' work. Although there was significant discussion in the literature regarding the scientific rigor of the text and the social consequences of diagnostic processes there was limited discussion of the particular themes which emerged in relation to how normality was constructed.

The outcomes of this research which challenges the conceptual basis of the DSM-IV's (APA 1994) definition of mental disorder are consistent with other discussions in the psychiatric literature which propose a closer examination of the process of psychiatric diagnosis (Clark 1995, Milton & Davis 1995, 1997, Crow 1998, Kendler 1998).

These findings may not necessarily be confined to this text but may be inherent in any current psychiatric classificatory system. Lempriere (1995) proposes that the purpose of classification systems are: to facilitate communication among clinicians and researchers; to provide a nosological reference system for use in practice; to opti-

mize research by ensuring sample cases are as homogenous as possible; and to facilitate statistical record keeping. He suggests that the weaknesses in such classificatory systems 'is the potential reification of hypothetical approaches, arbitrary categorisation and the dulling of reflection'.

Classification has its utility in clinical practice and research but should be utilized with an awareness of the assumptions that underpin it. Categorical systems form the basis of frameworks for interpreting experiences and are fundamental features of mental functioning. The findings of this research suggest that the DSM-IV (APA 1994) definition of mental disorder is based on particular assumptions as to what constitutes normality.

This is not to suggest that mental distress or mental disorder does not exist, rather it suggests the need for more rigorous explication of the assumptions inherent to the DSM-IV (APA 1994) diagnostic process. Uncritical acceptance and utilization of this classification system excludes the possibility of more innovative research and treatment for people experiencing mental distress. Most of the diagnostic criteria described lack evidence that they can be attributed to an internal mental dysfunction.

Although the psychiatric profession and other clinicians benefit from the expanding domain of the DSM-IV's (APA 1994) clinical jurisdiction, the process of psychiatric diagnosis is of wider concern because 'issues of psychiatric diagnosis, commentary by psychiatrists on all manner of social issues, and the use of medical authority are so ubiquitous in our lives' (Kutchins & Kirk 1997, p. 10). The DSM-IV (APA 1994) carries considerable influence in determining the social conditions within which we live.

'The truths of science and the powers of experts act as relays that bring the values of authorities and the gods of business into the dreams and actions of us all. These techniques for the government of the soul operate not through the crushing of the subject in the interests of control and profit, but by seeking to align political, social and institutional goals with individual pleasures and desires, and with the happiness and fulfilment of the self.' (Rose 1990, p. 256)

This process suggests that in ordinary life people now orient themselves more than ever before to general behavioral precepts proclaimed or at least supported by psychiatric discourse. Individuals turn to medicine for advice on how to live their lives and in the process incorporate medical language into everyday speech (de Swaan 1990).

'The cultural authority of clinical discourse and practice produces and reproduces reality through language that constructs, upholds, and at the same time veils the structures of domination and authority of the specific clinical institution and of the larger politico-economic system.' (Houghton 1995, p. 131)

The discourse of the DSM-IV (APA 1994) provides an image of what individuals could become and helps realign what they are with what they want to be – or what psychiatric discourse decrees that individuals should strive to be. This image of normality is dependent on the modification of personal desires with institutionally or socially valued goals. It could be regarded as a central text in ensuring that individuals meet social requirements for acceptable subjectivity. When individuals fail to measure up to these requirements they become part of the ever increasing psychiatric attention on all aspects of everyday life.

The categorization of behavior and language as disordered has the effect of creating a distance between those people experiencing mental distress and the rest of society. The role of the mental health nurse could focus on attending to the significance embedded in the narratives of those that they care for in an attempt to establish connection and recognition. This could involve a focus on attempting to restore the individual's connection with the human community: to label others' as mad and therefore insignificant is to abandon them to the margins of society. To attempt to make connection with this experience is an attempt to re-establish some measure of participation in the community of others (Crowe & Alavi 1999). There is a need to develop an understanding of other possibilities for understanding others' behaviors and a need to integrate psychotherapeutic and nursing skills to meet the needs of the consumer in a relationship of partnership (Crowe 1998). This may involve the development of new discourses about mental distress that situate the consumer and the context in which their distress occurs as central to mental health nursing practice.

References

- Allen R. & Nairn R. (1997) Media depictions of mental illness: an analysis of the use of dangerousness. *Australian and New Zealand Journal of Psychiatry* 31, 375–381.
- American Psychiatric Association (APA). (1994) *Diagnostic and statistical manual of mental disorders*. American Psychiatric Association, Washington, DC.
- Bourdieu P. (1977). *A Theory of Practice*. Cambridge University Press, Cambridge.
- Brown P. (1995) Naming and framing: The social construction of diagnosis and illness. *Journal of Health and Social Behaviour* (Extra issue), 34–52.
- Busfield J. (1996). *Men, Women and Madness: Understanding Gender and Mental Disorder*. Macmillan, London.
- Clark L. (1995) The challenge of alternative perspectives in classification: A discussion of basic issues. In: *The DSM-IV Personality Disorders* (ed. Livesley, W.J.) Guilford Press, New York.
- Crowe T. (1998) From Kraepelin to Kretschmer leavened by Schneider. *Archives of General Psychiatry* 55, 502–504.
- Crowe M. & Alavi C. (1999) Mad talk: attending to the language of distress'. *Nursing Inquiry* 6, 26–33.
- Crowe M. (1997) An analysis of the sociopolitical context of mental health nursing practice. *Australian and New Zealand Journal of Mental Health Nursing* 6, 59–65.
- Crowe M. (1998) The power of the word: some post-structural considerations of qualitative approaches in nursing research. *Journal of Advanced Nursing* 28, 339–344.
- de Swaan N. (1990). *The Management of Normality*. Routledge, London.
- Durie M. (1996) Maori cultural identity and implications for mental health. Paper Presented to Australia and New Zealand College of Mental Health Nurses 22nd Annual Conference Culture and Caring: Caring in Culture. Auckland, October 10–13.
- Fairclough N. (1992). *Discourse and Social Change*. Polity Press, Cambridge.
- Foucault M. (1977). *Discipline and Punish: the Birth of the Prison*. Tavistock, London.
- Foucault M. (1973). *Birth of the Clinic*. Tavistock, London.
- Frow J. (1996) Metaphor and metacommunication in schizophrenic language. Paper Presented at Narrative and Metaphor Conference Auckland University, New Zealand.
- Gatens M. (1996). *Imaginary Bodies: Ethics, Power and Corporeality*. Routledge, London.
- Harper D. (1994) The professional construction of 'paranoia' and the discursive use of diagnostic criteria. *British Journal of Medical Psychology* 67, 131–143.
- Hazelton M. (1997) Reporting mental health: a discourse analysis of mental health-related news in two Australian newspapers. *Australian and New Zealand Journal of Mental Health Nursing* 6, 73–89.
- Hepworth J. (1994) Qualitative analysis and eating disorders: discourse analytic research on anorexia nervosa. *International Journal of Eating Disorders* 15, 179–185.
- Houghton C. (1995) Managing the body of labour: the treatment of reproduction and sexuality in a therapeutic institution. In: *Gender Articulated: Language and the Socially Constructed Self* (ed. Hall, K.& Bucholtz, M.). Routledge, New York.
- Kendler K. (1998) The structure of psychosis: syndromes and dimensions. *Archives of General Psychiatry* 55, 508–509.
- Kutchins H. & Kirk S. (1997). *Making Us Crazy*. Free Press, New York.
- Lemperiere T. (1995) The importance of classifications in psychiatry. *Encephale* 5, 3–7.
- Lupton D. & McLean J. (1998) Representing doctors. Discourses and Images in the Australian press. *Social Sciences and Medicine* 46, 947–958.
- Lupton D. (1992) Discourse analysis: a new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health* 16, 145–150.
- Lupton D. (1998). *The Emotional Self*. Sage, London.
- Milton T. & Davis R. (1995) Conceptions of personality disorders: historical perspectives, the DSMs, and future directions. In: *The DSM-IV Personality Disorders* (ed. Livesley, W.J.) Guilford Press, New York.
- Nessa J. & Malterud K. (1990) Discourse analysis in general practice: a sociolinguistic approach. *Family Practice* 7, 77–83.
- Pardeck J. & Murphy J. (1993) Postmodernism and clinical practice: a critical analysis of the disease model. *Psychological Reports* 72, 1187–1194.

- Poole R. (1990) Modernity, rationality and the masculine. In: *Feminine Masculine Representation* (eds Threadgold, T. Cranny-Francis, A.). Allen & Unwin, Sydney.
- Rose N. (1990). *Governing the Soul: the Shaping of the Private Self*. Routledge, London.
- Rose N. (1996). *Inventing Ourselves: Psychiatry Power and Personhood*. Cambridge University Press, Cambridge.
- Sass L. (1992). *Madness and Modernism*. Basic Books, New York.
- Scheper-Hughes N. & Locke M. (1987) The mindful body. *Medical Anthropology Quarterly* **11**, 6–41.
- Seidel G. (1993) The competing discourses of HIV/AIDS in sub-Saharan Africa: discourses of rights and empowerment vs discourses of control and exclusion. *Social Science and Medicine* **363**, 175–194.
- Smith S. (1993). *Subjectivity, Identity and the Body*. Indiana University Press, Bloomington.
- Stoppard J. (1997) Women's bodies, women's lives and depression: towards a reconciliation of material and discursive accounts. In: *Body Talk: the Material and Discursive Regulation of Sexuality, Madness and Reproduction* (Ed. Ussher, J.) Routledge, London.
- van Praag H. (1997) Over the mainstream: diagnostic requirements for biological research. *Psychiatry Research* **72**, 201–212.
- Wilson M. (1993) DSM-III and the transformation of American psychiatry: a history. *American Journal of Psychiatry* **150**, 399–410.