UNIVERSITÀ DEGLI STUDI DI MILANO-BICOCCA

DIPARTIMENTO DI PSICOLOGIA

DOTTORATO DI RICERCA IN PSICOLOGIA

SOCIALE, COGNITIVA E CLINICA

XXV CICLO

DISCOURSE, SOCIETY AND MENTAL ILLNESS: DECONSTRUCTING DSM THROUGH CRITICAL AND LACANIAN DISCOURSE ANALYSIS

Tutor: Dott.ssa MONICA COLOMBO

Tesi di dottorato di

KATIA ROMELLI

ANNO ACCADEMICO 2012/2013

Only thing of which one can be guilty

is of having ground relative to one's desire

(Lacan, 1959-1960/1992, p. 319)

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INTRODUCTION

This doctoral thesis presents a research focus on the discursive construction of the concept of mental disorder.

The interest in this topic starts when the proposed revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by American Psychiatric Association (APA), has reopened a long lasting debate in mental-health field on the criteria adopted in defining pathology/normality. For this reason, the main research question revolves around how the boundaries between normality and pathology in the psychiatric domain have been discursively established and what has been the role played by DSM discourse in this process.

This study takes a critical psychology perspective, which aims both to historicize psychiatry's more essentialist claims and to challenge the pathologization of individual experience dominating both in clinical psychology and psychiatry. In this general theoretical framework, I integrate the critical discourse analysis approach, inspired by the reflections of Foucault about discourse, knowledge and power, and the semiotic analysis, drawn on Lacanian discourse analysis. Both of these theoretical references aim at understanding relation between discourse and other elements of social life, including social relations (among which relation of power), social institutions and social identities.

The analysis is conducted through a multi-method approach, which integrates several traditions with a particular concern about the ways in which power and ideology are discursively enacted, produced, reproduced and resisted by text and talk.

This contribution aims to extend psychosocial understanding around the ways in which the current assumption about mental health and mental distress are historically, socially and politically constructed in the contemporary Western context.

Chapters outline

Chapter 1. The epistemological and theoretical framework of the doctoral thesis is presented. The general theoretical approach that oriented the research and the analysis of the data collected is the critical psychology perspective (Fox, Prilleltensky, & Austin, 2009). The two main theoretical resources are represented by critical discourse analysis, in its Foucauldian tradition (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995) and semiotic analysis, defined in terms of Lacanian discourse analysis (Parker, 2005a; Pavon-Cuellar, 2010).

Chapter 2. The first study presented in the dissertation is aimed to analyse how DSM, edited by the APA, has progressively positioned itself as the most authoritative text on mental health in the Western culture. In line with the theoretical framework I deconstruct the discourse of DSM over time integrating critical discourse analysis with the concepts of legitimization (van Leween, 1995; 1999; 2007) cultural hegemony of Gramsci (1929-1935/1975; Laclau & Mouffe, 2001). Consistently with these premises, this study examines how legitimisation and hegemony have been discursively constructed and enacted, in all the editions of DSM, from DSM-I to DSM-5, and highlights the role played by the APA.

Chapter 3. The second study presented in the dissertation is aimed to investigate the scientific debate started from the proposal of deletion of Narcissistic Personality Disorder from the latest edition of DSM. In order to reconstruct and deconstruct the decisional process through which the APA aims at establishing if narcissism should be included among mental disorders or not, I integrate the Foucauldian's concept of governmentality (Foucault, 1982-1983/2008) with the theories of argumentations (van Eemeren, Grootendorst, Jackson, & Jacob, 1993; van Eemeren & Houtlosser, 2002; van Eemeren, 2009) approached by critical discourse analysis (Fairclough & Fairclough, 2012; Fairclough & Fairclough, 2013). Consistently with these premises, this study examines how the controversy has been discursively managed in the papers published between 2010 and 2013 related to this debate.

Chapter 4. The third study presented in the dissertation is aimed to investigate the relationship between the discourse of the DSM over time and the discourse of other

social actors, in particular dissenter movements. Psychoanalytic reflections about the power and the exercise of power through discursive practices are the theoretical framework. In particular, I lean on Lacanian Four Discourses Theory (Lacan, 1969-1970/2007), to identify and analyse the crucial factors through which language exercises both formative and transformative power in human affairs. Consistently with these premises, this study examines the effects of this relationship in shaping subjectivity of: patients, mental-health professionals and members of dissident movements.

Chapter 5. In this chapter conceptual connections between different studies and final reflections about methodology are presented.

THEORETICAL FRAMEWORK AND OBJECT OF ANALYSIS

I. THEORETICAL FRAMEWORK

1.1 Critical Psychology

Critical Psychology is rooted in Critical Theory born in Germany in the Thirties (Adorno, 1963-1969/1998; Horkheimer, 1932-1941/1974; Horkheimer & Adorno, 1931-1946/1999). The philosophers of the Frankfurt School rejected the notion of objectivity, because “the facts which our senses present to us are socially preformed in two ways: through the historical character of the object perceived and through the historical character of the perceiving organ. Both are not simply natural; they are shaped by human activity, and yet the individual perceives himself as receptive and passive in the act of perception.” (Horkheimer, 1937/1992, p. 200). Likewise, intellectuals themselves are not disembodied entities from society; knowledge can be obtained only from within a society of interdependent individuals.

In this perspective, the emphasis in critical psychology is aimed at understanding how human being constructs reality through a complex interaction of consciousness, language, power, and embedded social living. The theoretical backgrounds of critical psychologists are broad and diversified. Indeed, it is not possible to identify one critical psychology, but rather there are multiple forms, multiple critical perspectives on psychology. Moreover, there are three main assumptions implicit in most critical psychology works (Fox et al., 2009; Hook et al., 2004; Parker, 2013a):

- Descriptions and explanations of phenomena can never be 'neutral'. So, in place of an “outside” perspective, the critical psychologists know that they observe and describe the world from a particular position (a theory always guides a researcher,

whether these is implicit or explicit). This means the discourse of researcher is affected by her or his subjectivity.

- A refuse to attempt to set *a priori* meaning on concept. So, in place of fixed method abstracted from context, critical psychologists are concerned with the phenomena of study as historically, socially and culturally constituted. This means that the analysis is oriented to noticing how the phenomenon has come into being and how it changes.
- The impossibility to "*dimostrare, argomentare ex prioribus*"[1]. So, in place of simple steps of procedure that should be followed, critical psychologists know that they must bring to bear upon the phenomenon a theoretical understanding. This means that the task is to develop theory and methodology useful for the peculiar purposes in research.

In sum, it is possible to affirm that critical psychology is more an "approach, a kind of orientation toward psychological knowledge and practice. This is an orientation that cuts across the various sub-disciplines in psychology and is made up of diverse theoretical perspective and forms of practice" (Hook et al., 2004, p.11).

Moreover, critical psychology approaches underline the *particular* way in which psychology constructs its object of study. Then, critical studies emphasise how some varieties of psychological action and experience are privileged over others, how dominant accounts of psychology operate ideologically and how they are embedded in power relations (Fox et al., 2009; Parker, 1999; Prilleltensky, 1994). In this perspective, critical studies in psychology have to analyse the ways in which psychology as a discipline penetrates commonsense, the ways in which the ideological assumptions about the mind, behaviour and human nature influence social practices.

In the field of mental health, critical psychology focuses on highlighting the contingent, socially produced character of categories of mental distress and of associated professional practices. Hence, within this paradigm, the dominant system of knowledge

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[1] This expression, attributable to Scholasticism, refers to possibility deducing from universal the particular. In this perspective the *a priori* knowledge is synonymous of "universal" and "pure". In this perspective, psychology calls into question the system of thought aimed at identifying absolute and immutable principles at the foundation of judgments, and the size of the absolute truth, actionable and achievable through the purification of the processes of the elements related to sensitivity and subjectivity (Langston, 2011).

regarding mental distress, and diagnosis, the practice of assigning a pshychopathological category to a person are treated as topic of investigation, and historical, social and political embedded (Georgaca, 2013a).

1.2 Discourse Analysis: Critical Discourse Analysis and Semiotic Analysis

Many disciplines as anthropology, history and sociology, psychoanalysis and social psychology, political science, linguistics and literally theory, have used the concept of discourse to define and explain problems in their respective fields of study. As with other complex and contested concepts, meaning, scope and application of discourse is relative to the different theoretical systems in which it is embedded (Howarth, 2000). But in many case, this concept is linked to the idea that language is structured according different patterns that characterise different domain of social life, most familiar examples are "medical discourse" and "political discourse"(Jorgensen & Phillips, 2002).

Discourse analysis does not identify only one approach, but a series of interdisciplinary approaches that can be used to explore many different social domains in many different types of studies. For this reason, inside the discourse analysis terrain there is not a clear consensus as to what discourses are or how to analyse them. Indeed, different perspectives offer their own suggestion on it. Even if, all share the idea that discourse is defined in terms of *construction* and *function* (Nikander, 2006; Potter, 1996), which means that texts construct the objects to which they refer. In other words, they create specific versions of the phenomena and processes they set out to describe. Within discourse studies, some authors (i.e. Alvesson & Karreman, 2000; Potter & Wetherell, 1987) have proposed a distinction, and a consequent classification of different theoretical and methodological approaches, among micro, meso and macro conceptualizations of discourse.

On one hand, approaches relying on micro conceptualizations of discourse, like conversation analysis (Antaki, 2011; Sacks, Schegloff, & Jefferson, 1974) or ethnomethodology (Atkinson & Hammersley, 2007; Baszanger & Dodier, 1997), focus their attention to the social and discursive practices, and to their variations at the local level. Hence, inside this theorisation of discourse analysis the authors are more interested to examine the *variability* offered in the people's account, which means to look at the

dynamics of interaction; and the *rhetorical strategies* that speakers use in order to present their version of world and the function that the deployment of specific discourse has on the unfolding interaction.

On the other hand, approaches referring to meso and macro conceptualizations of discourse focus their attention on the relationship between discourses and the broader historical and socio-cultural context. In this perspective, discourse is defined as a form of *social action*, which means that people use language to achieve certain interpersonal goals (N. Fairclough & Wodak, 1997; N. Fairclough, 1992). That is to say, discourse analysis puts attention on the ways in which the use of language and the management of the interaction serve interpersonal, social and political functions. Hence, discourse entails *subject positions* both in the speaker and in the receiver, which means that when someone speaks it is positioned in specific way and call upon others to be positioned accordingly (Davies & Harré, 1990). The strategies of positioning are often related to power inequality. Consequently, in the meso and macro conceptualisation discourse is wrapped up with *power* (Foucault, 1972, 1982), because it makes available certain version of reality and hides other possible versions, which means that exists a close mutual relationship between discourse, power and practices; indeed, dominant discourses, which become taken for granted, support and enable social and institutional practices that in turn maintain them. Furthermore, critical discourse analysis aims to deconstruct how dominant social structures naturalise conventions to obscure the role of power in the production of knowledge (Bourdieu, 1977).

Inside this broad terrain, each approach to discourse analysis is not just a method for data analysis, but a theoretical and methodological whole perspective, which implies ontological and epistemological assumptions about language and with specific techniques for analysis. Actually, in discourse analysis, theory and method are intertwined and researcher must accept the basic philosophical premises involved in each approach in order to use discourse analysis as their method in empirical studies (Jorgensen & Phillips, 2002). Moreover, usually a researcher combines elements from different analytical perspectives to provide different forms of knowledge about a phenomenon, and consequently to produce a broader understanding of it.

In this doctoral thesis, I choose to move beyond the local and individual level and to consider forms of discourse analysis that aim to study the socially-structured power, the ideological systems of meaning and their implications on subjectivity.

1.2.1 Critical Discourse Analysis: the Foucauldian approach

Foucauldian concept of discourse is more related to a meso- or macro-level than to a micro-level (Diaz-Bone et al., 2007). Indeed, he is interested in studying are the rules that determine which statements are accepted as meaningful and true in a particular historical era. These rules arrange and establish the social world in a specific way and shape social practices. These practices constitute particular form of subjectivity in which human subjects are managed and given a peculiar form (Foucault, 1976, 1980a).

Moreover, the theme of power becomes central to the philosophy of Foucault starting with the inaugural lecture at the Collège de France, *The order of Discourse* (1970/1981), and the study about the origin of the prison system, *Discipline and Punish* (1977). This theme is strictly connected with the reflections about discourse and knowledge formulated by Foucault in the Sixties (Foucault, 1965, 1972, 1976). In the Sixties, Foucault investigates the relation between power and knowledge through the *archaeological* approach, which is related to the clarification of the history of the rules that regulates particular discourses as the discourse of madness (Foucault, 1972). Archaeology has been an essential method for Foucault, however archaeological analysis could say nothing about the causes of the transition from one way of thinking to another and so had to ignore the forceful case for the contingency of entrenched contemporary positions. For this reason, starting from *Discipline and Punish* (1977) he investigate discourse through *genealogy*. Genealogy looks after the forces and events that shape discursive practices into units, whole and singularities.

The central focus in Foucauldian reflections about discourse, power and knowledge is on the rules, systems and procedures which constitute, and are constituted by, our 'will to knowledge' (Foucault, 1970/1981). Indeed, Foucault once again refers to Nietzsche, which showed that, implying a desire for truth, every speech has inherent in it the “will to power” and that the opposition between true and false is one of the selection procedures in which power operates on the speech (Nietzsche, 1887/2012) .

Foucault identifies three procedures of control and delimitation of discourse: internal, external and concern the conditions of implementation of speech. Within these procedures, peculiar attention is put on the opposition between true and false, and on partitions.

In Foucauldian perspective, the opposition between true and false is relative, mobile and revised throughout history, because linked to the authority legitimated in the different historical times and, consequently, to the different standards of truthfulness accepted. Therefore, truth is a discursive construction and different regimes of knowledge determine what is true and false. Moreover, Foucault defines a discipline as "a domains of objects, a set of methods, a corpus of preposition considered be true" (Foucault, 1970/1981, p.59). In other words, a discipline is what is required for the construction of new statements. Moreover, "truth is not only the outcome of construction, but of contestation. […] Truth, that is to say, is always enthroned by acts of violence. It entails a social process of exclusion in which arguments, evidence, theories and beliefs are thrust to the margins, not allowed to enter 'the true'" (Rose, 1999, p. 111). Obviously, it is always possible that someone says something true, but in order to recognized a statement as such it is necessary that the speaker is placed "in the truth" (Foucault, 1970/1981, p.60) of its own historical time. In other words, a truth stigmatized as false in a particular historical time, it could be recognized as real in a later time if accompanied by new standards of truthfulness and the support of the institutions. Illustrative of this process is the debate between Galileo and the Church about the astronomic theories. Hence, it is possible to affirm that every society has its own order of truth, because it accepts certain discourses, which runs as true. The battles over truth are not abstract: to be in the true, facts and arguments must be permitted to enter into complex apparatuses of truth (nowadays, for example, in scholarly journals, conferences and the like) which impose their own norms and standards upon the rhetoric of truths. Hence, truth entails an exercise in alliances and persuasion both within and without the bounds of any disciplinary realm. This means that knowledge and power are indistinguishable: the exercise of power generates new forms of knowledge and knowledge brings with it the effects of power. As a result, these procedures define a discrete realm of discursive practices, a conceptual terrain in which knowledge is formed and produced. In other words, what is analysed here is not what is thought or said *per se*,

"but all the discursive rules and categories that were *a priori*, assumed as a constituent part of discourse and therefore of knowledge" (1981, p. 48). In this way, the effects of discursive practices is to make it virtually impossible to think outside of them; to be outside of them is, by definition, to be mad, to be beyond comprehension and therefore reason (Young, 1981).

Another method to control and delimitate the discourse is represented by partition or rejection: in the Foucauldian view the main example is represented by reason and madness (Foucault, 1965, 1976). The word of the fools is usually considered ineffective and unimportant, only used to affirm the difference between reasonable and senseless speech. According to Foucault, the madness presents as a question of hermeneutics, a control technique and a treatment strategy of death and suffering. Indeed, mental illness represents the "proof of a return to the underworld" of a subjectivity in crisis, between being and nothingness. In this border between being and nothingness, Foucault leads his own investigation to find the criteria of inclusion and exclusion trough which the discourses – about psychology, psychiatry, sexuality, education and law – legitimised themselves over time. Using the words of Machery: "dans la perspective ainsi définie, il n'est plus possible de parler de maladie mentale, de personnalité, de psychologie, comme si ces notions correspondaient à des contenus objectifs, dont les contours pourraient être cernés et isolés, sans tenir compte préalablement du système historique des conditions à partir duquel elles prennent sens corrélativement les unes aux autres"[2](Macherey, 1986, p. 756). Indeed, Foucault demonstrates that the world of madness has been organised on the basis of a peculiar meaning and function intrinsically connected to a model of ethics and epistemology. Moreover, he highlights that, between the Seventeen and the Ninth centuries, the world of madness become the world of exclusion through the social practice of internment; after this movement of segregation, the fools fall into a state of 'minority' legal and existential in which he/she is subjugated, blamed and, first of all, infantilized (Foucault, 1965).

[2] "In this perspective, it is no longer possible to speak about madness, personality and psychology as objective notions, which have identified and isolated meaning, regardless by the historical context in which they are embedded and connected with one other" (my own translation).

In conclusion, it should be clear that the power devices, implementing selections and prohibitions, prevent the proliferation of free speech and originate a disciplinary society, which finds its own expression in the institutions as prison, hospital, army, school and factory. Consequently, there is a mixture among speech acts and organization of society, because in the institutions are implemented control strategies. In this perspective, the power forms a chain that is based on relationships that reproduce and expand in the social network. Against a theorization of the power only as repressive device, Foucault suggests that power relations are exercised "over free subjects" (Foucault, 1982, p.790), and individuals are the vehicles of power and not its point of application. "Slavery is not a relationship of power" (p.790) affirms Foucault. Hence, it is necessary that a certain degree of freedom characterizes the domain, because power may become possible through the *movement* of relationships unfair, but at the same time unstable, and so mobile and reversible. In this kind of social conditions, people may react and relate with one other in a different way. The interrelationship between power and freedom is captured by the concept of *governmentality* (Foucault, 1982-1983/2008). With this concept, Foucault introduces a new dimension into his power analysis, allowing to underline the relation between subject and power from the angle of the "conduct of conduct" (Foucault, 2000, p. 341). Within this framework, Foucault examines processes of state formation in connection with the development and changing forms of subjectification. In this vein, "the governmentalisation of the state […] is simultaneously a history of subject" (Bröckling, Krasmann, & Lemke, 2010, p. 2) and free act is a practice rather than a principle. Indeed, liberal forms of government does not limit itself to a simple guarantee of freedoms, existing independently of governmental praxis, but it organises the condition under which individuals can make use these freedoms. Freedom is an effect of governmental praxis and it is an indispensable instrument of the liberal government (Bonnafous-Boucher, 2001). In fact, liberal government systematises and calculated form of exercising power, not directly affecting individual and collective agents and their option of action, but rather to intervene indirectly in order to structure fields and degrees of possibility. Consequently, power is defined as "constantly in tension, in activity" and the focus shifts from the designation of people who exercise power, the decision-makers, to the explanation of how and why the decision was made and how it is accepted by all the social actors in the domain. Furthermore, he point out that power is

both a productive and a constraining force*:* “What makes power hold good, what makes it accepted, is simply the fact that it does not only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression.” (Foucault, 1980a, p. 119).

The focus of a Critical Discourse Analysis inspired by Foucault, it should be on how effects of truth are created in discourses. Thus, what are to be analysed are the discursive processes through which discourses are constructed in ways that give the impression that they represent true or false pictures of reality. Hence, in this perspective, Critical Discourse Analysis aims to offer an approach promotes a type of discourse-oriented research that primarily studies the way social dominance and inequality are enacted, legitimised, reproduced, and resisted by text and talk.

1.2.2 Semiotic Analysis: the Lacanian Approach

Discourse is not confined to language at all but also includes all semiotically structured phenomena. According to Umberto Eco (1976), “semiotics is concerned with everything that can be taken as a sign” (p. 7) and in this perspective, it involves anything which “stands for” (Chandler, 2007, p.2) something else. In a semiotic sense, signs take the form of words, images, sounds, gestures and objects. Contemporary semioticians study how meanings are made as such, being concerned not only communication but also with the construction and maintenance of reality (Chandler, 2007b; Hodge & Kress, 1988; Sturrock, 1986). According to Barthes (1957), semiotics “est une science des formes” [3] (p. 184), given that its own aim is to study how the significations has been constructed beyond the content.

> What semiotics has discovered in studying “ideologies” (myth, rituals, moral codes, arts, etc.) as sign-system is that the *law* governing, or, if one prefers, the *major constraint* affecting any social practices lies in the

[3] “Semiotics is a science of the forms” (My own translation)

> fact that it signifies; i.e., that it is articulated *like* a language. Every social practice, as well as being the object of external (economic, political, etc.) determinants, is also determined by a set of signifying rules, by virtue of that fact there is present an order of language. […] On may say, then, that what semiotics had discovered is the fact that there is a general social law, that this law is the symbolic dimension which is given in language and that every social practice offers specific expression of that law. (Kristeva, 1986, p. 25)

Semiotics drawn heavily influences on structuralism and in particular in structural linguistics, even if it is a field of study involving many different theoretical stances and methodological tools. In cultural studies, the Semiotic Analysis emerges as instrument to "decode" image (Parker, 2013, p. 232), and it draws explicitly or implicitly on psychoanalytic notions of subjectivity and the production of subject positions for readers of text (Parker, 2013b; Pavón-Cuellar, 2010). In this perspective, the Semiotic Analysis could be viewed as post-Foucauldian analysis in that it builds upon some of the premises of the Critical Discourse Analysis but also introduces specific theoretical concepts. Actually, the Semiotic Analysis is not confined to images and it has methodological implication for how to read written texts. To analyse text, Semiotic Analysis drawn on structural linguistic theories (Saussure, 1916/2009) in which it is possible to include Lacan's reflection on subjectivity and symbolic system, and the concept of "ideological interpellation" elaborated by the structuralist political theorist Althusser (Althusser, 1971)[4].

In this doctoral study, I lean mainly on Lacan's theory of language, executing a Lacanian Discourse Analysis (Pavon-Cuellar, 2010). Lacanian Discourse Analysis has

[4] This account of "ideological interpellation" is a narrative of how a human being becomes a self-conscious subject. This narrative of subjectification was intended to help advance Althusser's argument that regime or states are able to maintain control by reproducing subjects who believe that their position within the social structure is a natural one. Specific social and economic structures, however, require particular ideologies. These ideologies are instantiated by institutions like family, schools, church, and so on, which provide the developing subject with categories in which she can recognize herself. In as much as a person does so and embraces the practices associated with those institutions, she has been successfully "interpellated" and recognized herself as that subject who belongs to this social structure. The effect of these recognitions is to continue existing social relations (W. Lewis, 2009).

attempted to develop an analysis that does not burrow underneath language, or inject interpretation into text (Parker, 2005). Indeed, the Lacanian theory of language offers a series of conceptualizations intertwined with critical social psychology about the subject-to-society relation and the spontaneous emerge of certain forms of authority and social identification (Hook, 2008). Moreover, this theory of language helps to highlight how the relations established between subject and society create ostensible and inevitable effects of power and truth. Lacan's work reconceived Freud's psychoanalysis as logic-based, linguistic-based and narrative-based, indeed Lacan's psychoanalytic theory combines a theory of mind (in Freudian meaning), with theories of linguistics, semiotics and logic (e.g. de Saussure, Peirce and Gödel), and in doing so he provided a powerful link to contemporary discursive conceptions of subjectivity (e.g. Fairclough & Wodak, 1997; Fairclough, 2003; Hodge & Kress, 1988).

According to Jacques Lacan, a discourse is:

- an essential strategy of argumentation about how we understand ourselves but also how we (consciously and unconsciously) understand the social relationships as defined through our participation in discursive network (T. Brown, 2008). While discourse appears to demonstrate unity and coherence within the text, the subject participates in the sense of closure – in part through "identification" with characters. The coherence of discourse constructs the coherence of the subject;
- a formal system. Indeed, Lacanian analysis of language emphasizes the formal relation of discourse over content (Bracher, Alcorn, Corthell, & Massardier-Kenney, 1994; Verhaeghe, 1995; see Chapter 4 for a discussion of this issue).

The Lacanian theory of language is based on the concept of Other, with the capital "O" (Lacan, 1954/2006, 1961/2008). The Other refers to the register of the symbolic order, namely, the overarching "objective spirit" (Hegel, 1807/2000) of trans-individual socio-linguistic structures configuring the fields of inter-subjective interactions. This means that the Other makes possible the interchange and the dialectics of inter-subjectivity, because it represent the foundation of the symbolic system. However, at the same time, the Other is always enigmatic, conditioned by a fundamental alterity, and so structurally unknowable (Lacan, 1968/2006b). Indeed, the Other refers to ideas of anonymous authoritative power and knowledge: i.e., God, nature, society, State, science and so on. Nevertheless, another subject or institution may occupy this position, and may

thus “embody the Other” (Hook, 2008, p.55) for another subject. Furthermore, the Other is grasped as social substance, traditions and unwritten obligations that define a given societal situation. Actually, any act of signification is only intelligible in a background framework of rules and presuppositions that co-determines the meaning. The Other forms the frame structuring our perception of reality; its status is normative because it is a world of symbolic rules and codes. In this perspective, the Other could be conceptualised as the anchoring-point that a given society relies upon to construct and maintain its own identity and coherence. That is, any symbolic or social system will yield certain prioritized values and notions. These primary values and notions represent the anchoring-points around which signifiers gain meaning. Any symbolic or social systems need these assumptions around which all gain sense and identity and all is ordered and positioned. In Lacanian perspective, these particular anchoring-points are label master signifiers (see Chapter 4, section 4.2.1 for a discussion of this issue). Highlighting the master signifiers potentially operant in relation to a discourse allows understanding something of how a discourse may affect a particular symbolic or social system (Neill, 2013; Pavon-Cuellar, 2010; Hook, 2008; Parker, 2005b). It can also allow to disentangle connotations which can otherwise appear natural (Bourdieu, 1977).

In conclusion, it is possible to affirm that Lacanian Discourse Analysis aims to move deeper the analysis of the ways in which language and subjectivity interact and to underline subjective positions in a collective dimension through the discourse of cultural criticism (Parker, 1997). In conclusion, it is possible to affirm that Lacanian Discourse Analysis aims to move deeper into the ways in which language and subjectivity interact and to underline subjective positions in a collective dimension through the discourse of cultural criticism. Indeed, contemporary leaning on Lacan theory as theoretical and methodological framework towards cultural studies and social sciences (Parker, 2007, 1987, 1997; Zizek, 2002; Hook, 2008) and political theory (Zizek, 2004; Laclau & Mouffe, 2001; Lemke, 1995). Through psychoanalysis, it has been proved that not only does the matter depend on the act of speaking, but that also the act of speaking itself depends on the collective structures of language.

1.2.3 "Power doesn't exist" and "The Other lacks": a comparison between Foucault and Lacan

In this section I connect the Foucauldian and the Lacanian reflections about power. Even if this two theoretical approaches present unbridgeable gap and it is well known the Foucault's harsh verdict on psychoanalysis, I think that some aspects create unwittingly similarities between these two authors.

For Lacan the basic assumption about the power is that there is the Other, that is "always already" there. For Lacan, the Other arises when we are confronted with the symbolic structure. It is the hypothetical authority that upholds the structure and supposed addressee of any act speech, beyond interlocution or intersubjectivity (Lacan, 1976a, 1949/1976b). For example, Lacan theorises the notion of *master signifier* (see Chapter 4, section 4.2.1) as a structural function on which the power relies and from which the power is promulgated. But this structural function is in itself empty, devoid of meaning (Lacan, 1969-1970/2007). The theory of Four Discourses is his most elaborate account of power and it took the starting point from this assumption.

For Foucault no such assumption is necessary. Indeed, the power doesn't come from a definable location. According to Foucault, this is the classical illusion of the political theory that saw power situated in a particular locus, or person, or group of people. Moreover, in Foucauldian perspective there is no hidden depth of power; neither can it be reduced to an origin transcendent or natural, from which it would derive and which would endow it with authority. Leaning on this conceptualisation, Foucault proclaimed himself anti-structuralist.

Nevertheless, In *Discipline and Punish* (Foucault, 1977), the centre-piece of the argument, the Panopticon, unites in effectively way a diversity of micro-relations of power, that it can be easy translate into a number of different domains. As Foucault observe: "It is surprising that the prison resemble the factories, schools, army barrack, hospitals, which all resemble prisons" (1977, p. 229). Hence, the multiplicity and heterogeneous micro-relations converges into one single image of power. Furthermore, the status of the Panopticon is that of a fiction, but it is a part of fiction that is necessary to account for reality, as Foucault himself points out: "these programmes induce a whole series of effects in the real" (1977, p.81). Thus, the programme doesn't describe what

really happens, rather what makes it happen. It is a fiction that produces real effect and function as a “historical a priori” (Dolar, 1998, p.89).

In conclusion, for both of them power is not analysable in itself. It is only possible to analyse how does power work, and underline its relations (with knowledge) and effects (on individuals and on practices). This idea is well expressed in Foucauldian sentence "the power doesn't exist". But, even for Lacan power is strictly linked with the non-existence. Indeed, his sentence "the Other lacks" is a way to affirm that the Other doesn't exist: it is necessary, but it is a historical a priori. For this reason it is not analysable in itself. The only events analysable are the consequences of its effect on the subjectivity and on the society.

II. OBJECT OF ANALYSIS

1.3 Aims

The specific way in which science operates may be revealed adequately not only examining the contents, but also analysing and working out the way of the speaking of science. Knowledge is made into science by a transformative mechanism, which consists in a process of establishing a body of intersubjectively valid rules and a series of narrative and linguistic conventions. Substantially it is a matter of articulation, a matter of language.

This doctoral study interrogates the construction of otherness in mental health domain, and in detail the constitution of otherness through the manufacture of boundaries between normality and pathology. This work does not contribute to arguments that debate the “truth” of particular mental disorders or claims that “mental distress” is purely a social construct. This means that instead of engaging in a battle of truth and fiction with the human sciences as to the existence of mental disorders, I will focus on how the object “mental disorder” has been formed; that is, how the difference between normality and pathology is articulated and brought to attention, what might be the “effects in the real” (Foucault, 1980, p. 237) and how it shapes the subjectivity of both potential patients and mental-health professionals. Moreover, Foucault notes that

“psychiatric discourse finds a way of limiting its domain, of defining what it is talking about, of giving it the status of an object – and therefore of making it manifest, nameable, and describable” (Foucault, 1972, p. 46). He suggests that the construction of categories and description of disorders serves to provide the human sciences with a locatable object of examination (Foucault, 1976). Of interest here is how psychiatric discourse functions to define “objects, fully formed and armed, that the discourse of psychopathology has then merely to list, classify, name,” (Foucault, 1972, p. 47) and how the statement “enables [the object] to appear to be placed in a field of exteriority”, as a function of certain discursive dividing practices. (Foucault, 1972, p.50).

In particular I will focus on the discourse of Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA). Indeed, the DSM discourse has progressively become “the most authoritative text on mental health in the Western culture” (Crowe, 2000, p.69) and the APA has been recognised as an institution able to determine the existence and legitimacy of different mental categories at particular times. Because of this, the discourse of DSM exerts an influence, in terms of social practices and policies, on several domains: not only the health and mental-health area, but also the insurance and legal fields. It also contributes to shape social perceptions and opinions about “abnormality”. The critical approach has been useful to highlight the circular relationship connecting description of mental disorders with culture. Indeed, cultural concerns and the concerns of psychopathology are not separate (Parker et al., 1995). In this sense, I consider the discourse of DSM as a historically, politically, and culturally charged, constantly changing reflection of society.

1.4 Two brief histories

1.4.1 Madness in Western culture: culture concerns and concerns of psychopathology

Different cultures and epochs have radically different conceptions of what is mental illness. Leaning on the Foucauldian history of madness (Foucault, 1965), I start this brief reconstruction of the changes occurred in the conceptualisation of madness in relations to the changes occurred in Western culture from the Middle Age. Indeed in the Western culture, it is from the disappearance of leprosy in Europe that the experience of

isolation and internment of madness has been started. This process of isolation and imprisonment reached the acme in the Seventeenth century, when hospitals and health care facilities that were intended to accommodate lepers were turned in places of correction for fool people. During the Middle Ages, madness was perceived as representative of the opposition between Good and Evil. In this perspective, madness was conceptualised as an inseparable part of human nature. For Foucault, the key to understanding the medieval conception of madness is abandonment: "Poor vagabonds, criminals, and 'deranged minds' would take the part played by the leper, and we shall see what salvation was expected from this exclusion, for them and for those who excluded them as well" (Foucault, 1965, p.7). Journeys, represented by Bosh in the painting *The boat of fools*, became synonymous with both the divide between madman and citizen and the connection between the two. The journey, as metaphor of research of the sanity, represented a safeguard, something that was able to isolate, distinguish the madman from and connect the madman to a state of grace, to a religious level. This was because, the lunatic cannot freely connect with society, but he may connect with society through his punishment (the abandonment) and his salvation. Indeed, in this age, madness had no cure except forgiveness by a divine intervention. Foucault thus places the madness in the Middle Ages in a borderline position, "on the horizon of medieval concern" (Foucault, 1965, p.11).

It is with the reflections of Descartes about the authority of thought (Decartes, 1637/2000) that the conceptualisation of madness shifts from the opposition between Good and Evil to the opposition between Reason and Unreason. According to Felman (2009), "the entire history of Western culture is revealed to be the story of Reason's progressive conquest and consequent repression of that which it calls madness" (p. 209). Actually, until the Eighteen century the madman was not seen as sick and the bridge to the medical treatment of the fool was the moral treatment of the insane. This regime of moral improvement often involved treatment intended to bring the individual back into an engagement with civilized society (Parker et al., 1995). For Foucault, the institution of these houses and hospitals of confinement represent "the moment when madness was perceived on the social horizon of poverty, of incapacity for work, of inability to integrate with the group; the moment when madness began to rank among the problems of the city" (Foucault, 1965, p. 64). In this perspective, madness "was starting to be seen not so

much as completely "outside", but as problem "inside" society" (Parker et al., 1995, p.7). Madness, here, graduated from a localized, personal conundrum into a widespread, social epidemic. Furthermore, madness in this era became a social and economic issue. In other words, during the Enlightenment the culture concern was a "loss of potential efficiency" (Rose, 1986, p.52).

In the postmodern era, the conceptualisation of the mental distress is traced back to the nature of psyche, which is now, according to science and philosophy observable carefully and classifiable (Parker et al., 1995). This classification has proceeded apace until the present day: the emphasis now is on the individuality of the "patient" and the specific of the symptoms they display. In the "hard-line medical approaches" (Parker et al., 1995, p. 7) the emphasis is on the exhibited symptoms, and in the softer humanist varieties the person is valued as the carrier of the symptoms. The more recent changes in diagnostic categories still follow changes in moral reasoning in the surrounding society, and the decision to take out a category often reflects changes in morality.

In conclusion, popular representations do not float around ready to be used at will by whomsoever may wish, but are organized in material structures of power as practices.

1.4.2 The APA and the development of the DSM

During the 19th and 20th centuries, medical education and services for the "poor and lunatics"(Barton, 1987, p.22) proliferated in the U.S. under the influence of the medicine and "humanitarian policies" (Barton, 1987, p.17) predominating in Europe (APA, 2012a). In 1844, 13 superintendents and organisers of psychiatric institutions (then-called "insane asylums") founded the Association of Medical Superintendents of American Institutions for the Insane. The Association's name was changed, first to the American Medico-Psychological Association in 1892 and, finally, to the American Psychiatric Association in 1921. In 1917, the APA's Committee on Statics established and adopted the Statistical Manual for the Use of Hospitals for Mental Diseases. Nine years later, the APA collaborated with the American Neurological Association and the American Medical Association to create the psychiatric subsection of the Standard Classified Nomenclature of Disease (the "Standard").

The first edition of the DSM was published by the APA in 1952. It was a glossary of clinical entities and included 106 categories. The history of the APA is closely related to the history of psychiatry in the United States (Hirshbein, 2009); indeed, during the 20th century, when psychoanalysis was “a leading therapy in the U.S.” (APA, 2012), most APA members adopted a psychodynamic approach. In fact, the DSM-I was extensively influenced by psychodynamic theories as well as Mayer’s concept of “reaction” (Mayer, 1950). From this perspective, mental disorders were regarded as reactions to psychological, social, and biological stressors. This approach persisted in the second edition of the DSM (APA, 1968), which contained 185 clinical entities. In 1973, because of the social pressure from the emerging antipsychiatric movement and gay/lesbian organisations, the APA published a new edition of the DSM-II that no longer listed homosexuality as a pathological condition (APA, 1973)

With the increasing prominence of the biochemical and somatic approach (Ayd & Blacwell, 1971) the APA abandoned psychodynamic terminology and presented a multiaxial system founded on the evidence-based medical model. The number of clinical categories grew to 265. The DSM-III-R (APA, 1987) was published as a revision of the DSM-III; in this version, the number of diagnostic entities increased to 297. The biomedical approach endures with the DSM-IV. The DSM-IV was published in 1994 (APA, 1994). This edition represented a comprehensive review of the literature “to establish a firm empirical basis for making modifications” (APA, 2012b). The included changes were related to the classification system; “disorders were added, deleted, and reorganised” (APA, 2012b), as were proposed diagnostic criteria. The most recent editions of this manual – the DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000) – include 365 diagnostic categories.

In May 2013, the DSM-5 was published. According to the current dominant approach to medicine and psychology, the DSM-5 takes (or reaches to take) cognitive neuroscience, brain image and genetics as key reference points for the understanding of mental distress.

Chapter 2

DSM OVER TIME: FROM LEGITIMISATION OF AUTHORITY TO HEGEMONY

2.1 Introduction

In the mental-health domain, diagnosis can be regarded as a matter of the "politics of definitions" (Conrad & Schneider, 1992, p.25) since the diagnostic process is characterised by a high degree of subjectivity and controversy (P. Brown, 1995). Competing schools within the psy-complex (D Ingleby, 1979; Rose, 1985a) hold divergent beliefs regarding the existence of certain conditions, the aetiology of certain mental disorders and the pathological processes that lead to their development.

In this study, I focus on how the Diagnostic and Statistical Manual of Mental Disorders (DSM), edited by the American Psychiatry Association (APA), has progressively positioned itself as "the most authoritative text on mental health in the Western culture" (Crowe, 2000, p.69) exerting an influence not only on the health and mental health domain, but also on social practices, for instance in the insurance and legal fields. Mental health care professionals exercise moral and intellectual leadership in society (Albee & Joffe, 2004), and their professional discourses (beliefs, attitudes, explanations, courses of action) shape society's assumptions and beliefs about psychological distress. Indeed, as noted by Georgaca and Avdi (2012), there is "a mutual relationship between discourses and institutions; discourses are produced and disseminated through institutional practices and they in turn legitimize and maintain these practices" (p. 148).

In the Foucauldian tradition, the notion of discourse refers to historically developed systems of ideas that form institutionalised and authoritative ways of addressing a topic: the so-called "regimes of truth" (Alvesson & Karreman, 2011, p. 129). Moreover, discourses are regarded as bodies of knowledge and expressions of

power/knowledge relations "that systematically form the object of what they speak" (Foucault, 1977, p. 49). The opposition between true and false is relative, mobile and revised throughout history, being linked to the historically-bound legitimate authority and thus to the different standards of accepted truthfulness. Therefore truth is a discursive construction and different regimes of knowledge determine what is true and false. Foucault defines a discipline as "a domain of objects, a set of methods, a corpus of prepositions considered to be true" (Foucault, 1970/1981, p.59). In other words, a discipline is what is required for the construction of new statements. With his own investigation Foucault aimed to find the criteria of inclusion and exclusion through which discourses – about psychology, psychiatry, sexuality, education and law – legitimised themselves over time. It is suggested that Foucault-inspired discourse studies have generally involved treating data "as expressions of culturally standardised discourses that are associated with a particular setting" (Miller & Fox, 1997, p. 35).

Relying on a critical discourse analysis (CDA) perspective, in this study I analyse the DSM discourse as a form of historically determined discourse which entails power relations.

In my view, CDA is particularly useful, due to the way it aims to integrate and triangulate knowledge about historical sources and the background of the social and political fields within which discursive events are embedded. Discursive and non-discursive practices are regarded as strictly interconnected: through discourse, practices are prepared, promulgated and legitimised (ex-ante and ex-post). From this standpoint, CDA can offer a set of analytical tools to empirically examine how authoritativeness is discursively constructed and reconstructed over time. Consistently with these premises, this study examines how legitimisation and hegemony are discursively constructed and enacted, in all editions of the DSM – from the DSM-I to the DSM-5 – and highlights the role played by the APA.

2.2 Theoretical framework

To deconstruct how the authoritativeness of the DSM has been constructed and legitimised over time, I combine a critical psychology (CP) perspective with critical discourse analysis (CDA).

CP and CDA share a particular concern with issues of power and ideology and the ways in which they are discursively produced and reproduced. Over the past decades, a number of conceptual and analytical tools have been developed within these theoretical frameworks to analyse the relationships between discourse and dominance, including legitimisation and hegemony. In this work, *legitimisation* is used to examine the self-legitimisation strategies employed by the APA and the ways in which the hegemony of the DSM in the *psy* field was discursively established, and *cultural hegemony* is applied in the analysis to reconstruct the process through which the APA conveys specific meanings about what mental distress is, creating and establishing within the psychiatric domain a dominant view that justifies the status quo.

2.2.1. Critical Psychology and Critical Discourse Analysis in mental-health

Inspired by the Foucauldian tradition, CP addresses the way in which psychological and psychiatric knowledge is culturally and historically constructed (Radley, 1994; Samson, 1995).

Since the 1990s, the categories adopted by DSM have been debated and criticised from a CP perspective: it is contented that the discourse on mental illness and the diagnostic system presented in DSM are shaped by "cultural dictates" (Hare-Mustin & Marecek, 1994, p. 535), the values of the dominant élite (Caplan, 1991, 1995). In addition, in DSM the patterns of symptoms are viewed as evidence of an underlying objective dysfunction; consequently individual experience of distress is objectified. In sum, DSM sets normative standards that allow professionals to undertake dividing practices as well as to make decisions about whether an individual is normal or abnormal and whether particular behavioural patterns must be regarded as functional or dysfunctional (Foucault, 1972, 1976). Therefore, the meaning attributed to any psychological entity (e.g., mental

disorders) is better conceptualised as “a socially constructed product of discourse, that is, as a historically situated effect of power” (Banister et al., 2011, p. 143).

Indeed, critical psychology aims to:

a) view psychiatry’s more essentialist claims from a historical perspective and challenge the pathologisation of individual experience dominating both clinical psychology and psychiatry (Bilic & Georgaca, 2007; Georgaca, 2013b; Parker et al., 1995);

b) highlight the role of the socio-cultural context in the production of the meanings associated with mental distress through which certain types of experiences are pathologised (Cromby & Harper, 2009; Crowe, 2000; Parker, 2008).

Despite the intersecting theoretical backgrounds and overlapping interests of CP and CDA, disciplinary fragmentation and overspecialisation have thus far reduced the opportunities to combine them into an integrated approach. CDA aims to offer an interdisciplinary approach to the study of discourse that views language as a form of social practice constructed for specific purposes and serving the interests of particular groups, deconstructing how dominant social structures naturalise conventions to obscure the role of power in the production of knowledge (N. Fairclough & Wodak, 1997; N. Fairclough, 1992).

2.2.2. Legitimisation in critical discourse studies

Legitimisation can be defined as the product of a multiplicity of discursive strategies and devices that explain and justify a social activity, typically involving the provision of “good reasons, grounds, or acceptable motivations for past or present action” (van Dijk, 1998, p. 255). Taking previous studies on legitimisation into account (i.e., Martin Rojo & van Dijk, 1997; Van Leeuwen & Wodak, 1999; Van Leeuwen, 1995, 2007), this study considers and further develops a set of categories proposed by Van Leeuwen (1995, 2007) to analyse legitimisation. The author refers to four main legitimisation strategies: authorisation (reference to authority figures or traditions), moral evaluation (reference to a value system), rationalisation (references to goals and uses of institutionalised social action) and mythopoesis (narratives that reward legitimate

actions) (Van Leeuwen, 2007). Other commonly used legitimisation techniques include references to temporality (hypothetical future) and altruism. All of these strategies can be used individually or in combination with others. In this sense, legitimacy is always established in relation to discourses that provide the "frames" through which individuals make sense of particular issues and give meaning to them (Van Dijk, 1998; Van Leeuwen and Wodak, 1999). From this perspective, legitimisation is the creation of a sense of positive, beneficial and ethical action (Van Leeuwen and Wodak, 1999; Van Leeuwen, 2007). Different types of arguments can be presented in the pursuit of legitimisation, ranging from objective information, such as scientific evidence used to construct truth, especially in scientific discourse (Mccann-Mortimer, Augoustinos, & Lecouteur, 2004), to personal experiences.

2.2.3. Hegemony in critical discourse studies

Legitimisation can be regarded as strictly connected to hegemony. According to Laclau and Mouffe (2001), "structural undecidability is the very condition of hegemony" (p. xii). From this perspective, hegemony concerns not only the exercise of power but also the attempt to control the fixation of meaning in a particular social context. A discourse becomes hegemonic when the proliferation of antagonisms creates a great number of elements (in this peculiar case e.g.: symptoms, mental distress, psychic structure, and so on) whose nature is not ascribable to "evidence". This type of situations creates a "vast area of floating elements and the possibility of their articulation" (Laclau & Mouffe, 2001, p. 136). In discursive terms, hegemony is constructed through the establishment of ostensible connections among particular "floating" signifiers, which, in turn, convey certain worldviews, norms and values within a system.

This fixation of meaning can be regarded as key feature of any type of technocratic discourse (Mckenna & Graham, 2000), including the DSM discourse: through claims of objectivity based on the accumulation of supposed evidence and facts, it constructs "true" causes and necessary solutions that could be valued by society and should be accepted by all parties (McKenna and Graham, 2000, p. 222). In this sense, technocratic discourse conceals the interests and values that it holds in order to promote specific policies. This type of discourse aims to construct hegemony because it presents itself as

"above the fray" (McKenna and Graham, 2000, p. 221) and derived from unbiased and value-free knowledge produced by experts and the "technical élite" (McKenna and Graham, 2000, p. 222).

2.3 Method of analysis and corpus

I adopt a multi-level model of analysis that embraces the notion of genre (Bazerman, 1994, 2004; N. Fairclough, 2003b) and the concept of repertoire in scientific discourse (Mulkay & Gilbert, 1984). In approaching genres, critical discourse analysis focuses on "the structural features of the specific social occasion in which the text has been produced [seeing] these as giving rise to particular configurations of linguistic factors in the text which are realisations of, or reflect, these social relations and structures […] and how relations of power are realized linguistically" (Kress & Hodge, 1979, p. 33). A genre shapes the schematic structure of the discourse and constrains content and style choices (Fairclough, 2003). Because actors use different genres in different social and institutional contexts, discourse practices can be analysed on the basis of how actors exploit different genres to legitimise their own policies and to delegitimise their opponents in different situations and contexts (Chilton & Schäffner, 2002).

As far as the concept of repertoire is concerned, Gilbert and Mulkay (1984) suggested that scientists use two principal repertoires - the contingent and the empiricist – that contribute to scientific debates and aim to persuade readers of the correctness or incorrectness of a specific point of view. Genres and repertoires are considered to be "the origin, part of the validation system, and means of circulation, storage, and access of particular pieces of knowledge" (Bazerman, 2011, p. 233).

The data set is constituted by the Forwards and Introductions to the different editions of DSM, from DSM-I through to DSM-5. The materials were approached considering the following interrelated dimensions: (a) semantic macro-areas; (b) discursive strategies; and (c) linguistic means.

The analysis was based on repeated readings of the materials to identify patterns and recurring organisations. The entire corpus was read repeatedly, and all instances

coded as relevant to any themes or discursive strategies were noted. Extracts related to each theme were placed in separate document files and numbered for reference. The extracts included in this chapter are meant to indicate the range of uses of certain strategies; they have been renumbered according to the order of presentation.

2.4 Analysis

2.4.1. DSM-I and DSM II: self-legitimisation strategies

2.4.1.1. Setting the stage

The Forwards of DSM-I (APA, 1952) and of DSM-II (APA, 1968) are mainly narrative accounts whose purpose is to recount events that unfolded during a certain period and that involved many different actors. The purpose of scientific narratives is to legitimise and justify actions and positions in the real world: one of their effects is to normalise the accounts they project over the events, so that these accounts come "to be perceived as self-evident, uncontestable and non-controversial" (Baker, 2006, p.11). Two main strategies can be discerned to fulfil this purpose:

a) *Once upon a time...*Through temporal, spatial and social coordinates, these accounts construct a coherent story in which a variety of professional, political and institutional actors are located, as exemplified in the excerpt [1]:

> [1] At the beginning of World War II, American psychiatry, civilian and military, was utilizing a system of naming developed primarily for the needs and case loads of public mental hospitals. Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists found themselves operating within the limits of a nomenclature specifically not designed for 90% of cases handled. […] In 1944, the Navy made a partial revision of its nomenclature to meet the deficiencies mentioned, but attempted to stay within the limits of the Standard where possible. In 1945, the Army established a much more sweeping revision, abandoning the basis outline of the Standard and attempting to express present day concepts of mental disturbance. This nomenclature eventually was adopted by all

> Armed Forces, and in 1946 the Veterans Administration adopted a new nomenclature which resembled closely that of the Armed Forces. In 1948, a revised International Statistical Classification was adopted, and categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature. By 1948, the situation in psychiatric nomenclature had deteriorated almost to the point of confusion which existed throughout medical nomenclature in the twenties. (APA, 1952, p. vi-vii)

In this extract, events are displayed in chronological order, as a sequence of "facts" leading up to the problematic situation that the APA is now attempting to resolve through the publication of DSM. Throughout this account, the APA conceals the narrator – "here no one speaks" as suggested by White (1981, p.7) – and, by constructing a coherent and (supposedly) objective narrative about psychiatry in the U.S., gives the impression that "the events tell themselves" (White, 1981, p.7). In this way, the replacement of the previous nomenclature proposed in DSM appears to be incontestable. In addition, this account not only allows for the construction of a coherent story, relating events and allocating specific roles to the many social actors involved – such as professionals and institutions – but it also allows for the expression of a moral evaluation towards those events and actors (Baquedano-Lopez, 1997). Indeed, in developing this story line, several self- and other presentation strategies are used, all of which imply positive or negative evaluations.

b) *Self and other presentation*: *empiricist vs contingent repertoires*. The other social actors are represented as pursuing their own interests and goals or as unable to develop a uniform nomenclature [2]:

> [2] Many teaching centers devised modified systems of nomenclature for their own use, but the official nomenclature into which diagnoses were coded for statistical and medical record files remained the original 1933 nomenclature, as published in the Standard. (APA, 1952, p. vi)

Their nomenclature is described as “in itself predictive of the difficulties which would soon be encountered” from “the origin” (APA, 1952, p. vi).

In this narrative, the APA positions itself as the only *super partes* actor that can fulfil the needs and demands of others while guaranteeing neutrality and objectivity. The APA is implicitly represented as an organism that recognises the needs of mental health professionals and is able to provide them with solutions.

Moreover, the process leading to the publication of the first edition of DSM is depicted as consensual [3]:

> [3] A high percentage of psychiatrists contacted felt that change in the nomenclature was urgently needed, with special attention to the areas of personality disorders and transient reactions to special stress. (APA, 1952, p. vii)

This is noteworthy, if we consider the fact that a hegemonic élite is one that gains support for itself from others. This outcome is achieved via two devices. Firstly, the élite has to take into consideration the interests and tendencies of the groups over which hegemony has to be exercised (Gramsci, 1929-1935/1975). Secondly, any concessions to public demands should be publicised in order to demonstrate the ruling class’s probity and hence to justify their moral and political leadership.

The APA reinforces its position through the adoption of the “authorisation strategy” described by Van Leeuwen (2007), which allows the APA to be established as invested by other relevant institutions with the authority to set up a general nomenclature, as shown in the excerpt [4]:

> [4] Accordingly, the revision was presented to the Council of the American Psychiatric Association at its meetings on November 6, 1950, with the recommendations that it be adopted as the officially supported nomenclature of the American Psychiatric Association, that it be recommended by Council to the Standard Nomenclature for inclusion in the 1951 edition, and that the Committee be authorized to prepare this

> Diagnostic and Statistical Manual for publication by the Association. These recommendations were approved by Council. (APA, 1952, p. ix-x)

Furthermore, the two repertoires identified by Gilbert and Mulkay (1984), the empiricist repertoire and the contingent one, are selectively employed throughout the different editions of DSM to accomplish specific goals. In this case, the empiricist repertoire is deployed to frame the activities and theoretical preferences of the various competing schools within psychiatry and to delegitimize their positions [5]:

> [5] The development of a uniform nomenclature of disease in the United States is comparatively recent. In the late twenties, each large teaching center employed a system of its own origination, no one of which met more than the immediate needs of the local institution. Despite their local origins, for lack of suitable alternatives, these systems were spread in use throughout the nation, ordinarily by individuals who had been trained in a particular center, hence had become accustomed to that special system of nomenclature" (APA, 1952, p. v).

In the contingent repertoire, the contingent nature of scientific activities and theoretical preferences is explicitly acknowledged, as personal and social factors are. As Mccann-Mortimer and colleagues (2004) argue, scientists use the empiricist repertoire to justify and validate their own views and beliefs. In contrast, scientific opponents, whose views are regarded as incorrect, are largely described in terms of the contingent repertoire. The contingent nature of the nomenclature adopted by actors other than the APA is expressed here through the use of terms such as "its own", "local", "special", "particular", or "individual" to describe the classification systems they employ. There is an implicit idea here that these nomenclatures are a product of theoretical, technical and personal preferences and are not based on "objective" scientific knowledge.

2.4.1.2. Establishing historical antecedents and an analogy with medicine

The Forward of the first edition of DSM begins with a clear statement of the problem that the APA is attempting to solve: the presented issues of the lack of a

“uniform nomenclature” (APA, 1952, p. v) and the “polyglot of diagnostic labels” allow for describing the current situation of psychiatry as “deteriorated” (APA, 1952, p. v) and almost reaching the point of “confusion” (APA, 1952, p. v) or “chaos” (APA, 1952, p. v). By using words such as “need” (APA, 1952, p. vi; vii; viii), “necessary” (APA, 1952, p. vi), “urgently” (APA, 1952, p. viii), “untenable” (APA, 1952, p. vii) and “deficiencies” (APA, 1952, p. vii), the APA creates a sense of crisis and urgency. An analogy between U.S. psychiatry in the 1940s and medicine in the 1920s is explicitly established: as already happened in medicine, the adoption of a “nationally accepted standard nomenclature” (APA, 1952, p. v) or an “official nomenclature” (APA, 1952, p. vii) would allow the “deteriorated situation” and “polyglot of diagnostic labels and systems" (APA, 1952, p. v) in psychiatry to be solved [6]:

> [6] In late 1927, the New York Academy of Medicine spearheaded a movement out of this chaos towards a nationally accepted standard nomenclature of disease. In March 1928, the first National Conference on Nomenclature of Disease met at the Academy; this conference was composed of representatives of interested governmental agencies and of the national societies representing the medical specialties. A trial edition of the proposed new nomenclature was published in 1932, and distributed to selected hospitals for a test run. Following the success of these tests, the first official edition of the Standard Classified Nomenclature of Disease was published in 1933, and was widely adopted in the next two years. (APA, 1952, p. v)

This analogy is established through an account whose narrative structure can be regarded as prototypical: it consists of a description of the situation as “chaotic”, the break of the previous balance, the reinstatement of a different balance and a happy ending (Bernardelli & Ceserani, 2005). According to Van Leeewen (2007), this kind of analogy is a common method for expressing moral evaluation and comparisons in discourse and it almost always has a legitimatory or de-legitimatory function.

In this framework, the need for a uniform nomenclature is justified by two main arguments: 1) the biomedical foundation of psychiatry and its "integration [...] with the rest of medicine" (APA, 1968, p. vii), and 2) its communication-related benefits [7].

> [7] In selecting suitable diagnostic terms of each rubric, the Committee has chosen terms which it thought would facilitate maximum communication within the profession and reduce confusion and ambiguity to a minimum. (APA, 1968, p. viii).

These two arguments are grounded on the assumption that both the biomedical foundation of psychiatry and communication can be perceived as valuable and uncontroversial. This idea is reinforced through the use of the contrastive procedure to assert that a uniform nomenclature is needed: the general/local interest and uniformity/chaos dichotomies are not neutral and clearly imply an evaluative dimension. As Edwards and Potter (1992) suggest, the use of contrast is a central feature of a rhetorical process through which a "factual" version is constructed in opposition to an "alternative which is itself formulated in an unconvincing or problematic manner" (p. 163). Binary schemes, which rigidly juxtapose opposites, can be regarded as an essential feature of legitimising discourse.

2.5 DSM-III and DSM-IV: from legitimisation to hegemony

2.5.1. Redefining mental disorder and establishing the nature of valid knowledge

As mentioned above, the Introductions of DSM-III (APA, 1980) and of DSM-IV (APA, 1994) are basically expository texts. This genre is normally used to convey conceptual information and abstract knowledge (Di Pardo, 1990; Grabe, 2002). In this case, the text aims to present a new definition of mental disorder and a new set of diagnostic criteria. At the same time, the APA is positioning itself as the only legitimate

actor that can establish the nature of valid knowledge in this domain. Three main strategies can be discerned to fulfil this purpose:

a) *Use of the empiricist repertoire*. The discourse in DSM-III (APA, 1980) and in DSM-IV (APA, 1994) is presented as a natural sciences discourse in which the empiricist repertoire is predominant (Gilbert and Mulkay, 1984). This repertoire is usually deployed in formal texts to establish intellectual legitimacy in a particular domain. Consistently with this, in DSM-III (APA, 1980) and DSM-IV (APA, 1994), the actions and decisions of the APA are presented as aiming to give primacy to empirical data [8]:

> [8] Decisions had to be substantiated by explicit statements of rationale and by systematic review of relevant empirical data. To increase the practically and clinical utility of DSM-IV, the criteria sets were simplified and clarified when this could be justified by empirical data. (APA, 1994, p. xx)

Hence, the new approach to the diagnosis and classification of mental disorders is supported by arguments presented as the state of affairs (e.g., Di Pardo, 1990), given that the knowledge seems “to flow unproblematically from a methodology that is characterized by objectivity and rigor” (Burchell, 2007, p. 146).

b) *Manufacturing consent by claiming for an“atheoretical” approach*.

Through this second strategy, the APA presents its own nomenclature as acceptable “to clinicians and researchers of varying theoretical orientations” (APA, 1980, p. 2) because it is value-free and independent from the competing schools within psychiatry. In this manner, the objectivity of this classification is based on acceptance by all parties (McKenna, 2000), and this reinforces the consensus around DSM system of classification. However, as mentioned above, this change in DSM-III and in DSM-IV reflects a macro-discursive turn within the scientific field implying a wider focalisation on biology (Rose & Novas, 2003). Therefore, the DSM system of classification is not “atheoretical” (APA, 1994, p. 7), as the APA changes its paradigms of reference moving from psychodynamic theories to biomedical models.

c) *Defining mental disorder*. In addition to the new multi-axial approach to evaluation, an explicit definition of mental disorder is provided [9]:

> [9] Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder". The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction […] In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern 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 risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. (APA, 1994, p. xxi-xxii)

Through this definition, the APA created coalescence among particular signifiers such as “individual”, “disability”, “dysfunction”, and “risk of suffering”. Therefore, definition of mental disorders is a product of an external practice, and this sets out a central dimension of politics to determine what mental disorder in our society is and what it is not.

In sum, I can affirm that all of these strategies have the implicit advantage of consolidating the APA’s hegemonic position. The APA presents itself as an actor which is able to define what valid knowledge is in the domain of mental health.

The achievement of a dominant position is explicitly stated in DSM-III-R (APA, 1987) [10]:

> [10] DSM-III was intended primarily for use in the United States, but it has had considerable influence internationally. As a result, the entire manual, or the Quick Reference to the Diagnostic Criteria ("Mini-D"), has been translated into Chinese, Danish, Dutch, Finnish, French, German, Greek, Italian, Japanese, Norwegian, Portuguese, Spanish and Swedish. (APA, 1987, p. xviii).

2.5.2. Making a claim for clinical effectiveness

The effectiveness of the new classification system for both clinical practice and training is explicitly stated in DSM-III to justify its adoption. For this reason, great importance is attributed to descriptions and lists, which aim to inform the reader and to offer explanations related to new concepts (Nystrand, 1989). The predominant role assigned to elucidation is consistent with the idea that expository texts are based on a "teacher-centered power" model (Di Pardo, 1990, p. 86) in which someone who has an authority based on expertise transmits his or her own knowledge to a lay audience [11]:

> [11] The potential user of DSM-III should not be intimidated by its large size. Several features are included that can help the user become adept at making optimal use of the manual. By examining the listing of Axis I and Axis II diagnoses and conditions contained in Chapter 1, the user can become familiar with the organization of the classification into major and minor diagnostic classes. By studying the Chapter 2, The Use of This Manual, the reader will learn how to use the multiaxial system, record principal and secondary diagnoses, indicate various levels of diagnostic certainty, and use the diagnostic criteria as guides in making diagnose. […] In making a DSM-III diagnosis the clinicians may find it more convenient to consult the Quick Reference to the Diagnostic Criteria form DSM-III (Midi-D), a pocket-sized booklet

> sold separately, that contains only the classification, the diagnostic criteria a listing of the most important conditions to be considered in a differential diagnosis of each categories, and an index. It should be noted that the index in both this book and the Quick Reference can be used when the clinicians is in doubt about the DSM-III term that corresponds to a DSM-II term or the name of some other widely used diagnostic category. (APA, 1980, p. 10-11).

In the above extract, the repeated employment of the term "use", both as a noun and as a verb, is noteworthy and is clearly associated with the establishment of normative standards for clinical practice, particularly with regard to orienting the diagnostic process. From this perspective, DSM becomes a tool for the transmission of the discipline's norms and therefore for the establishment of a system of intellectual control (Gramsci, 1929-1935/1975). Educational purposes play a central role in the construction of a cultural hegemony that is established through civil institutions, such as schools (Gramsci, 1929-1935/1975).

2.6 DSM-5: preparing future changes

The narrative of DSM-5 is similar to a mythological account centered on the myth of the 'big enterprise' necessary to re-establish the classification system of mental disorders. As the APA highlights, the creation of the last edition of DSM involved "hundreds of people" (APA, 2013, p. 5) working for a "12-year process" (APA, 2013, p. 5). Indeed, the development of the classification system presented in DSM-5 appears to be a choral process to which everybody has participated, including "physicians, psychologists, social workers, nurses, counsellors, epidemiologists, statisticians, neuroscientists, and neuropsychologists [...] patients, families, lawyers, consumer organizations, and advocacy groups" (APA, 2013, p. 6).

According to Barthes (1957), there are two levels of signification in myths: a sentence refers to a number of concepts that, in turn, recall another dimension, the dimension of ideology. Ideology is meant as linked to the system of values and beliefs embedded in a society. Moreover, the myth transforms history in nature: indeed, in

mythological accounts the historical dimension is concealed, given that all events are presented as grounded in nature. Hence, the myth aims to establish a contingent event as eternal. Two main strategies are discerned to fulfil this purpose:

a) *The comparison: History vs Science.* In this edition, history, on the one hand, is presented as a source of misunderstanding and error, and science, on the other hand, is presented as a non-historical knowledge, and consequently lacking of fallacy, as showed in the excerpt [12]:

> [12] Of course, principled disagreements on the classification of psychopathology and on specific criteria for certain disorders were expected given the current state of scientific knowledge. However, most of the salient differences between the DSM and the ICD classification do not reflect real scientific differences, but rather represent historical by-products of independent committee processes. (APA, 2013, p. 11)

Therefore, if history has divided and created rifts, the clinical and scientific information, due to its non-historical foundation, is presented as an element of union and aggregation, as explained in the next paragraph.

b) *The coalescence of the other social actors.* In DSM-5 the APA does not introduce other social actors, or, to be more precise, the others are presented as included in the DSM discourse. Indeed, on the one hand, the APA reproposes the idea of DSM criteria as tools to create a "common language for communication between clinicians" (APA, 2013, p. 10). This idea was introduced for the first time in DSM-II (cf. APA, 1968, p. viii). The Introduction of DSM-5 is structured as a scientific text, in which great emphasis is placed on processes and methods, which makes DSM-5 knowledge appear transparent and verifiable. This kind of language seems to make DSM-5 knowledge accessible to all.

On the other hand, the APA finds a "harmonisation with ICD-11" (APA, 2013, p. 11), aimed at developing "new treatments, and the consideration of global applicability of the results by international regulatory agencies" (APA, 2013, p. 11). In the Third and Fourth editions, the APA presented DSM as the more empirically grounded manual and, consequently, as the most useful one in clinical practice (see .dsm). In this perspective, the discourse of DSM appeared as the most fruitful discourse among different psychiatric

discourses. Now, the APA tries to grasp universal knowledge about mental disorders, towards which all the social actors working in the psychiatric field could converge; in this way, the APA discursively conceals otherness, meant as difference, from the mental health domain.

2.6.1 Grasping future knowledge about mental disorders

In DSM-5, the APA presents the changes included in the new classification system as based on scientific progress. Indeed, the scientific foundation of DSM-5 is the driving force that justifies the problematisation of the previous knowledge about mental disorders, as the excerpt [13] shows:

> [13] While DSM has been the cornerstone of substantial progress in reliability, it has been well recognized both by the American Psychiatric Association (APA) and the broad scientific community working on mental disorders that past science was not mature enough to yeld fully validated diagnoses – that is to provide consistent, strong, and objective scientific validators, of individual DSM disorders. The science of mental disorders continues to evolve (DSM-5, 2013, p.5)

Nevertheless, although the narration of DSM-5 is grounded on the mainstream scientific discourse, defined in terms of "cognitive neuroscience, brain imaging, epidemiology, and genetics" (DSM-5, 2013, p.5), the current scientific evidence is considered "not yet available to support widespread clinical use" (DSM-5, 2013, p.11). For this reason, "the DSM-5 Task Force recognises that it is premature scientifically to propose alternative definitions for most disorders." (DSM-5, 2013, p.13). Indeed, using the "Truth Will Out Device" (Gilbert and Mulkay, 1984), the APA prevents and manages any on-going disagreement or criticism affirming that sufficient evidence will be found in the future to support a "new diagnostic approach" (DSM-5, 2013, p.13). Truly, DSM-5 is presented as a "bridge" (DSM-5, 2013, p. 13) between previous and future knowledge about mental disorders. Therefore, this discourse appears to be trapped in a circularity according to which the scientific progress justifies the need for change, but, at the same

time, does not offer a direction for changing, given that only "emerging scientific evidences" (DSM-5, 2013, p. 10) might be able to do so. As Foucault stresses (XX), circularity is one of the elements identified as a symbol of power relations. Moreover, the removal of a subject, shown by the fact that in the manual there are only references to disembodied entities, such as "past science" and "future research", deletes the possibility for a debate. When agency is objectified, the statement seems self-evident, and so could appear incontestable (Mckenna & Graham, 2000).

2.7 Discussion

In the previous literature, many studies (e.g., Cermele, Daniels, & Anderson, 2001; Crowe, 2000; Georgaca, 2013) have criticised and deconstructed different aspects of DSM focusing on the epistemological assumptions embedded in the notion of mental disorder proposed by the APA and on the implications that this concept brings with it. The adoption of DSM standards has been regarded as producing three main consequences: (a) pathologisation, (b) medicalisation, and (c) stigmatisation (e.g., Bracken et al., 2012; Timimi, 2002). The increasingly sophisticated classification system adopted by the DSM over time, has been regarded as a way to establish control over the subjective experience of psychological distress and to realise the purpose of this apparent transformation of the subjective into the objective (Rose & Novas, 2003). The influence of the DSM in the cultural, economic and political fields has been highlighted as well (i.e., Alarcón, 2009); for instance, diagnosis has become an essential instrument in the construction of the concept of risk (Rose, 1985a; Wermuth, Donzelot, & Hurley, 1981) and a tool for the assessment of families and communities as well as the basis for public policy decisions.

With this study, I aimed to step back and call attention to the discursive strategies that have been used to manufacture consent around the DSM's classification system and to legitimise the hegemony of APA discourse over time. Indeed, according to Gramsci (1929-1935/1975), political hegemony can be considered to ground itself on cultural hegemony. In this vein, I see the self-legitimisation strategies adopted in the DSM-I (APA, 1952) and in DSM-II (APA, 1968) as a preliminary and necessary step to present the APA as the only actor able to direct the evolution of psychiatry towards a uniform and

consensual nomenclature. Only after the achievement of this position within the psychiatric domain the APA, with DSM-III (APA, 1980) and DSM-IV (APA, 1994), can start exercising a political influence, establishing the very nature of valid knowledge and then influencing “civil institutions” (Gramsci, 1929-1935/1975). Hegemony is maintained by the élite teaching their ideas and their values. Education, therefore, lies at the heart of hegemony – indeed Gramsci argues that ‘every relationship of hegemony is necessarily a pedagogic relationship’ (Gramsci, 1929-1935/2001, p. 284). The cultural and political hegemony of the APA is reinforced through educational/training purposes, which allow hegemony to endure over time. The DSM-5 represents an additional step. In the latest edition, hegemony is established, and the aim is to present the DSM knowledge as a universal knowledge which is able to harmonize all the social actors inhabiting the psychiatric domain.

Given that the present study, to my knowledge, is the first reconstruction of the whole evolution of the DSM discourse along its history, it helps to highlight the cultural and historical foundation of the DSM form of knowledge. In doing so, I aim at maintaining a space for dialectic and debate about mental distress, promoting the existence of otherness, construed as difference, argumentation, contrast, divergence, within the mental health field.

Chapter 3

NARCISSISTIC PERSONALITY DISORDER AND DSM-5: RECONSTRUCTION AND DECONSTRUCTION OF THE SCIENTIFIC DEBATE

3.1 Introduction

The proposed revision of the DSM, and, in particular, the proposed exclusion of Narcissistic Personality Disorder (NPD) from the latest edition, has recently reopened a long lasting debate in psychiatry and clinical psychology on the criteria adopted in the diagnosis and classification of mental disorders (Miller, Widiger, & Campbell, 2010; Ronningstam, 2009).

The interest around this new edition of the DSM, is due, on the one hand, to the influential role played by the DSM classification system in the mental health domain (see e.g. Alarcón, 2009; Crowe, 2000); on the other hand, it is linked to the high degree of interpretation that characterises diagnosis in this field. Indeed, even if the reference model of the APA is the neo-Kraepelinian paradigm (APA, 2002), there are no tests which are able to connect organic markers and mental disorders (P. Brown, 1995) and this leaves the diagnostic process in the realm of incertitude and controversy, with frequent disputes about definition of disorders, change in structure, diagnostic modalities and clinical evaluation approaches; A situation which provides “a lens for viewing many of the social conflicts which revolve around issues of medicine and health” (Brown, 1995, p.38).

In this study, I investigate the decision process through which the boundaries between normality and pathology are established in DSM-5. For this purpose, I analyse the scientific debate which developed as a consequence of the proposal of deletion of NPD in order to reconstruct and deconstruct the decisional process through which the APA aims at establishing if narcissism should be included among mental disorders or not.

Indeed, the classification of Personality Disorders in DSM-III and DSM-IV was criticised as being less effective in establishing a "boundary with normal personality functioning" (APA, 2006, p. 28). Hence, the decisional process on the NPD, shows how the APA claims to be able to determine the existence and the legitimacy – and, conversely, the inexistence and the illegitimacy – of a condition, which is defined as a mental disorder, in a particular historical time.

This study aims to highlight how the APA manages the degree of discretion in the diagnostic process trying to define the boundaries between pathology and normality. For this purpose, this study draws on the Foucauldian concept of governmentality (Foucault, 1982-1983/2008) and on the theories of argumentation (van Eemeren et al., 1993; van Eemeren & Houtlosser, 2002; van Eemeren, 2009). I refer to governmentality as the way in which governments try to produce the citizen which is best suited to fulfil a government's policiesand organise practices through which individuals are governed. I refer to argumentation as a verbal, social and rational activity aimed at convincing someone of the acceptability of a standpoint by putting forward a constellation of propositions justifying or refusing the proposition expressed. I lean on these theories to examine the debate on the proposed deletion of NPD from DSM-5 (APA, 2013) in terms of deliberation on the policies in the mental health domain.

3.2 DSM-5

3.2.1 History and evolution

Since 1999, the APA and the National Institute of Mental Health (NIMH) organised meetings and conferences to manage the revision of DSM's classification system (APA, 2013). Indeed, psychiatrists, psychologists, researchers and other mental health professionals worked to set up the guidelines for the review. The guidelines were focused on critical problems identified in the previous manuals, with particular reference to DSM-III (APA; 1980) and DSM-IV (APA, 1994). Firstly, epidemiological and clinical studies have shown high rates of comorbidities among disorders, undermining the hypothesis that different syndromes represent different aetiologies. Secondly, many syndromes show a high degree of short-term diagnostic instability. Finally, few specific treatments are identified for specific disorders.

In line with these problems, the review of DSM aimed on:

1. decreasing the "not otherwise specified" diagnoses through the identification of more accurate and specific criteria;
2. desertion of the categorical model. That is, to "shift paradigm" (APA, 2002, p. xix) and embrace a dimensional approach alongside the categorical one, to evaluate the severity of the symptoms as well as the presence;
3. pursuing "the strongest scientific evidence" (APA, 2013). The scientific paradigm in DSM-5 is defined in term of neuroscience and genetics; therefore the biomedical model is reaffirmed as the theoretical foundation of DSM.

Moreover, the last aim of this change process is to align the DSM and the International Classification of Disease systems of classification (ICD-11).

In 2007 and 2008, members of Task Force and Work Groups were nominated to draft the diagnostic criteria and identify a framework that could place disorders along a continuum to better understand the potential connections and interrelationships among them. In 2010, a first preliminary form of DSM-5 was posted on the website www.dsm5.org, giving the public the possibility to post comments; 8.000 comments were submitted (APA, 2013). After an additional review, a second open comment period was launched in 2011; the draft received more than 2.000 comments (APA, 2013). Proposed criteria were posted on the website for a last public comment in May 2012. The final review was realised by the Summit Groups and by the Board of Trustees and it was approved in December 2012. The DSM-5 was published in May 2013.

3.2.2 DSM system of classification and Personality Disorders: an overview

Personality disorders were first placed on a separate axis in DSM-III (APA, 1980), in order to focus the attention of clinicians on the presence of this kind of mental distress (APA, 2006). Personality disorders were among the more controversial and unsettled disorders in DSM classification, due to the fact that diagnosis of personality disorders was based on a categorical approach. The question of whether personality disorders are discrete clinical conditions or arbitrary distinctions along the continuum of the general functioning of personality has been a long-standing dispute inside the *psy* field (Blashfield,

1984; Kendell, 1975; Schneider, 1923). For this reason, proposals for a dimensional model of personality disorders have been made throughout the history of the APA's diagnostic manuals (e.g.,Eysenck, 1970; Presly & Walton, 1973; Tyler & Alexander, 1979). Indeed, several authors (Cloninger, 1987; Eysenck, 1987; Frances, 1982; Kiesler, 1986; Walton, 1986; T. A. Widiger & Frances, 1985) highlighted the limits of the categorical approach, and the improvements in validity and clinical utility that would be obtained through a dimensional model of classification. Proposals for a shift in how personality disorders are classified and diagnosed continued to be made after the publication of the DSM-III- R (e.g., Benjamin, 1996; Clark, 1992; Cloninger, 1993; Pincus & Wiggins, 1990; Tyrer, 1988) and DSM-IV (e.g., Cloninger, 1993; Pincus & Wiggins, 1990; Tyrer, 1988).

In sum, the main reasons for the dissatisfaction with the existing diagnostic categories about personality disorders are: 1) excessive diagnostic co-occurrence (Bornstein, 1998; Lilienfeld, 1994; Livesley, 2003); 2) inadequate coverage (Pincus, McQueen, & Elison, 2003); 3) heterogeneity within diagnoses (Millon, Davis, Millon, & et al., 1996; A. L Pincus & Wilson, 2001); 4) arbitrary and unstable diagnostic boundaries (Blashfield, Blum, & Pfohl, 1992; Narrow, Rae, Robins, & et al., 2002); and 5) inadequate scientific base (e.g.,Bornstein, 1992).

The topics covered were: 1) integration of dimensional and categorical models, in response to these criticisms of the categorical classification of personality disorders; 2) inclusion of behavioural, genetics and neurobiological research, to increase the empirical support of personality disorder diagnostic categories and to develop a dimensional model which would be able to explicate the genetic and environmental structure underlying phenotypic variation; 3) focus on the role played by childhood and adolescent antecedents in the development of personality disorders; 4) evaluate the variation of personality functioning across culture, to figure out the implication of these differences for a universal measure of maladaptive personality functioning; 5) lessen the division between Axis I and Axis II, in order to understand why and how the personality and clinical disorders are interconnected; 6) decrease the category "not otherwise specified" (NOS), through an adequate coverage of the maladaptive personality functioning seen in clinical practice. The use of the NOS category is perceived as a failure of the existing set of 10 diagnoses to provide adequate coverage of the existing conditions; 7) introduction of flexible cut-off points which are able to support the different social and clinical decisions

(e.g., whether to provide treatment, medication, or insurance coverage); 8) increase the clinical utility, to empower the role of DSM regarding ease of usage, communication, and treatment decisions.

In 2009, the APA established the criteria to change the system of classification which allowed to delete or add a diagnosis. In this study, I focus on the settled guidelines for deletion, due to their relevance in the debate on NPD. The first criterion is the clinical utility of the syndrome, defined in terms of "its frequency of use, its importance in making treatment decisions and its role in stimulating the development of clinical programs and increasing attention to the diagnosis in professional and lay groups" (APA, 2009, p. 8). The second criterion is about the validity of the syndrome. In considering a diagnosis for deletion it is necessary to evaluate the empirical support for its validity, defined in terms of: 1) number of studies that have examined the validity of the syndrome, 2) methodological quality of the studies and findings produced (APA, 2009). To these two broader criteria, the APA adds a further criterion: the consensus. Indeed, the APA affirms that "a broader consensus of expert clinical opinion would generally be expected for all proposed changes or additions to DSM-V" (APA, 2009, p. 5).

3.3 Narcissism and DSM

In this section I reconstruct the history of the concept of narcissism, inside and outside the *psy* field, and the historical context that characterised the introduction of Narcissistic Personality Disorder (NPD) in DSM-III.

For the first time in 1887, the French psychologist Alfred Binet introduces the "fable of the beautiful Narcissus" (Shorter, 2005, p. 184) speaking about a perversion behaviour in a case of fetishism (Binet, 1887a, 1887b). At the same historical time, Havelock Ellis uses the term *narcissism* in the psychiatric field ina study about sexology (Ellis, 1892/2008). With this term, he designates a pathological attitude of sexual life, in which the subject reaches sexual arousal by admiring his own body as a sexual object and source of desire and pleasure. Ellis compares this behaviour with the Greek myth of Narcissus. Isidor Sadger and Otto Rank introduce the term in the psychoanalytic field, extending the concept beyond sexual phenomena (Nunberg & Federn, 1973). However, it

was Freud who brought the use of the term narcissism in the psychoanalytic domain. The term narcissism appears in Freud's work for the first time in *Three Essays on Sexuality* (1905), where he posits the existence of a stage in sexual development between auto-erotism and object-love in which the subject takes himself, his own body, as his or her love-object (Freud, 1905/1977, 1911/2012). Although in this first conceptualisation narcissism is called upon mainly to account for object-choice in homosexuality, in the pivotal essays *On Narcissism: An Introduction* (Freud, 1914/1977b) it is theorised in a more developmental perspective as a normal maturation phase of healthy development in all children. Indeed, Freud guesses that before children are able to invest their libidinal energy in other people, they go through an adaptive period of *primary narcissism* in which they invest all their psychic energy on themselves and cannot take the perspective of others. Healthy development consists in a departure from primary narcissism, which allows the investment of libidinal energy into another person.

In the 60s and 70s, the theme of narcissism came to the attention of both practitioners in the *psy* field and a lay audience.

In the 1960s, Heinz Kohut challenges Freudian orthodoxy and presents a new theorisation of narcissism. In his theory of personality, he outlines the development and centrality of a cohesive psychological structure called the self. The self is the initiating centre of the person's psychic world and is closely bound up with relationships with others. In this perspective, serious vulnerability in the self gives rise to a variety of phenomena which are expressions of pathological or abnormal narcissism: the need to merge with an all-powerful object, an *idealised parental imago* and an exhibitionistic image of the self, the *grandiose self* (Kohut, 1966, 1968). Moreover, Kohut conceptualises the aetiology of narcissism as a result of a developmental arrest; that is, a mismatch of the child's normal narcissistic needs and of the environment's ability to adequately respond to them.

Kernberg's views of narcissism differ widely from those just outlined. In Kernberg's theory, narcissism refers to two different concepts: one at a theoretical level and one at a clinical level. At the theoretical level, within psychoanalytic theory, it refers to the libidinal investment of the self. At the clinical level, it means the normal or pathological regulation of self-esteem. Moreover, Kernberg's theory of narcissism in strictly linked with the

borderline personality organization (Kernberg, 1975). From this perspective, a normal Self and its normal libidic investments assure the regulation of self-esteem. Normally the regulation of self-esteem is assured by: 1) an integrated concept of Self in contrast to a split or disorganised concept of Self that gives a general sense of uncertainty and lack of capacity for internal well-being and safety. So, an integrated sense of Self is a first precondition for normal narcissism; 2) an integrated representation of Self and an internal world of significant others whose representations we have internalised; 3) a regulated internal consciousness - the super-ego and the ego ideal – that is to say an internal mental structure which tells us 'you are doing all right, you deserve to think well about yourself, you can be proud of yourself'. Finally, normal self-esteem permits to express instinctual needs in an acceptable way, through our sexual and aggressive impulses and being effective and successful in pursuing our tasks, ambitions and ideals (Kernberg, 1970).

At the end of 1970s, the journalist Tom Wolfe and the cultural historian Christopher Lasch publish two works, which both explore the roots and the normalisation of narcissism in contemporary American culture (Lasch, 1979; Wolfe, 1976). According to Lasch (1979), intense transformations have involved American society in the 20th century, producing a deep crisis of values that developed a form of narcissism that required, for most people, to seek constant external validation. These transformations were analysed in connection tothe post-World War II experience of economic wealth, liberal government and politics, spiritual bankruptcy, and persistent but unsuccessful attempts to achieveself-actualisation. The same tendency, and similar reasons underlying it, is highlighted by Wolfe in his article *The 'Me' Decade* (1976), in which he describes a new general attitude of Americans towards atomised individualism.

In this historical and cultural context the Narcissistic Personality Disorder was included in DSM-III, and defined as shown in box 3.1.

Box 3.1

301.81 Narcissistic Personality Disorder

The essential feature is a Personality Disorder (p. 305) in which there are a grandiose sense of self-importance or uniqueness; preoccupation with fantasies of unlimited

success; exhibitionistic need for constant attention and admiration; characteristic responses to threats to self-esteem; and characteristic disturbances in interpersonal relationships, such as feelings of entitlement, interpersonal exploitativeness, relationships that alternate between the extremes of overidealization and devaluation, and lack of empathy.

The exaggerated sense of self-importance may be manifested as extreme self-centeredness and self-absorption. Abilities and achievements tend to be unrealistically overestimated. Frequently the sense of self-importance alternates with feelings of special unworthiness. For example, a student who ordinarily expects an A and receives an A minus may at that moment express the view that he or she, more than any other student, is revealed to all as a failure. Fantasies involving unrealistic goals may involve achieving unlimited ability, power, wealth, brilliance, beauty, or ideal love. Although these fantasies frequently substitute for realistic activity, when these goals are actually pursued, it is often with a "driven," pleasureless quality, and an ambition that cannot be satisfied. Individuals with this disorder are constantly seeking admiration and attention, and are more concerned with appearances than with substance. For example, there might be more concern about being seen with the "right" people than having close friends. Self-esteem is often fragile; the individual may be preoccupied with how well he or she is doing and how well he or she is regarded by others. In response to criticism, defeat, or disappointment, there is either a cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness. Interpersonal relationships are invariably disturbed. A lack of empathy (inability to recognize and experience how others feel) is common. For example, annoyance and surprise may be expressed when a friend who is seriously ill has to cancel a date. Entitlement, the expectation of special favors without assuming reciprocal responsibilities, is usually present. For example, surprise and anger are felt because others will not do what is wanted; more is expected from people than is reasonable.

Interpersonal exploitativeness, in which others are taken advantage of in order to indulge one's own desires or for self-aggrandizement, is common; and the personal integrity and rights of others are disregarded. For example, a writer might plagiarize the ideas of someone befriended for that purpose.

Relations with others lack sustained, positive regard. Close relationships tend to alternate between idealization and devaluation ("splitting"). For example, a man repeatedly becomes involved with women whom he alternately adores and despises.

Associated features. Frequently, many of the features of Histrionic, Borderline, and Antisocial Personality Disorders are present; in some cases more than one diagnosis may be warranted. During periods of severe stress transient psychotic symptoms of insufficient severity or duration to warrant an additional diagnosis are sometimes seen. Depressed mood is extremely common. Frequently there is painful selfconsciousness, preoccupation with grooming and remaining youthful, and chronic, intense envy of others. Preoccupation with aches and pains and other physical symptoms may also be present. Personal deficits, defeats, or irresponsible behavior may be justified by rationalization, prevarication, or outright lying. Feelings may be faked in order to impress others.

Impairment. By definition, some impairment in interpersonal relations always exists. Occupational functioning may be unimpaired, or may be interfered with by depressed mood, interpersonal difficulties, or the pursuit of unrealistic goals.

Complications. Dysthymic Disorder, Major Depression and psychotic disorders such as Brief Reactive Psychosis are possible complications.

Prevalence. This disorder appears to be more common recently than in the past, although this may only be due to greater professional interest in the category.

Predisposing factors, sex ratio, and familial pattern. No information.
Differential diagnosis. Borderline and Histrionic Personality Disorders are often also present; in such instances, multiple diagnoses should be given.

Diagnostic criteria for Narcissistic Personality Disorder
The following are characteristic of the-individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress;

A. Grandiose sense of self-importance or uniqueness, e.g., exaggeration of achievements and talents, focus on the special nature of one's problems.

B. Preoccupation with fantasies of unlimited success, power, brilliance/beauty, or ideal love.

C Exhibitionism: the person requires constant attention and admiration.
D. Cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness the response to criticism, indifference of others, or defeat

E. At least two of the following characteristic of disturbances in interpersonal relationships:
(1) entitlement: expectation of special favors without assuming reciprocal responsibilities, e.g., surprise and anger that people will not do what is wanted
(2) interpersonal exploitativeness: taking advantage of others to indulge own desires or for seJf-aggrandizement; disregard for the personal integrity and rights of others
(3) relationships that characteristically alternate between the extremes of overidealization and devaluation
(4) lack of empathy: inability to recognize how others feel, e.g., unable to appreciate the distress of someone who is seriously ill.

DSM-III, p. 315-317

According to Migone (Migone, 1993a, 1993b), the introduction of Narcissistic Personality Disorder in the DSM-III would be justified both by social and political reasons. The first motive is linked to the wider interest in narcissism as a paradigm to explain social attitude in the American society (i.e., Lasch 1979; Wolfe, 1976). The second one is linked to the primacy of reflection about narcissism in the *psy* field, hence to what was recognised as mainstream in psychology (i.e., Kernberg, 1970, 1975; Kohut, 1966, 1968). Indeed, the theories of Kohut and Kernberg had a revolutionary impact on the psychological domain, and brought reflections about narcissism and personality disorders at the top of the agenda.

A noticeable contradiction seems to characterise this inclusion: the main studies to support reflection about narcissism are psychoanalytic, but with DSM-III the APA

decides to leave psychoanalysis as reference frame, and to embrace an "atheoretical" (APA, 1980, p.7) approach toorder aetiology. Several authors, among which some members of the Task Force of DSM-IV and DSM-5, suggest that the origin of the dissatisfaction about the category of Narcissistic Personality Disorder has its roots in this contradiction (Levy, Chauhan, Clarkin, Wasserman, & Reynoso, 2009; J. D. Miller & Keith Campbell, 2011; Morey & Stagner, 2012; Rivas, 2001; Ronningstam, 1991). For example Ronningstam (1991) highlights the psychoanalytic origin of the concept of the NPD and the difficulty of translating a psychoanalytic reflection in descriptive and behavioural terms:

> Despite its introduction into our diagnostic system in DSM-III [NPD] remains a disorder about which there has been little empirical evidence and around which basic questions of description, clinical utility and *validity still remain. There was no precedent in earlier DSMs [...]. The* stimulus for the inclusion of an NPD category in DSM-III derived from the wide spread usage of the term by psychodynamically informed clinicians. The DSM-III definition of NPD arose out of that committee's summary of the pre-1978 literature. (p. 167)

Moreover, Migone (1993) recounts a further critique against the introduction of NPD: the strict bond of narcissism and American culture.

In conclusion, since its inclusion inside the DSM system of classification, the NPD has been a source of problems and controversies. Indeed, the recent debate about this peculiar personality disorder started in 2010, when the Personality Disorders Work Team proposed to delete narcissism, along with paranoid, schizoid, histrionic and dependent personality disorders from DSM-5. The proposal to conceal (delete? Spiegare meglio cosa intendi, se pensi che sia nascosto da qualche altra parte, penso dovrai aggiungere una frase in più) NPD aims to replace the previous categorical classification with a new one which is able to identify the severity of a disorder. Severity is based on two dimensions: Self (i.e., sense of identity) and Interpersonal functioning (i.e., empathy). So in the end, the NPD is reintroduced (surreptitiously) in the DSM system of classification, conversely to the others four disorders. The proposal, published online on the DSM-5 website, is causing a heated debate that is the main object of my analysis.

3.4 Theoretical Framework

3.4.1 Governmentality and social sciences

As introduced in the section 1.2.1, the concept of *governmentality* is referred to a range of forms of action and fields of practice aimed at steering individual and collective conduct (Foucault, 1982-1983/2000). Moreover, the reflection on governmentality allows new ways to conceptualise: a) the relationship between techniques of power and forms of knowledge, since governmental practices make use of specific types of rationality, regimes of representation, and interpretative models, and b) the interrelationship between power and subjectivity. In this vein, potentially every human realm and activity falls within the purview of government.

In addition, the notion of freedom, with the associated celebration of the power of the individual, and of the values of autonomy, participation and choice, underpins attempts to specify and construct new forms of social arrangements. According to Foucault, in liberal government control is not centralised but dispersed, indeed it flows through a network of open circuits that are rhizomatic[5] and not hierarchical. For example, discipline is a model of power that works through the calculated distribution of space and time, observes and attempts to fabricate subjects who are simultaneously useful and compliant (Foucault, 1982-1983/2000). In this perspective, freedom is considered an illusory "weapon in 'saying no to power'" (Rose, 1999, p.64).

From a social point of view, studies on governmentality focus on technologies and rationalities of government in several domains and deconstruct the idea of universal reason, or of rationalisation in the sense of an optimised means-end-relation. In this perspective, what is considered rational depends on which starting points, means and goals are recognised as plausible; which criteria of legitimacy and acceptability are established; and which authorities and inventories of knowledge are evoked to define statements as true and practices as rational. Consequently, "rationality is understood in relational terms" (Bröckling, Krasmann, & Lemke, 2010, p. 11) and it shapes ways of

[5] The term *rhizomatic* is a philosophical concept developed by Deleuze and Guattari. With this term, originally used in botany, the authors describe philosophical research and reflection that allows for multiplicities, non-hierarchical entry and exit points in data representation and interpretation (Smith, 2012)

thinking which make reality conceivable and manageable, which is to say, subject to calculation and transformation. Therefore, from this point of view, governmentality entails an array of strategies and devices, which are themselves shaped and administered in the light of expert truth claims that support the power of experts and promote their knowledge (Rose, 1999b). Indeed, in liberal forms of government non-political social actors have a central role in shaping individual and collective conducts. These social actors (which may include legal, medical and religious practitioneers) represent an alternative form of authority.

Hence, studies which undertake a governmentality perspective draw attention towards: a) the heterogeneity of authorities that sought to govern conduct; b) the heterogeneity of strategies and devices used by the different social actors involved, and (c) highlight conflicts between different authorities and the ways in which society has been shaped by such conflicts (Miller & Rose, 2008; Rose, 1999). The multiplication of authorities entails a multiplication of possibilities and strategies deployed around different problematisations in different area, and different goals. Furthermore, since all problems of social life are problems of social control, all the authorities involved in governing conduct employ strategies of social control aimed at acting pre-emptively upon potentially problematic zones and at structuring them in such a way as to reduce the likelihood of unsettled situations (Miller & Rose, 2008; Rose, 1999, 2000). Thus they attempt to prevent or reduce conflict by acting upon physical and social structures and they enact a social control which operates through instrumentalising a different kind of freedom and social participation.

3.4.2 Theory of argumentation in critical discourse analysis

Argumentation theory and critical discourse analysis come from different theoretical backgrounds and have differing aims and methods. However, they share an interest in argumentative discourse and they meet in the description and analysis of actual argumentative practices (Fairclough & Fairclough, 2013; Fairclough & Fairclough, 2013; van Rees, 2007).

On the one hand, CDA is aimed at highlighting the power relations embedded in discourse and, for this reason, it is unsurprising that an important strand of critical

discourse studies should be interested in the language of persuasion, management of controversy and justification (Fairclough, Mulderring, & Wodak, 2011). These discursive devices can be seen as fitting into the broader analysis of argumentation in discourse.

On the other hand, argumentation theory looks at arguments as a communicative activity aimed at supporting a standpoint, and it takes explicit account of all relevant contextual, syntactic, semantic and pragmatic factors in the production and interpretation of arguments (van Eemeren & Grootendorst, 2004; van Eemeren & Houtlosser, 1999). In this vein, argumentation analysis allows identification of the strategies used to resolve conflicts of opinion. Furthermore, argumentation analysis also underlines how participants use arguments to detract from their opponents' image and to enhance their own image (van Rees, 2007).

In approaching argumentation theory, CDA focuses on arguments as a set of strategies adopted to achieve particular social, political and psychological goals. Hence, the analysis of arguments is focused on how discourses provide agents with reason for action. But argument is also a product: in the process of argumentation certain arguments come to be recurrent and come to achieve the relative durability and stability associated with practices and discourses (Fairclough & Fairclough, 2012; Fairclough & Fairclough, 2013). Taking previous studies into account (Atkin & Richardson, 2007; Ieţcu-Fairclough, 2010; Ihnen & Richardson, 2011; Reisigl & Wodak, 2001; Richardson, 2001) this study considers a set of argumentative strategies proposed by Fairclough and Fairclough (2012) to analyse political discourse. According to the authors, politics is defined as ways of acting in response to circumstantial premises and goals. More specifically, in this perspective political discourse is involved in *practical argumentation*, that is argumentation for or against particular ways of taking decision. Thus, practical argumentation can be seen as "means-ends argumentation" (I. Fairclough & Fairclough, 2012, p.4), where the claim or conclusion is a judgment about what means should be pursued to attain the end. In other words, the proposed action is presented as necessary or sufficient to achieve the final goal. Moreover, practical argumentation is often characterised by complex chains where the goals of one action, once turned into reality, become the circumstantial premise of a further action. According to CDA, the focus on circumstances and events does not obscure a focus on what agent *do*. Indeed, circumstances include institutional facts; thus they are selected as relevant premises

“precisely in relation to what agents value or care about” (Fairclough & Fairclough, 2012, p. 40), for example, what is socially recognised as moral value, current concerns or value of the commitment. Hence, “the facts of the matter are only a problem in relation to the agent’s concerns or value” (Fairclough & Fairclough, 2013, p. 46): for different agents, with different concerns, the situation might call for a totally different type of action or no action at all.

In conclusion, argumentation theory offers a particularly effective way of helping CDA analyse the relations of power and domination manifested in particular bodies of texts. Moreover, it helps show how peculiar beliefs and concerns shape practical reasoning and, contingently, influence decisions and actions on matters of social and political importance. Finally, this interdisciplinary collaboration poses critical questions about how context of action, values and goals are represented in the premises of arguments which can feed into a critique of ideology.

3.5 Method of Analysis and corpus

The main data set is constituted by 29[6] papers published between 2010 and 2013 about the Personality Disorders, in particular the Narcissistic Personality Disorder, and DSM-5, plus the 3 Guidelines for making changes in DSM-5 published by the APA in 2002, 2006 and 2009. In 2010, the APA published on the website www.dsm5.org the proposal of deletion for 4 personality disorders, among which the NPD. In 2013, DSM-5 was published.

Papers have been collected through the website of the American Psychiatric Association and the search engines Web of Knowledge, Google Scholar and PubMed (key words: narcissistic personality disorder, DSM-5, removing/removal/elimination/deletion).

[6] The references of these papers are reported in the Appendix.

Key words	Timespan	Search Engines	Output
Narcissistic Personality Disorder + DSM-5/DSM-V	2000-2013	Google Scholar, Web of Knowledge, PubMed	2197
Narcissistic Personality Disorder + DSM-5/DSM-V	2010-2013	Google Scholar, Web of Knowledge, PubMed	1244
Narcissistic Personality Disorder + deletion/removing +DSM-5	2010-2013	Google Scholar, Web of Knowledge, PubMed	146

Tab. 3.1: Papers collected through search engines

As shown in the Tab. 3.1, total papers collected have been 146. Within these references, I selected the papers which explicitly referred to a controversy about the deletion of NPD. Through this process, the 29 papers of the data set have been pinpointed.

To analyse the debate around the NPD in DSM-5 it has been necessary to reconstruct some aspect of this debate: a) the temporal evolution: from the first proposals for making changes in the Personality Disorders system of classification (APA, 2006; Kupfer, First, & Regier, 2004) to the final version of the Section II in DSM-5; b) the social actors involved; and c) the stances presented. This reconstruction is fundamental to set up the social, cultural and historical scene in which the debate evolved.

At a first reading, it was possible to divide papers into two main groups. The first group is linked to the psychodynamic area, in which authors foster the retention of the NPD in DSM-5 due to its clinical utility. The manifesto of this group is the paper *Personality Disorders in DSM-5* (Shedler et al., 2010). The second group is more numerous and various. Some components of this group are members of the APA and the debate is mostly centred around the criteria adopted to define the boundaries between normal and pathological functioning of personality.

The materials were approached considering the main normative claims made, the types of reasons offered to support them, and the rhetorical choices used to support peculiar premises and strategies of action.

The analysis was based on repeated readings of the materials to identify patterns and recurring organisations. The entire corpus was read repeatedly, and all instances of themes or argumentation strategies were noted and coded. Extracts related to each theme were placed in separate document files and numbered for reference. The extracts included in this paper are meant to indicate the range of use of certain strategies; they have been renumbered according to the order of presentation.

3.6 Analysis

3.6.1. DSM and NPD: premises, (values) and goals

In 2006, the APA published the *Guidelines* (2006), whose aim was to address future changes and research about personality disorders. The text contains several formulations of the basic arguments about what should be done to rethink the classification of personality disorders. In the Introduction of the document two main premises are presented as factual circumstance. Firstly, "personality disorders are regarded as being among the most important diagnoses within the APA's diagnostic nomenclature because they have the unique distinction of being placed on a separate diagnostic axis" (APA, 2006, p. xxv). Secondly, the Personality Disorders system of classification in DSM-III and DSM-IV presents some problems [1]:

> [1] Personality disorders, however, are among the more controversial and problematic disorders within the diagnostic manual. Maser et al. (1991) surveyed clinicians from 42 countries with respect to DSM-III-R (American Psychiatric Association 1987): "The personality disorders led the list of diagnostic categories with which respondents were dissatisfied" (p. 275). A number of reasons exist for this dissatisfaction with the existing diagnostic categories. We will summarize here some of the concerns regarding the categorical approach: 1) excessive diagnostic co-occurrence, 2) inadequate coverage, 3) heterogeneity within

> diagnoses, 4) arbitrary and unstable diagnostic boundaries, and 5) inadequate scientific base (APA, 2006, p. xxvi)

In line with these *premises*, certain *actions* are conducted. The strategy of action leads to a process of empirical studies and research, whose *goal* is to offer clinicians a system of classification which is able "to guide their practice and facilitate their conceptualization of a patient's pathology" (APA, 2006, p. xxvi). If this goal is not reached, clinicians risk "being faced with repeated analyses that could not be generalised from one patient to another" (APA, 2006, p. xxvi).

This strategy of action leads to a first proposal of change, published by the Personality Disorder Work Team (PDWT) in 2011. In this document, the PDWT proposed the deletion of 5 personality disorders: narcissistic, histrionic, paranoid, schizoid and dependent (Skodol et al., 2011). According to Fairclough and Fairclough (2012) the conclusion presented by the PDWT appears to flow unproblematically from the premises, as shown in the extract [2]:

> [2] The proposal for the specified PD types in DSM-5 has three main features: (1) a reduction in the number of specified types from 10 to 5; (2) description of the types in a narrative format that combines typical deficits in self and interpersonal functioning and particular configurations of traits and behaviors; and (3) a dimensional rating of the degree to which a patient matches each type. The justifications for these modifications in approach to diagnosing PD types include excessive co-morbidity among DSM-IV-TR PDs, limited validity for some existing types, lack of specificity in the definition of PD, instability of current PD criteria sets, and arbitrary diagnostic thresholds (Skodol et al., 2011, p. 136)

In relation to NPD, the debate revolves around frequency and clinical usefulness.

a) *Frequency.* The PDWT affirms that [3]:

> [3] NPD is the least-frequently occurring PD in the general population, with a median prevalence across the 12 studies reviewed by Torgensen (2009) of 0.5%. Only in recent NESARC study […] it has been found to be moderately common in clinical settings (5.7%; Stuart et al., 1998; Zimmerman et al., 2005), but less common than the average PD (9.3%)" (Skodol et al., 2011, p.147).

Moreover, the PDWT detect a moderate impairment in social and occupational functioning of individuals diagnosed with NPD. In other words, narcissistic personality does not excessively affect the everyday functioning of an individual. Finally, the PDWT criticise the criteria used to describe the NPD, which are considered not suitable.
Authors that challenge these affirmations support their positions contesting the data presented by the PDWT. For example, Ronningstam (2009, 2011, 2013) and Levy and others (2009) criticise the detection mode used for evaluating the occurrence frequency. In particular, Ronningstan (2011, 2013) emphasises that a wide range of phenotypes characterise the NPD manifestations, and suggests that the different NPD manifestations could justify the difficulty of finding diagnostic criteria which are able to catch a reliable presence of the disorder both in the general population and in the clinical one [4]:

> [4] The discrepancy between their interpersonal appearance and relatedness (Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009), and their internal experiences and reasoning (Horowitz, 2009), combined with limitations in their willingness or ability for self-disclosure, certainly both limit and bias accurate diagnostic evaluations based on self-rating and interpersonal disclosure. This has also invited to an over reliance on external behavioral traits and indications of exaggerated self-esteem as the base for diagnosis (Ronningstam, 2011, p. 250)

To support his position, Ronningstan presents research that reported conflicting rates of prevalence. Hence, with its counter-argumentation Ronningstan criticises the proposal of deletion suggesting that the main problem of NPD is not the low frequency, but the lack in methodological and diagnostical tools. According to the author

(Ronningstan, 2011, 2013), current methodological and diagnostic tools are unable to investigate the complexity of the phenomenon.

In sum, it is possible to restatethe counter-argumentation of Ronningstan in the following way: *premise*, the tools to inquire NPD are unsuitable; *goal*, it is necessary to develop new methodological and diagnostic instruments which may be able to investigate all manifestations of NPD, and not delete the diagnosis. So even if the conflicting data on the frequency of NPD is presented by Ronningstam as a counter-argumentation aimed to criticising the argumentation for deletion of NPD, the PDWT had used the same data as argumentation to corroborate the proposal of deletion.

According to Fairclough and Fairclough (2012, 2013), CDA allows to highlight how in argumentation the presumption of reasonableness is shaped and preserved on the basis of the premise and the embedded values. In acting, agents intend to transform circumstances into future state of affairs in accordance with the normative source that sets up their goals.

b) Clinical utility. With this expression the APA refers to the “extent to which DSM assist clinical decision makers in fulfilling the various clinical functions of a psychiatric classification system” (First et al., 2004). In particular, the concept of clinical utility includes the following functions for clinicians: (1) conceptualising diagnostic entities; (2) communicating clinical information to relevant others; (3) using diagnostic criteria in clinical practice such as for diagnostic interviewing and differential diagnosis; (4) choosing effective interventions; and (5) predicting future clinical management needs. In the *Guidelines* for making changes in the DSM-5 (APA, 2009), the clinical utility is related to the frequency and to the role of “stimulating the development of clinical programs and increasing attention to the diagnosis in professional and lay groups” (Kendler, Kupfer, Narrow, Phillips, & Fawcett, 2009, p.7). Hence, the APA creates a connection between these concepts.

In this perspective, it is interesting to underline that different authors (Bornstein, 2011; J. D. Miller et al., 2010; T. Widiger & Clark, 2000) indentify the reason for proposing the deletion of NPD in its exclusion from the Collaborative Longitudinal Personality Disorder Study (CLPS), a set of empirical research in which many members of PDWT were involved. In particular, Bornstein affirms [5]:

> [5] Many of the investigations which ostensibly provided evidence for the validity and clinical utility of PDs proposed for inclusion in the DSM-5 came from the Collaborative Longitudinal Personality Disorders Study (CLPS) dataset, wherein analyses focused exclusively on a subset of DSM-IV Axis II syndromes. Thus, studies by Bender et al. (2001) on treatment utilization, Grilo et al. (2005) on remission of major depression, Skodol et al. (2002) on level of functional impairment, and Skodol et al. (2005) on stability of functional impairment all included a subset consisting of 4 of the 10 DSM-IV PDs (schizotypal, borderline, avoidant, and obsessive-compulsive). Reliance on CLPS data creates a Catch-22 element in the research process: one cannot find evidence in support of the validity and clinical utility of disorders if the evidence base consists of studies wherein those disorders were not investigated. Put another way, it is impossible to ascertain from these studies whether functional impairment levels associated with narcissistic PD and paranoid PD (both proposed for deletion) are less than, comparable to, or greater than those associated with avoidant PD and obsessive-compulsive PD (both proposed for retention) because evidence bearing on this issue was never obtained (Bornstein, 2011, p. 241)

McKenna and Graham (2000) present *circularity* as a discursive strategy aimed at closing the field of reasoning, creating a circular dupe in which premises and consequences appear as axiomatic, and therefore as incontestable. Moreover, this kind of statement appears “to be true, but may be logically nonsensical. This is because the pseudo-scientific categories upon which technocratic tautologies rest are categories created such that the definition determines the categorisation of the phenomenon” (Mckenna & Graham, 2000, p.22). Indeed, with this discursive device premises and consequences become interchangeable: clinical utility influences stimulation of clinical programs and increases the attention of professional groups, but at the same time clinical programs and attention of professional group influence what is considerate usefulness in clinical domain.

The relationship established between these two concepts is contested by several authors, in particular Shedler, Fonagy, Gabbard, Gunderson and Kernberg (2010)in their manifesto against the deletion of NPD from the DSM-5, who affirm: “we presume that certain personality disorders have been omitted because of limited available research, but *absence of evidence is not evidence of absence*” (Shedler et al., 2010, my emphasis). In other words, there is the tendency to conceal what is not perfectly fitting with the current scientific paradigm, and so with the logic of hard measurements and statistical explanations.. But to refuse to follow this logic is not synonimous with not existing.

It is possible to read the debate around clinical utility, and its relation to empirical studies, through the reflections of Michel Foucault about biopolitical rationality (Foucault, 1982-1983/2008). In particular, I am referring to the apparatus[7] of epidemiology, that is an apparatus which “enables one to observe, measure, and permanently improve the ‘state of health’ of the population, in which illness is only a variable that depends on a long list of factors”[8] (Foucault, 1979/1994, p.731). In the Foucauldian perspective, the contemporary epidemiological apparatus, just like any other governmental apparatus, has one main purpose, that is to optimise behaviour and human performance, in order to increase the logic of individualisation and normalisation. Indeed biopolitical power spreads *norms,* which all obey, not because they are imposed by threats, but because they are spread through different means and non-political authorities. Thus, norms trace the boundaries of normality, which govern individual and collective conducts (Tarizzo, 2012). One of the means used to define these norms is the epidemiological evaluation, which is aimed to measure and calculate and to produce administrative regulations and protocols in response to different problematic areas. In the same way, epidemiology and evaluation are used by the APA to establish the boundaries of normality. The consequences of this process is an epidemiology of behaviour, that is to say a “government of the behaviour risk devoted to the increase optimisation of conduct” (Tarizzo, 2012, p. 144).

[7] *Apparatus* is a notion introduced by Michel Foucault, who understands it as a texture of entwined discursive and extra-discursive practices that articulates itself in the form of what we could define as an “acted-out knowledge”(Foucault, 1980, p. 195) . According to Foucault, the apparatus typically intertwines the *said* and the *unsaid* in a making. The apparatus is a system of relations which is internal to this making. Its habitual function is to “respond to an urgent need” (Foucault, 1980, p. 195).
[8] Original text in French, my translation.

3.6.2. Guidelines and decision process: consensus and discretionary degrees

Inconsistencies between the Guidelines published by the APA (Kendler et al., 2009) and proposals of deletion and retention formulated by PDWT (Skodol et al., 2011) represent another debatable aspect. Some authors (Bornstein, 2011; Mullins-Sweatt, Bernstein, & Widiger, 2012; Zimmerman, 2012) suggest that the proposal of PDWT does not take into account the criteria established by the APA for deleting a category[9]. Indeed, they underline that the Guidelines reported "a broad consensus of expert clinical opinion" (APA, 2009, p.5) as criterion to support the proposed change. Greater change required greater consensus: in this perspective, all positions against this proposal "indicate that the proposals for the deletion of one or more of the personality disorders might lack this consensus support" (Mullins-Sweatt et al., 2012 , p. 691). This sentence becomes relevant, in relation to PDWT's claim [6]:

> [6] However, the elimination of NPD as a specific PD "type" generated considerable controversy (e.g., Shedler et al., 2010). In responses to the first Web site posting, deletion of any of the DSM–IV PD types was one of the major objections to the proposal. Although all of the PDs had some advocates, regardless of the level of evidence to support them, NPD had by far the most supporters. At approximately the same time, the *DSM-5* Task Force initiated a review of the PD proposal and specifically requested that the Work Group focus their efforts on a mixed or "hybrid" approach with *diagnostic criteria* that combined dimensional elements and *DSM–IV–TR* PD types, instead of prototypes, which were viewed as too much like *DSM–II*. As a result of these processes, NPD was reinstated as a sixth specified type with criteria based on the combination of core self– other impairments and the specific pathological personality traits of grandiosity and attention seeking. (Skodol, Bender, & Morey, 2013, p.3)

[9] In my research I never found an objection against the Guidelines of the APA, a sign of almost complete acceptance of them.

Hence, the extract [6] evokes the idea that consensus was the main input of the review process that ended with the reinstatement of NPD in the system of classification. Indeed, Skodol and colleagues (2012) affirm: “as a result of a vote of the American Psychiatric Association’s Board of Trustees, the criteria for PDs in Section II of DSM-5 have not changed from those in DSM-IV” (p.4). This way to resolve the controversy on NPD is commented by Livesley (2012), who points out that “this addition appears to have been instigated by political rather than scientific considerations” (p. 366). Moreover, the author carries on his analysis sustaining that [7]:

> [7] Having decided initially, ostensibly on the basis of evidence, to include five types, this position was subsequently amended with the addition of narcissistic personality disorder. The critical issue here that speaks to the proposal’s scientific credibility is not whether narcissistic personality disorder should or should not be included but rather the grounds for the Work Group’s changing recommendations. Had new evidence suddenly emerged substantiating the validity of narcissistic personality disorder as a discrete type, its inclusion would have been justified. But this was not the case. What happened is that the lobby for narcissistic personality disorder suddenly became more powerful and able to ensure its inclusion (Livesley, 2012, p. 367)

Indeed, as Zimmerman (2012) suggests: “no research was cited for the Work Group’s reversal in deciding to retain narcissistic personality disorder” (p. 453).

In this perspective, it seems important to consider the role of consensus as criterion, which is implicated in the process through which boundaries between normality and pathology have been established in DSM. A main question leads this analysis: Who are the social actors at play from which consensus is being required?

As several authors highlight, the notion of consensus is strictly associated with interpersonal, economic and political issues (Blashfield & Reynolds, 2012; Lilienfeld, Watts, & Smith, 2012; Pilecki, Clegg, & McKay, 2011; T. Widiger & Clark, 2000), as shown in the excerpt [8]

> [8] True scientific progress, which we believe should be the basis of revision to the diagnostic manual, would not proceed through a process of democratically voting on the validity of alternative theories. Voting on whether or not premenstrual dysphoria is a mental disorder that should receive official recognition in DSM-V would make the decision less scientific and more political. (Wigiger & Clark, 2000, p. 948)

For this reason, the notion of consensus could be read trough Foucault's reflection about power (Foucault, 1977b, 1980a, 1981, 1982). As explained in section 1.2.1, the relation between power and knowledge reveals itself in the self-referential mechanism. Knowledge and power become indistinguishable: the exercise of power generates new forms of knowledge and knowledge brings with it the effects of power. Indeed, on the one hand in the Guidelines (APA, 2009) the agreement required for making change is defined as "broad consensus of expert clinical opinion" (p. 5), on the other hand, the Task Force's members involved in the review process of the DSM are defined in terms of "experts in psychiatric treatment, research and epidemiology" (APA, 2012). Hence, it appears a self-referential mechanism: the Task Force's members (of the APA) are experts, and so they are recognised as the social actor at play from which the consensus is being required. The philosopher of science Hull (1988) introduces the concept of *invisible college* to understand the interpersonal relations involved in the consensus process. With this term, Hull describes a group of people, based on communalities among the members, who collaborate in research, cite one another in their work and attend the same conferences. The term *invisible* is used as an adjective because to people from outside of scientific speciality, the link between these interpersonally related individuals is not obvious. It is possible to read the APA's Work Groups as a closed group of references, which creates social and political relations. On the one hand, these kinds of relationships could have positive influences on scientific knowledge, for example they could increase productivity. Nevertheless, on the other hand, this network of close references could have negative effects on the scientific research, for example they could obscure alternative perspectives (Lilienfield et al., 2012). Moreover, this closed system of references prevents the dialectical dimension of debate, and therefore the presence of a

"devil's advocate: meta-analysis demonstrates that it can help to combat group think and enhance quality of decisions" (Lilienfield et al., 2012, p. 832).

Therefore, the notion of consensus entails the existence of a group whose consensus is being required. So that the decision taken by consensus is acceptable for a broader audience it is necessary that it appears as a universal decision. In other words, the consensus has to appear as the consensus of all. This aspect is reached by the APA through the use of the web. At the beginning of the review process of the DSM system of classification, a website dedicated to DSM-5 was open (www.dsm5.org). On the web site all proposal were posted and an open forum permitted to send opinions and advices to the different Work Teams (see section 3.3). The APA often highlights the use of the website as an expression of freedom and openness, and the decisional outcome appears as a result of democratisation of the review process. Moreover, the APA presents itself as a social actor not involved in the conflict, but outside such conflict as the guarantor both of scientific progress about mental disorders and of speech right. But the democratic game is always attached to some existing consensus on one "truth", and through the regulation of access to resources and source of information, expressions of power inequality, it is related to a some particular power position (I Fairclough & Fairclough, 2012; Ieţcu-Fairclough, 2008; Rose, 1999b).

3.7 Discussion

The importance of accurate diagnosis as a prerequisite for effective treatment of mental illness has been a main and unchallenged concern both in psychiatry and clinical psychology over time, but with the publication of DSM, and in particular of DSM-III (1980), the APA draws the coincidence between diagnosis and evidence-based model and extends the importance of accurate diagnoses outside the psychiatric world. According to Mayes and Horwitz (2005): "psychiatry reorganized itself from a discipline where diagnosis played a marginal role to one where it became the basis of the speciality" (p. 250). Moreover, the diagnosis based on the neo-Kraepelian model allowed psychiatry to develop a "standardised system of measurement" (Mayes & Horwitz, 2005, p.251), transforming the diagnostic process in the mental domain in a process based on visible symptoms and measurement. This biomedical logic of understanding mental disorders is

based upon a dream of the technocratic control of problematic zones and, through the technocratic control, is aimed at reaching an agreement in the definition of mental disorder. This kind of logic has a main consequence: mental disorders exist only as outcome and effect of a prescription. Mental disorders are prescribed according to evaluation protocols that tend to be presented as objective and neutral.

In the first part of this study, I highlighted how the debate on NPD in the DSM-5 revolved around some hard data (i.e., frequency) and how any empirical data is able to brings with it a factual evidence and, therefore, to solve the controversy. This analysis highlights how every empirical data requires an interpretation to obtain meaning (Popper, 1934/2002). Indeed, in the debate around the NPD same data are used to support thesis diametrically opposite. Pilecki and colleagues (2011) suggest that in DSM-5 “the conclusions derived are necessarily based on consensus rather than on a unifying set of findings from the extant research. Since this process is, by definition, not guided by a central theory, there is a little in the way of an organising framework by which diagnoses arise” (p. 195). This point seems difficult to deny.

In addition, in the history of DSM it is possible to come across an antecedent. In 1973, because of the social pressure coming from the emerging antipsychiatric movement and gay/lesbian organisations, the APA published a new edition of the DSM-II that no longer listed homosexuality as a pathological condition (APA, 1973). This change is not supported by empirical data, but on a political choice. Indeed, the APA’s members voted for making this change in the nomenclature. In the proposal of the 1973, the APA affirm: “When all of the arguments are carefully examined, a few simple statements can be made with which hardly anyone can disagree” (APA, 1973, p. 2). In this case, as in the case of the NPD, consensus is used as criterion and means to overcome the *impasse*. Finally, consensus is used to reinforce the legitimacy of the APA and the authority position of the DSM in the psychiatric domain. Indeed, in both cases the final decision seems to flows unproblematically from the premises.

In line with the critical standpoint of this doctoral thesis, in this study I deconstructed the debate on NPD to highlight how even a biomedical model, presented as objective and *super partes*, needs to appeal to subjective criteria to establish what can be defined as mental disorder. Moreover, this definition is strictly influenced by the social, political and cultural values that characterise a historical moment. In this

perspective, changes in the nomenclature are more likely to be caused by these aspects than by scientific discoveries.

Chapter 4

SHAPING SUBJECTIVITIES: RELATIONS BETWEEN DSM DISCOURSE AND THE DISCOURSES OF DISSIDENT MOVEMENTS

4.1 Introduction

Lacan formulates the Four Discourses Theory in his seminar immediately after the global protests of the 1968; this temporality is not a coincidence, due to the Lacanian theory of Four Discourses is a psychoanalytic reflection about the relationship between language and exercise of power. Lacan developed the Theory of Four Discourses as an attempt to account for the structural differences among discourses, and identify and analyse the factors trough which language exercises both constitutive and transformative power in human affairs (Lacan, 1969-1970/2007). The symbolic order meanwhile relates in some aspects to the notion of "interpellation" (Althusser, 1971, p.174, see also the footnote 3 in the Chapter 1).

More precisely, his schemata – the discourses of Master, University, Hysteric and Analyst – offer the means of understanding four key social phenomena: governing, educating, protesting and revolutionising. We can better understand the constitute effect of the discourse if we refer to the realm of science. Although generally the science is considered a more intimate knowledge of the world, Lacan points out that science involves not a better understanding of the world but the *construction* of reality itself. Indeed, science presents as news, phenomena that existed even before, but about which we had not knowledge. In this way, science shapes our perception of the world and manufactures what we call reality. Discourse is similarly constitutive of the social order. Consequently, changes in discourse can produce changes in psychological and social realities. The purpose of Lacan Theory of Four Discourses is to show what sorts of changes are possible and how they might be brought about.

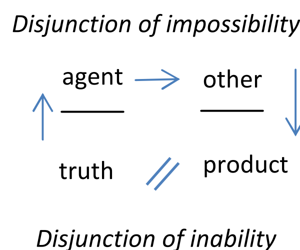
Leaning on the relational structure of the discourses presented by Lacan, I underline the relationship between the discourse of the DSM over time and the discourse of other social actors, in particular dissenter movements. Moreover, I analyse the effects of this relationship in shaping subjectivity of: patients, mental-health professionals and members of dissident movements.

4.2 Theoretical Framework

4.2.1 Lacanian Theory of Fours Discourses: Master, University, Hysteric and Analyst

As introduced in the Chapter 1, the Lacanian discourse theory focuses on the *formal* relationships that each discourse draws through the act of speaking. Lacan works beyond the content of discourse and in this perspective, a discourse represents an "empty bag with a particular form which will determine the content that one puts into them. [...] Each bag has four different compartments into which one can put things" (Verhaeghe, 1995, p.95) Lacan calls this compartment *positions*. The top position on each side represents the manifest factor, the bottom position the implicit one. In this way, a particular discourse allow to see certain things (on the upper level) while blinding one others (on the lower lever).

Disjunction of impossibility



Disjunction of inability

Fig. 4.1: Schema of discourses' structure

Each discourse starts with somebody talking, so the left-hand position is occupied by the factor more active and obvious in the discourse, called by Lacan the *agent*. Every message has a recipient that is placed in the right-hand position, labelled the *other*. This factor is called into action by the dominant one in the message. Those upper positions represent conscious expression of each speech act, and in that sense it is possible to find

them in every communication theory. The *agent*, however, “does not being from nothing, does not speak from nowhere [...] Other forces are at work” (Neill, 2013, p.23). In other words, the *agent* is not a speaker as the prime mover of its own discourse. Hence, it is possible to think the agent as Ideology and Tradition that affected the discourse (Neill, 2013). Moreover, given that the receivers are interpellated by the agent, they are compelled to produce something as a result. This result is represented by the position of *product* (i.e., the bottom right in the Fig. 4.1). This position does not stand simply for the result of the discursive operation, but rather for its “invisible remainder” (Žižek, 1998, p.82). In other words a product of the discourse in something that is not completely visible or included in the discursive network. To fill the bottom left compartments there is the *truth.* This factor underlies, support and give rise to the dominant factor, or constitute the condition of its possibility, but is repressed by it. In sum, the *agent* represents the *truth* for the *other*, and the *product* is what the other is compelled to produce as a result of its allowing itself to be thus interpellated.

Besides these four positions, the formal structure of a discourse consists of two *disjunctions*, expressing the disruption of the communicative line. On the upper level there is the d*isjunction of impossibility*. The agent, as every subject, is driven by a desire that cannot be completely verbalised, with the result that the agent cannot transmit his desire to the other; hence a perfect communication with words is logically impossible. On the lower level there is the *disjunction of inability*, which concerns the link between product and truth. If it were possible for the *agent* to verbalise his *truth* completely to the *other*, this *other* would respond with an appropriate *product*; as this precondition is not fulfilled, the *product* can never match what lies at the position of the desire/*truth*. As a consequence of this two disjunctions, every discourse is an “open-ended structure” (Verhaeghe, 1995, p. 96), in which the open-endedness functions as causal factor: because of the structure of lack, the discourse keep on turning. In that way, each of the four discourses represents a certain desire (through which the *other* is interpellated by the *agent*) and the failure of it, resulting in a particular social bond. In Lacanian’s words, each of the four discourses unite a group of subjects through a particular *impossibility* of a particular desire.

It should be clear that fundamental relations characterize the discourse, which exists before and goes beyond the spoken words. Consequently, the four positions and

the two disjunctions remain the same throughout the different discourses. What change it is the place of the terms, resulting from the quarter rotations, through which Lacan fills these positions: the master signifier (S_1), the system of knowledge (S_2), the alienated/divided subject ($), the object cause of desire (*a*). The differing effects produced by the four discourses result from the differing placement of these element in the positions of Agent, Other, Product and Truth. The permutation of these four elements defines the dialectic that leads the individual into the rotation of four discourses (Bracher et al., 1994).

In the next sections I present the four elements that characterised the Lacanian discourse theory: master signifier (S1), knowledge (S2), divided subject ($), and the object *(a)*

4.2.2 The master signifier – (S1)

Identification is particularly important in culture because is one of the major ways in which subjects are interpellated and their subjectivities changed by discourse. In fact, that identification plays a significant role in audience response and has important social consequence is a familiar notion (Bracher et al., 1994). The language forms the structural identification that constitutes the basis of our identities (Freud,1936/1992; Lacan, 1936/1976) and produces ad hoc identifications with characters or positions in discourse (Davies & Harré, 1990). Furthermore, identification can prompt us to feel or act in certain ways and can also re-form the subjectivity or behaviour as well.

In the Lacanian perspective, cultural discourse plays a role in social change, or in resistance to change, whenever a cultural phenomenon succeeds in interpellating the subject (that is, in summoning them to assume a certain subjective position or behaviour) by evoking some form of desire or by promising satisfaction of some desire. The question then becomes, how does the discourse operate with the desire in order to make interpellation possible? According to Lacan, in the language exist *identity-bearing words* called master signifiers. Master signifiers are any signifiers around which a subject, or a culture, organise its own identity, and which constitute powerful positive (or negative) values. Moreover, they are particular signifiers that try to organise all field of knowledge

(S2), and to create an order that hides the structural failure in the communication. Thus, master signifiers are the factors that articulate the system of signifiers (S2) on a subject: they are what make a message meaningful. Because of this fact, they are absolutely necessary. Master signifiers are significant both for the force they exert in messages, and for the larger role they play in structuring the subject sense of identity, through which I can recognize myself and be encountered and recognized by others. The most significant factor in these positioning is the imposition of a singular characteristic (unary trait, in Lacanian terms). While others terms may be challenged, S1 is simply accepted as having an innate value (i.e., God and Freedom). As Lacan explains, a discourse with interpellative force, is a discourse that, explicitly or implicitly, says “You are this” or “You are that”(Bracher, 1993).

4.2.3 The System of Knowledge – (S2)

This term represents the rest of the signifiers, the chain of signifiers that constitutes the “System of Knowledge”. That means that the S2 represents the existing body of knowledge. In other words, with this concept Lacan outlines the *truth of discourse*, as Foucault would say, and therefore what is recognised as knowledge in a particular historical time. This discourse emerges due to the master signifiers that ordered and defined the field of knowledge.

4.2.4 The alienated/divided subject – ($)

As Freud defined the subject as a "dual unity" with his *topos* of the conscious/unconscious (Freud, 1899/2002, 1922/2006) , even Lacan conceptualises the subject as a divided unity (Lacan, 1949/1976). Indeed, each of us always seems to be and remain incomplete, although we desperately aspire full consciousness and a sort of subjective completeness or perfection throughout our lives. For Lacan, the division inherent to the subject is inseparable from the lack that produces it and the "unsatisfied quest for the impossible, represented by metonymic desire" (Kristeva, 1998, p. 133). We use a trope to describe something related to the subject, because, as outlined just above about the master signifier, in Lacanian theory the evolution of the subject is related to the

evolution of language. Metonymy is a process in language whereby a concept is expressed in terms of another concept related to it by necessity. By the same token, the expression "metonymic desire" refers to the displacement of desire in the social context, in which the subject finds “something” to fill up this structural lack. Indeed, the subject is subjugated to the social relationship (i.e. family, group and society discourses), which through the S1 offers its identification and promises to fill up the subjectivity division conscious/unconscious, signifier/signified, other ways to say this division. Like the linear division of the sign (signifier/signified), which matches the signifier to a fixed signified (Saussure, 1916/2009), the "unitary" subject makes sense (becomes fixed) by association with unifying social structures (systems and structures of social domination).

The following diagram (Tab. 4.1) illustrates the relationship that Lacan established between "subject" and "signifier". The mutation imposed on them by the social order – the "unitary subject" for the one, the "closed sign" for the other – provides the foundation for Kristeva's discussion of the parallels that exist between the evolution of the subject and the evolution of language (Kristeva, 1977).

Divided subject (quest and lack) ↓	**Signifier** (possible signifiers) ↓
Unarity Law (S1) (social discourse) ↓	**Signified** (stasis of meaning) ↓
Unitary subject	**Closed sign** (social meaning)

Tab. 4.1: Relationship between “subject” and “signifier”

4.2.5 The object little a – (a)

As shown just above (section 4.2.4), it is a part of human condition that a subject is not able to comprehend and express himself entirely, and a way to fill up this lack is to find a master signifier (S1) in the field of the language. Therefore, “something” evades,

"something" remains open when something is concluded. At the same time, the metonymic desire generates a displacement of desire, manifested in the production of metonymic object of desire. This object of desire, called object *(a)* represents the final term of the desire itself. This peculiar object of desire gives to the subject an illusory way to fill up this lack, to find completeness, fulfilled satisfaction, and to gain an "ultimate solution", which, nevertheless, the subject can never reach fully, and especially never for a long-term satisfaction. So, the subject is forced to keep on moving. From this point of view, this fleeting "something" can be seen as the productive void inside human nature. For Lacan, it constitutes the basis of every form of causality for the humans.

4.3 Method of analysis and corpus

As explained in the Chapter 1, I examine the discourse of the DSM in its historical evolution, as a representative of the macro discourses that dominated the psychiatric field over the years. Moreover, according to the discourse analysis perspective, changes in discourse implies changed in the social world, and struggles at the discursive level take part in changing, as well as in reproducing social reality. Moreover, all discourse through its *interpellative force* contribute to constitute and transform human affairs, and so doing to shape subjectivities (Lacan, 1969-1970/2007).

In this section I examine the characteristics of the discourse of DSM, from DSM-I to DSM-5, and of other discourses present in the psychiatric field. These discourses have countered the dominant psychiatric discourse of which the DSM has been an expression. Dissident's movements to psychiatric discourse are various and they are representative of the historical, social and cultural context in which they were produced. In this doctoral study I choose to analyse books, journals and papers (see Tab. 1) published in defining time span:

- in the 1960s and 1970s, when the psychiatric knowledge has been founded on the positivism paradigm and the anti-psychiatry movement forcefully emerged;
- in the 1980s and 1990s, when the psychiatric knowledge has been shaped as natural science and grounded on biomedical and statistics models;

- in the 2000s, when the psychiatric knowledge has been inclined toward the neuroscientific paradigm.

The texts were chosen based on their historical and cultural relevance.

Moreover, as Lacan notes, no discourse can operate without master signifiers, consequently, the discourse of the Master is the first because it founds the Symbolic Order. Moreover, the discourse of the Master is particularly evident in attempts to promote peculiar epistemology or politics: “What I mean by that”, Lacan says, “is that [the discourse of the Master] encompasses everything, even what is believed to be revolution. More exactly, by what is romantically called Revolution, with capital R, this discourse of the Master accomplishes *its* revolution, in the other sense of the turning that buckles itself” (Lacan, 1969-1970/2007, p.99). This revolution is a revolving of the elements of discourse into the structures of discourse of the master, where the master signifier become overtly dominant and buckles the other elements of discourse so they can’t move and disrupts its dominance.

Therefore, a Lacanian discourse analysis aims not simply to isolate the different master signifiers, but also to locate the master signifiers dynamically in relation to the other factors of the discourse being played out. In this perspective the discourse of the Master is the historical starting point of the other discourses. The aim of these discourses is to stabilise and enact the Master’s will (as in the discourse of the University), to protest against the Master’s power and promoting a new social order (as in the discourse of the Hysteric) and finally, to subvert the logic of the Master (as the discourse of the Analyst). Considering the peculiar position of the Master discourse, I decide to pay particular attention to the dialectical relationship that the tree other discourses have with the discourse of the Master. Being able to recognise the master signifiers as potentially operant in relation to a discourse allows understanding something of how this discourse might be received by particular communities. It can also allow disentangling connotations which can otherwise appear natural (Neill, 2013).

I deconstruct the discourses of DSM-I (APA, 1952) and DSM-II (APA, 1968) through the discourse of the Master, the discourses of DSM-III (APA, 1980), DSM-IV (1994) and DSM-5 (2013) through the discourse of the University and the discourses of the protest

movements through the discourse of the Hysteric. Finally, I use the discourse of the Analyst to guide the final discussions of the study.

Time span	Corpus
1960s-1970s	- Basaglia, F. (Ed.) (1967). *Che cos'è la psichiatria?* Torino: Piccola Biblioteca Einaudi, - Rosenhan, D. L. (1973). On Being Sane in Insane Place. *Science*, *179*, 250-258
1980s-1990s	- V.A. (1986). *Asylum*, *1* (1), 1-31 - Ingleby, d. (Ed.) (1981). *Critical Psychiatry.* New York: Pantheon - Cohen,C. (1993). The Biomedicalization of Psyhciatry: A Critical Overview. *Community Mental Health Journal, 29* (6), 509-521
2000s	Lewis, B. (2006)Lewis, B. (2006). Postempiricism: Imaging a Successor Science for Psychiatry. In *Moving Beyond Prozac, DSM & the New Psychiatry*, University of Michigan Press; p. 143-165 Bracken, P. (2003).Postmodernism and psychiatry. *Current Opinion in Psychiatry*, *16*(6), 673-677.

Tab. 4.2: Data set for the analysis leaning on the Hysteric's discourse

4.4 Analysis

4.4.1. DSM-I and DSM-II as the discourse of the Master

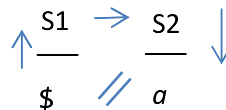


Fig. 4.2: Schema of the Master's discourse

As we seen above, the first major way in which culture operates on the desire is through the master signifiers. In the discourse of the Master the master signifier is in the dominant position and it addresses to the chain of knowledge. The aim of the master

signifier is to order the chain of the knowledge (S2) and create conformance and norm. When the master signifier occupies the position of truth, it holds meaning in place. Knowledge becomes certain—or better said, knowledge is accepted as certain. Indeed, this discourse is active and visible in the various discourses that valorise and attempt to enact a uniformity of identity and ego or promote mastery. Precisely, the discourse of the Master promotes "consciousness", "synthesis" (Lacan, 1969-1970/2007, p.79) and "self-equivalence" (Lacan, 1969-1970/2007, p.91). In consequence, master signifiers account for much of the *interpellative force* that discourse have, offering sense of security and well-being and giving a definitive sense of identity (Bracher, 1993). For all these reasons, the discourse of the Master is the discourse of governing.

In the first two editions of DSM, the APA relies upon the master's discourse to establish dominance in the psychiatric field. In the Foreword of DSM-I, the APA reconstructs the psychiatric knowledge of that time (the S2 in the Fig. 4.2) as fragmented, because characterized from many teaching centres and, consequently, from many different approaches to the mental disorders, with bad consequences on the clinical practice; as showed in the quotes [1]- [2]:

> [1] Many teaching center devised modified system of nomenclature for their own use, but the official nomenclature into which diagnoses were coded for statistical and medical record files remained the original 1933 nomenclature, as published in the Standard. As result, at the beginning of World War II, American psychiatry, civilian and military, was utilizing a system of naming developed primarily for the needs and case loads of public mental hospitals. The origin of this system was in itself predictive of the difficulties which would soon be encountered. (APA, 1952, p. vi).
>
> [2] By 1948, then, the situation in psychiatric nomenclature had deteriorated almost to the point of confusion which existed throughout medical nomenclature in the twenties. (APA, 1952, p. vii)

The APA presents the situation and its consequences as taken for granted; in fact there aren't arguments supporting this assumption. The assumption grounds, implicitly,

its roots in the analogy with the medicine situation of the Twenties (see Chapter 2, section 2.5.1). In my view, these are strategies to introduce the position of the APA as a Master. In fact, the APA affirms that "different names for the same thing imply different attitudes" (APA, 1968, p. viii) and entail different approach to understand and speak about mental disorders, creating a lack of uniformity in the psychiatric system of knowledge. In this perspective, the APA presents the nomenclature proposed in DSM as an instrument able to grasp this lack and fill it up, as exemplified in the excerpts [3]- [4]:

> [3] In selecting suitable diagnostic terms for each rubric, the Committee [*of the APA*] has chosen terms which it thought would facilitate maximum communication within the profession and reduce confusion and ambiguity to a minimum. Rationalists may be prone to believe the old saying that "a rose by any other name would smell as sweet"; but psychiatrists know full well that irrational factors belie its validity and that labels of themselves condition our perceptions. (APA, 1968, p. viii)

> [4] In preparing this new edition Committee has been particularly conscious of its usefulness in helping to stabilize nomenclature in textbooks and professional literature. (APA, 1968, p. ix)

In other words, the APA aspires to fill the structural failure in the communication, to produce a discourse that flows unproblematically and without misunderstanding between psychiatrists and psychologists of different theoretical schools. The relationship between S1 and S2 in this discourse implies that the *other* sustains the Master in his illusion that he is at one with this knowledge. Indeed, in this mastery position, the APA must show no weakness, and in this sense hides that in the language something is always lost[10]. Moreover, the unconcerned toward the content of S2 in psychiatric domain, as the next excerpt [5] point out, support this reflection about the mastery position of the APA. The APA presents itself as an actor without its own knowledge about psychological

[10] Indeed, you could remember that weakness and loss are represented by $ and *a*, and in this discourse they are in the bottom compartments of the schema.

distress, it seems only an organiser of the knowledge that others social actors have (i.e: Armed Forces and Veterans Administration).

> [5] Consider, for example, the mental disorder labeled in this Manual as "schizophrenia," which, in the first edition, was labeled "schizophrenic reaction." The change of label has not changed the nature of the disorder, nor will it discourage continuing debate about its nature or causes. Even if it had tried, the Committee could not establish agreement about what this disorder is; it could only agree on what to call it. In general, the terms arrived at by representatives of many countries in the deliberations held under WHO auspices have been retained preferentially, unless they seemed to carry unacceptable implications or ambiguities. (APA, 1968, p. ix)

Indeed, the APA of the first two DSM does not want increase the knowledge about psychological distress or delve into the debate around it, as instead it will happen in the next editions:

> [6] The Committee accepted the fact that different names for the same thing imply different attitudes and concepts. It has, however, tried to avoid terms which carry with them *implications* regarding either the nature of a disorder or its causes and has been explicit about causal assumptions when they are integral to a diagnostic concept. (APA, 1968, p. vii)

In sum, the aim of the APA is not to add positive content about mental distress, but merely to add empty signifiers (S1) around which organises the previous knowledge (S2). Using Lacan's words: "There is as a matter of fact a question to be asked. Does the Master who brings about this operation of the displacing, the conveyancing, of the slave's knowledge[11] want to know? Does he have the desire to know? A real master [...] doesn't

[11] To introduce and explain the discourse of the Master, Lacan use the Hegel's master-slave dialectic.

desire to know anything at all – he desire that things work.” (Lacan, 1969-1970/2007, p.24).

In this perspective, with this operation the APA tries to mark the boundaries between what is imputable to pathology and what is imputable to normality. This has two consequences. First, on one hand, the APA occupies the mastery position, because of it presents itself as a social actor legitimated to set up a general nomenclature, both from other public institution and the community of psychiatrists (see Chapter 2, section 2.5.1). On the other hand, because of the APA presents itself as an actor able to reach a perfect communication, without misunderstanding, inside the psychiatric domain. According to Lacan (1969-1970/2007), the communication is always a failure: there is a structurally impossibility to delete the misunderstanding from the communication. This concept is represented by the position of *product* (see Fig. 4.1), that is, there is always something which is not included in the discursive network. In this line, Verhaeghe (1995) suggests that the impossibility to say everything creates the idea of a utopian social harmony, in which the perfect communication is reached. Hence, this utopian expectation fosters the master signifiers (S1) that represent the possibility to grasp a social order in which the System of Knowledge (S2) reinforces the fantasy of a communication without failure. By promising satisfaction of this desire, the APA creates an in-group with a clear implication in terms of identification and recognition. In other words, mental-health professionals conform to an image outside of themselves as it were, and perhaps, as result of this identification with a movement can provide individual professionals with a sense of collective purpose (T. Brown, 2008; Laclau, 2005).

Second, the medical discourse, on which the APA desires to shape the discourse of DSM, is the classic example of a discourse that functions as a discourse of the Master (Bracher et al., 1994; Clavreul, 1978; Zizek, 2004; Clemens & Grigg, 2006), and in functioning as a master, it reduces “the patience to an object of its knowledge” (Verhaeghe, 1995a, p. 109). Indeed, ordering the field of psychiatric knowledge, the APA tries to create a benchmark in the psychiatric domain turning subjectivity experience of suffering into a norm.

4.4.2 DSM-III, DSM-IV and DSM-5 as the discourse of the University

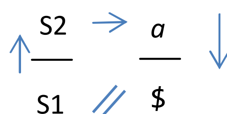


Fig. 4.3: Schema of the University's discourse

Lacan suggests a historical movement from the Master's discourse to the University's discourse. Indeed, the discourse of the University provides a legitimisation of the Master's will. In this discourse (S2), The System of Knowledge, is in the dominant position and the *other* "is reduced to being the mere object" (Verhaeghe, 1995, p. 102). The *other* is represented by the cause of desire peculiar for every subject *(a)*. So, The System of Knowledge here tries to rationalise and generalise *(a)* as representative of the subjectivity, transmitting knowledge presented as an accumulated, organised and "transparent unity" (Verhaeghe, 1995, p.102). The hidden *truth* is that every field of knowledge can only function if one has a guarantee for it: the master signifier[12].

Good examples of this discourse are bureaucracy and education (either in familiar, academic and institutional contexts). Truly, the function of this discursive structure is to educate, in the root sense of that term that is to form particular types of subjects. Individuals are interpellated to act, think and desire only in ways that function to enact, reproduce, or extend "The System" (Bracher, 1993, p. 55). In Lacanian's terms, this discourse "is nothing but knowledge" (Jacques, 1969-1970/2007, p.34), it is pure impersonal system.

Since the DSM-III, leaning on the discourse of the University, the APA props up its position as master claiming its authority by virtue, reason and expertise. While in the DSM-I and DSM-II, the APA works to establish uniformity in psychiatric knowledge, with DSM-III, DSM-IV and DSM-5 the aim is to introduce a peculiar knowledge: the APA's

[12] The primary example of this relation between knowledge and master signifier is represented by Descartes, who placed God to guarantee the correctness of his science (see also Glynos & Stravakakis, 2002).

knowledge about the mental distress (S2). This knowledge is presented as objective because founded on statistics, trials, data collections and reliability of these data.

Indeed, with the editions published in the 1980 and in the 2013, the APA puts forward new epistemological perspectives to approach and classify the psychological distress, founded on the modern scientific paradigm (biomedical and neuroscientific), thereby it aims at constructing a universal knowledge. In fact, its knowledge is based on measurements and production of "hard facts", and the Introductions of these editions are overflowing with details about rationale and data collections, as the excerpts [7]-[8]-[9] show:

> [7] The development of this manual over the last five years has not gone unnoticed; in fact, it is remarkable how much interest (alarm, despair, excitement, joy) has been shown in successive drafts of this document. The reasons for this interest are many. […] Secondly, from its very beginning, drafts of DSM-III have been widely circulated for critical review and use by clinicians and investigators. This made them aware of the many fundamental ways in which DSM-III differs from its predecessor, DSM-II, and from its international contemporary, the mental disorders chapter of the ninth revision of the *International Classification of Diseases* (ICD-9). For example, DSM-III includes such new features as diagnostic criteria, a multiaxial approach to evaluation, much-expanded descriptions of the disorders and many additional categories (some with newly-coined names); and it does not include several time-honored categories. Finally, interest in the development of this manual is due to awareness that DSM-III reflects an increased commitment in our field to reliance on data as the basis for understanding mental disorders. (APA, 1980, p.1)

> [8] In the past, new classifications of mental disorders have not been extensively subjected to clinical trials before official adoption […]. For these reasons, a series of field trials was conducted, beginning in 1977 and culminating in a two year NIMH-sponsored field trial from

September 1977 to September 1979. In all, 12,667 patients were evaluated by approximately 550 clinicians, 474 of whom were in 212 different facilities, using successive drafts of DSM-III. (APA, 1980, p. 4-5)

[9] The use of field trials to empirically demonstrate reliability was a noteworthy improvement introduced in DSM-III. The design and implementation strategy of the DSM-5 Field Trials represents several changes over approaches used for DSM-III and DSM-IV, particularly in obtain data on the precision of kappa reliability (a statistical measure that assesses level of agreement between rates that corrects for chance agreement due to prevalence rates) in the context of clinical settings with high levels of diagnostic comorbidity. (APA, 2013, p. 7)

In this way, this knowledge appears even-handed and incontestable. The APA is really careful to point out this empirical foundation of the Manual and, especially in DSM-III, present the knowledge as disconnected to every theoretical model. Showing its own knowledge as nonpartisan, the APA conveys the idea that this System of Knowledge is neutral, consequently all mental-health professionals can embrace it.

[10] "The major justification for the generally atheoretical approach taken in DSM-III with regard to etiology is that the inclusion of etiological theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations, since it would not be possible to present all reasonable etiological theories for each disorder. For example, Phobic Disorders are believed by many to represent a displacement of anxiety resulting from the breakdown of defensive operations for keeping internal conflict out of consciousness. Other investigators explain phobias on the basis of learned avoidance responses to conditioned anxiety. Still others believe that certain phobias result from a dysregulation of basic biological systems mediating separation anxiety. In any case, as the field trials have demonstrated, clinicians can agree on the identification of mental

> disorders on the basis of their clinical manifestations without agreeing on how the disturbances come about. (APA, 1980, p. 7).

The "atheoretical approach" (APA, 1980, p.7) conveys, on one hand, the APA as a non threatening institution, because *super partes* and so harbinger of positive values (e.g. non conflicting relationship, harmony and concord), on the other hand, reinforces the idea that DSM is an object around which is possible to identify and recognise a community of people that share the same perspective about mental disorder and, consequently, the same language to speak about them. Indeed, as explained above, every knowledge functions by a guarantee. In my point of view, the APA puts as guarantee of its expertise, at least, two master signifiers. The first master signifier used by the APA in DSM-III, DSM-IV and DSM-5 is the S1 around which it tried to create uniformity in psychiatric language, "facilitate maximum communication within the profession and reduce confusion and ambiguity to a minimum" (APA, 1968, p. viii), as re-emphasised in the Introduction of DSM-III:

> [11] "The development of this manual over the last five years has not gone unnoticed; in fact, it is remarkable how much interest (alarm, despair, excitement, joy) has been shown in successive drafts of this document. The reasons for this interest are many. First of all, over the last decade there has been growing recognition of the importance of diagnosis for both clinical practice and research. Clinicians and research investigators *must have* a common language with which communicate about disorders for which they have professional responsibility." (APA, 1980, p. 1; emphasis added)

In this perspective, we can read the caution used by the APA to introduce the revision of the classification system proposes in DSM-5, as the following excerpt shows:

> [12] "Although the need for reform seemed apparent, it was important to respect the state of the science as well as the challenge that overly rapid change would pose for the clinical and research communities. In

> that spirit, revision of the organization was approached as a *conservative*, evolutionary diagnostic reform that would be guided by *emerging scientific evidence* on the relationships between disorder groups. By reordering and regrouping the existing disorders, the revised structure is meant to stimulate new clinical perspective and to encourage researchers to identify the psychological and physiological cross-cutting factors that are not bound by strict categorical designations.
>
> The use of DSM criteria has the clear virtue of creating a common language for communication between clinicians about the diagnosis of disorders." (APA, 2013, p. 10; emphasis added)

Therefore, the revision of classification system is drawn as a potential threat to the identity of the in-group which is originated around the "common language" (DSM-III, 1980, p.1) proposed by DSM during the time. For this reason, the APA chooses a "conservative" (DSM-5, 2013, p.10) approach and underlines the role of the Manual as object of unity, both in explicit and implicit way. In the explicit way, with the sentence above, and in implicit way using the word "DSM" (DSM-5, 2013, p.10) as a general term, without a reference number able to identify a single edition. With this lexical choice the APA calls to mind of readers "The System of Knowledge" produced and enacted of the APA overtime as a whole.

In addition to the master signifier *uniformity*, the APA in DSM-III, DSM-IV and DSM-5 ground it own System of Knowledge (S2) around ,the master signifier of the scientific era, which can be summed with the sentence: "Keep on knowing more and more" (Bracher, 1993, p. 58). As we have seen, in the field of science, the major master signifier is knowledge itself, which is always account as valuable (Bracher, 1993; Glynos & Stravakakis, 2002). In this perspective, we can explain the reference to the "emerging scientific evidence" (DSM-5, 2013, p.10) in the previous sentence. This reference is used as an "identity-bearing word" (Bracher et. al, 1994, p.23) able to interpellate the members of the in-group shaped around the "System of Knowledge" created by DSM and give them (again) a common goal.

Last but not least, as showed in the Chapter 2 section 2.6.2, in these editions the educational purpose is very important and it is extend to all operators of the *psy*-complex (D Ingleby, 1979; Rose, 1985b) – psychiatrists, psychologists, social workers, etc. Indeed, a lot of attention is put on explanations, procedures, teaching; need to update knowledge about the DSM classification system to increase their own expertise as professionals. In this way, the APA makes sure that a people who recognises himself as member of the in-group shaped around the DSM, could be able to reproduce and popularise this system of knowledge.

So, the discourse of the University reveals the relationship between knowledge and master signifier and, according to Verhaeghe, shows that "one of the classical requirements of science: the so-called objectivity [...] is a mere illusion" (1995, p. 102). In this particular case, the structure of the discourse of University allows to illustrate that the discourse of the last tree editions of the DSM (1980, 1994, 2013) is a result of the APA positioning inside the psychiatric domain and, in consequence, they are affected by the cultural and political values of this peculiar institution. All teaching, in fact, begins as a discourse of mastery, with the imposition of the basic concepts of a discipline - master signifiers that serve to ground and explain the procedure of a body of knowledge that will constitute the discipline. So, the discourses of DSM-III, DSM-IV and DSM-5 function as an ideology that can provide an effective point of reference for mental-health professionals and researching evaluating the social connectivity of their respective work. Mental health professionals aspire to evaluating their own practices in those terms. Researchers can judge their work according to how it supports the cause of the psychiatric discourse objectives. That is, the vocabulary of the ideology provides the apparatus through which on is recognised, and through which one learns to recognise oneself (Zizek, 1989) .

In my opinion, the attempts to reinforce the identity of the community constructed around the DSM and to shape mental-health professionals as the means of production and reproduction of The System of Knowledge, have the aim to conform the subjectivity (to conform the peculiar object *a*) of people who are supposed to be active agents in this process. But, social effects of this discursive position of alienated subject – $ in this discursive structure is in position of *product* – are not hard to find. Indeed, the discourse of the University often produces rebellion and protests. This rebellion takes the position of the agent in the discourse of the Hysteric.

4.4.3 Movements of protest as the discourse of the Hysteric

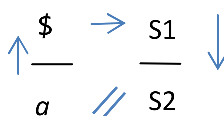


Fig. 4.4: Schema of the Hysteric's discourse

In the discourse of the Hysteric the divided subject ($) acts as an agent. In the other discourses the subject is subjected: the master ordered the subject, the university learned it and the analyst interrogated it. Above all, it is important to underline that the label *hysteric* refers to a discursive position and not to a clinical evaluation. Nevertheless, this discourse takes its name to the *logic of refusal* peculiar of the hysterical neurosis (Lacan, 1969-1970/2007). Indeed, in the hysterical neurosis the physical symptom manifested the refuse of the subject to embody, literally by the symptoms of conversion, the master signifiers (S1) that constitute through the language the subjectivity position that society makes available to individuals. The subject ($) is thus divided due to this conflict. Indeed, in hysterical neurosis this refusal of the body to follow the master signifier is representative of the conflict between ideals, promoted by the master signifier (S1), and desire (*a*) (Bracher et al., 1994). Indeed, Lacan suggests that in the Hysteric's discourse, the subject is driven by his own symptom. That is, in the hysterical structure the discourse is dominated by the failure of a subject "to coincide with or be satisfied with the master signifier offered by society and embraced as the subject's ideal" (Bracher, 1993, p.66). For this reason, the discourse of the Hysteric is the discourse of resistance, protest and compliant. This discourse challenges and critiques the other discourses. The master declares law, identification and he tells what to do, the university's discourse justifies master's will and it explain why should obey, finally the hysteric's discourse calls into question. Why must it be like this? Can it not be otherwise? What grounds these claims? "The hysterical subject is the subject whose very existence involves radical doubt and questioning, her entire being is sustained by the uncertainty as to what she is for the Other" (Schroeder, 2008, p.149). The unknown desire (*a*) fuels the subject to demand to the other (S1) and, at end of this process, produces new knowledge (S2), new

possibilities, and more discourse. Because of that, the hysteric's discourse makes possible to reclaim a new way to understand human affairs and hence new social practices. Often, this discourse is embedded in mass movements of protest, for this reason I read the movements of protest to the psychiatric mainstream through this discourse.

Since the 1960s, a series of movements developed a radical critique of traditional psychiatry. They challenge the psychiatry mainstream and promote alternatives and transformative experiences. These movements represent a complex phenomenon and consequently, consequently even the corpus of analysis is broad and various (see Tab. 4.2). Despite that, all of these movements interrogate the implicit assumptions and the power relations on which the psychiatric practices are based. For that reason, I decide to concentrate my analysis on the discursive structure that all these references presented in their relationships with the mainstream of the psychiatry; trying to move beyond the content of the peculiar reference analysed. Hence, the focus will be not on the different argumentations presented by the movements and determined by the historical, social and cultural context (for example, the protest against the insane asylums and the inhumanity of treatment of the 1960s and 1970s, or the challenge to psychiatric classification due to their effects of stigmatisation and the impressive use of psychopharmacological drugs that characterises the current movements).

Protest movements not call into question the master signifiers about the object of the study (for example, how to define mental-health disorders). Indeed, the core of the hysterical question is the status of the knowledge itself. That is, the movements of protest aim to scatter and create a fracture in the epistemologies, on which psychiatric knowledge and practice have been constructed, and, as consequence, to produce a turn in the psychiatric discourse itself. For this reason, often, cultural criticisms are shape as the Hysteric's discourse. In this field, dissident movements refuse the idea that psychiatry is a natural science and therefore, they reject the master signifiers (S1) that underlie the positivist paradigm. Usually, in the references analysed, argumentations against the *objectivity* and the *scientific rigor* of this paradigm are present (Cohen, 1993; Ingleby, 1981; Rosenhan, 1973). And, not infrequently, these two aspects are labeled as "myth" (Cohen, 1993, p.512; Ingleby, 1981, p. 28); since, the *myth* is a way to give an explanation and order the phenomena, and not a way to mirror the reality. Furthermore, disapproval

toward the *causal mode* and the *organic foundation* as the only legitimate justifications for the mental illness is express. According to Cohen (1993):

> With decline of the religious and political authority science is one of the few remaining legitimate authorities. Any model that can emulate the scientific methods of the physical sciences lays claim to legitimacy. (1993, p. 511)

These critiques against the positivist paradigm aim to highlight the lack entailed in this epistemology. For this reason, the discourse presented by the dissident movements is strictly related to the position of the divided subject ($). Indeed, the aim of the Hysteric's discourse is to show the lack in the Other, calling S1 into question. Moreover, through the discourse of the Hysteric also the audience is interpellated to the position of $, as the excerpt [13] shows:

> [13] Per questo il nostro discorso anti-istituzionale, anti-psichiatrico (cioè anti-specialistico) non può mantenersi rispetto al terreno specifico del nostro campo d'azione. La polemica al sistema istituzionale esce dalla sfera psichiatrica, per trasferirsi alle strutture sociali che lo sostengono, costringendoci ad una critica della neutralità scientifica, che agisce a sostegno dei valori dominanti, per diventare critica e azione politica. […] Il lavoro scientifico, finché si mantiene all'interno dei valori della norma, è serio e rispettabile in quanto si premunisce e si garantisce dal venir contraddetto e negato dalla realtà. Ma se un lavoro si fonda sulla realtà e sulle sue contraddizioni, senza voler costruire un modello che confermi e codifichi le proprie ipotesi, porta con sé il rimprovero di dilettantismo velleitario rispetto a tutto ciò che ancora non è incluso nella norma, e conduce alla contraddittorietà di una situazione dialettica, sempre in movimento[13]. (Basaglia, 1971, p. 7-8)

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[13] That is why our anti-institutional, anti-psychiatric (i.e, anti-specialist) discourse cannot remain only in the field of our action. The controversy comes from the institutional system of psychiatric, to move toward the

In the excerpt [13], Basaglia introduce two concepts related to the divided subject ($). First, he highlights that knowledge referring to the human nature is structurally fragmented and characterised by contradictions, because of the impossibility to comprehend and express entirely the human condition (see section 4.2.4 of this Chapter). I suggest that this critique to the scientist paradigm in summarised with the sentence of Serge Andé "pas-toute soumise à la loi signifiant"[14] (Ouvry, 2001, p.71).

Second, the problem of the inconsistency of knowledge does not implicate only the subjectivity of patients, but also the subjectivity of mental-health professionals. In fact, they are involved not as experts that operate behind the "smokescreen" (David Ingleby, 1981, p.37) generated by the techniques (and therefore as social actors engaged to enact the System of Knowledge (S2) – see section 4.2.3), but as subject that actively participate to the construction of new knowledge and social practices about mental distress. In this perspective, the reflection about the mental distress may not remain under the "scientific patina" (Cohen, 1993, p. 510), but should return in the realm of public discussion.

In conclusion, in addition to the recognition and liberation of the subjectivity of patients, there is a focus on the recognition and liberation of the subjectivity of mental-health professionals. Indeed, according to Schroeder (2008), the Histeric's discourse is "the discourse of the governed, not the governor" (p. 149). Referred to these themes, Basaglia affirms:

> [14] [...] il gruppo di malati, medici, psicologi, infermieri e amministratori […] con le loro discussioni e i saggi sulla realtà asilare, hanno intrapreso

---

social structures that support it. This process forces us to a critique of scientific neutrality, which supports the dominant values, and it transforms our discourse in critical and political action.

[…] Scientific work, as long as it is locate inside the logic of norms and standards, is serious and respectable because it avoid to be contradicted by reality. In contrast, if a scientific work founds itself on reality and its own contradictions , without aiming at constructing a model of this knowledge that confirms and codifies its own assumptions , is accused of amateurishness because it leads to the contradictions of a dialectic and always motion situation. (My translation)

[14] Not all can be submitted to the law of the signifier (My translation)

> – partendo da una verifica della realtà – una lotta che deve muoversi a un livello scientifico e politico insieme. Se, infatti, il malato è l'unica realtà cui ci si debba riferire, si devono affrontare le due facce di cui tale realtà è appunto costituita: quella del suo essere un malato, con una problematica psicopatologica (dialettica e non ideologica) e quella del suo essere un escluso, uno stigmatizzato sociale. […] La nostra realtà è affondata in un terreno profondamente contraddittorio e la conquista della libertà del malato deve coincidere con la conquista della libertà dell' intera comunità. (Basaglia, 1967, p.11)[15]

In connection with this focus, I think it is significant a picture published in review *Asylum* (1986, p. 7) (Fig. 4.5).

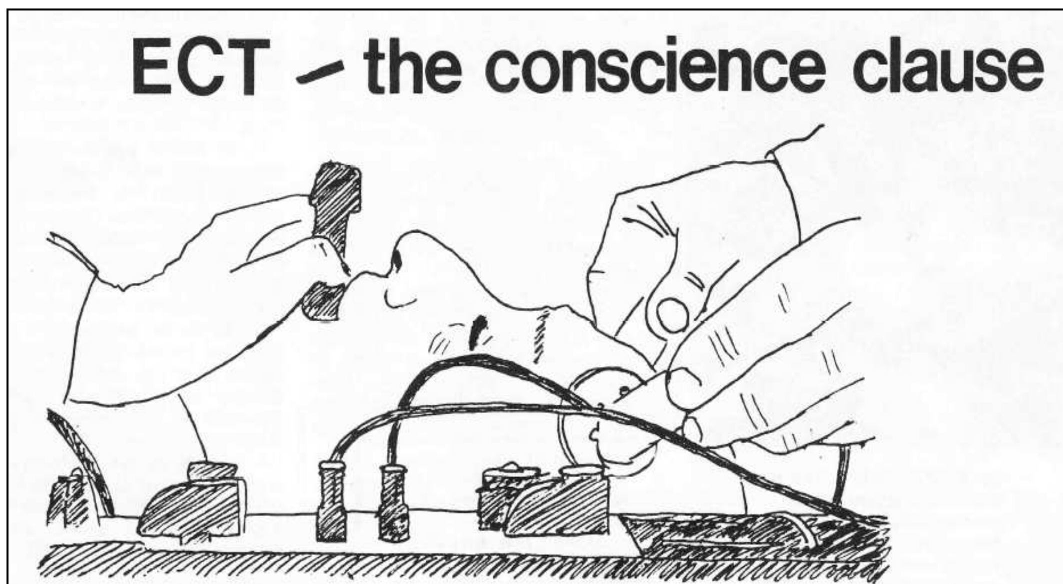

Fig. 4.5: ECT-the conscience clause (Bigwood, 1986, p.7)

[15] Patients, physicians, psychologists, nurses and employees, with their discussions and essays about the life in the asylums – that began by doing a verification of the reality – started a fight, which must have scientific and politics at the same time. Indeed, if the patient is the only reality to which we refer, we have to deal with the two aspects that constitute this reality: on one hand, the person as sick with a psychopathology (dialectic and not ideological), and, on the other hand, the person as excluded and social stigmatised. (my translation)

The picture appears in a paper, or better in a testimony, of a nurse who claims for a right to refuse doing ECT treatment to patients. Hence, this is not an article against the treatment ECT, or not mainly, but it claims the right to the nurse to express her own opinion and, consequently, to refuse to participate during the treatment. Indeed, the focus of the article is on the freedom of expression. These two different levels, the legal level and the level close to the expression, and so to the discourse, are represented by the use of the word "clause", with its two meaning: provision and phrase. Barthes (1957) called *anchoring* the mechanism through which the meaning of an image is clarified and specified by a verbal text. In this way, the title *anchors* the sense of vague and multiple images to one or a few of the possible interpretations.

Furthermore, the picture shows the two "governed" (Schroeder, 2008, p.149) by the discourse of psychiatry: patients and mental health professionals. The patient is represented in his or her failure, the head as representative of the mind, and so as representative of his or her illness; the mental health professionals are represented only by their own hands. This representation is used by the hysteric discourse to denounce the deletion of subjectivity operated by the Master and the University discourses[16]. Indeed, neither could express his or her opinion, the mouth of the patient is closed by an object, the mental-health professionals have not a mouth, they are only the "operational arm" of the psychiatry. In conclusion, this testimony highlights that the representatives of the dissident movements reclaim their right to be divided between the universal and the individual, that is, between being recognised as a good professional, coherently with the ideal of experts, and a subjectivity position.

Moreover, the field of law is strictly related to the Hysteric's discourse. Indeed, dissident movements claim for rights, for themselves or for other people helpless, as the psychiatric patients. But, when the society recognises and ratifies a demanded right, this becomes a law, and it is included in the Symbolic Order. This change of position, through which a demanded right becomes law, transforms the object of the protest in a new S1, given that every new law establishes a new order to which everyone have to conform. For

[16] I think it is important to recall that the location of the subject ($) on the lower level of the discourse schema is guarantee of "obviousness" or "unquestionableness" (Neill, 2013, p.11) of the social expectations that are being played out. This guarantee is obtained, in the Master discourse through order and authority, in the University discourse through learning.

this reason the relationship between the Hysteric's discourse and the master signifiers is complex. On one hand, the Hysteric's discourse refuses to follow specific master signifiers, on the other hand it demands to the Other to recognise its protest and to produce a new S1 in position of mastery. In Lacanian words, the Hysteric's discourse remains in "solidarity" (Lacan, 1969-1970/2007, p.107) with the master signifiers as such. This solidarity manifests itself in the quest of a new order that will satisfy the need of security and stability, in the search of meaningless for a meaning or identity, and in the urge to have an ideal as point of reference.

4.5 Discussion

In this study, I decided to use the discourse of the Analyst as a critique reflection of the present work, and hence as a guide for the discussion. I take this choice, not because the discourse of the Analyst is the ultimate discourse, indeed, it is "one discourse among many" (Fink, 1996, p.129), but because it is a discourse of reflexivity. Indeed, the discourse of the Analyst starts from the question *che vuoi?*[17] (Lacan, 1976b, p.817), this question is not about will or ambitions, but it brings with it a reflexive aspect. Consequently, on the side of the subject, this question is transformed in "What am I?".

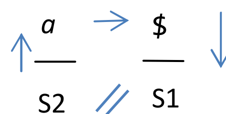

Fig. 4.6: Schema of the Analyst's discourse

By addressing the subject ($) the analyst takes the position of the lack, to make free the subject to produce a non conventional reply to the initial question in his essence, "What am I?". In this discourse, the truth (S2) is not represented by the expertise, but by the peculiar knowledge of the subject. The product of the analysis is the master signifier (S1). But, this time, it is not the master signifier imposed by the Other (as in the discourse of the Master), however it is the master signifier produced by the subject, its own S1, a new formulation of his identity or being. For this reason the discourse of the Analyst

[17] The questioni is formulated in Italian in the original French text.

promotes psychological changes. And, for the same reason this discourse can promote social changes.

Lacan himself hinted at this possibility when he indicated that the position of the analyst can be assumed in relation to society (Lacan, 1969-1970/2007). The best thing to do to bring about revolution, Lacan suggested, is thus "to be not anarchists but analysts" (Lacan, 1969-1970/2007, p.176), which means positioning oneself in such a way as to interrogate how culture participates in the position of mastery. As Bracher (1993) notes, often cultural criticism aims directly at "revolution in attempting to institute specific values" (p. 62) or in applying new master signifiers. This can be seen, for example, that some concepts are used as monolithic labels for a given discourse, leaving unexposed the details of its operation and therefore the mechanism of its power over human subjects. On the contrary, the cultural critic must analyse responses to a given artefact or discourse in order (1) to map the fundamental identifications (and the concomitant desires) that are promoted in a certain number of subjects by the cultural phenomenon in question, and (2) to expose the unconscious desires and fantasies that the cultural phenomenon is surreptitiously operating with and/or further repressing. Pursuing such a strategy entails three logical steps.

The first step involves identifying the elements of the discourse that produce effects on society. For example, how the master signifier has to be taken as a fact and how is its role in the construction of ideology. In my analysis, I underlined how the APA leans on the master signifier of *uniformity*, which is aimed to uniform the communication in the psychiatric domain, to foster the idea of a utopian social harmony freed from the misunderstanding.

The second logical task is to identify the no-manifest collective subjective factors that are produced by the discursive elements. For example, to inquire how the text operates with the master signifiers to produce particular form of the ego ideal. In this perspective, I underlined the role of the last editions of DSM (in particular III, IV and 5) in consolidating the psy-group identity, or better in shaping and consolidating of one's ideal ego (Lacan, 1976a).

The third step involves identifying a particular manifest and collective effect produced in a significant number of people by a cultural artefact or discourse. For example, when the response of a large number of people includes identical actions and

more or less identical demonstrated feelings, such as when there is a passionate and massive reaction to a particular discourse. For this reason, I underline the role of the dissenter movements as reaction to the discourse of DSM in several historical times.

Moreover, this study highlights the effects of the different discourses on subjectivity, focusing on their *interpellative force*. First, the DSM discourse has a normative effect in shaping subjectivity of individual with mental distress, that is it turns a subjectivity experience of sufferance into a norm. Second, it has effect in shaping subjectivity of mental-health professionals, which are called to enact and reproduce the APA's System of Knowledge. Furthermore, towards mental-health professionals the DSM discourse has clear implications in terms of identification and recognition. Finally, the DSM discourse has additional social implications, related to collective effects. Subjectivities of dissident groups' members are shaped by a radical rejection of the identification promote by the APA discourse. For this reason, the hysteric discourse challenges the institutional identification of mental-health professionals to encourage different forms of subjectivity for mental-health professionals, to support alternative perspectives to understand mental distress.

In conclusion, leaning on the Lacanian discourse analysis I address the texts analysed in this study seeking to produces new understanding, new meanings, which is to say, meanings which are not in the texts as such. In repeatedly mapping aspect of the text to element of discourse, I try to generate competing possible understanding. Moreover, to promote new meanings it is necessary decentre the discourse. For this reason I linked the psychiatric discourse of the DSM, whit other discourses presented in the psychiatric domain. With this operation I aimed to multiply the perspectives on it.

Chapter 5

CONCLUSIONS

This doctoral thesis interrogated the construction of otherness in mental health domain, and in detail the role of DSM, published by the APA, in the constitution of otherness through the manufacture of boundaries between normality and pathology.

Taking a critical perspective in psychology (Fox, Prilleltensky, & Austin, 2009; Hook et al., 2004; Parker, 1999), this study has been conducted leaning on two principal theoretical and methodological approaches: the critical discourse analysis within the Foucauldian tradition (Hook, 2007; Parker et al., 1995) and the Lacanian discourse analysis (Parker, 1997, 2005b; Pavon-Cuellar, 2010).

In this vein, my aim was analysing and working out the way in which the psychiatric science, trough discursive devices and a series of narrative and linguistic strategies, shape the concept of mental disorders proposed by the APA, and consequently shape different forms of subjectivity.

To this propose, I articulated the study in consequential moments.

In the first step, I reconstructed the evolution of the DSM's discourse along its history. This reconstruction helped to highlight the cultural and historical foundation of the DSM's knowledge. Indeed, following Foucault (1965, 1972, 1976), I retraced and linked the constituting field of power-knowledge in the mental domain in order to analyse which discursive strategies have been used to manufacture consent around the DSM's classification system and, consequently to legitimise the hegemonic role of the APA. This study underlined how the self-legitmisation strategies adopted by the APA in DSM-I (APA, 1952) and in DSM-II (APA, 1968) were preliminary steps to position itself as the only social actor able to direct and indicate the way in which psychiatric knowledge had to evolved. Only after the achievement of this authority position the APA was be able to exert a political influence (Gramsci, 1929-1935/1975), inside and outside the *psy* filed.

The specificities of this discursive strategies and the role played by the current dominant position of the APA inside, and outside, the psy-complex are discussed in the

details in the sections 2.5 and 2.6. Here, I would like to focus on how the object of my scrutiny, the concept of mental disorders, has been produced through the discursive practices of particular field of knowledge.

Starting from the DSM-III (APA, 1980) the APA draws the equivalence between diagnosis and based-evidence model, and this choice had consequences. Indeed, with this choice the APA situated the DSM's discourse inside the dominant scientific discourse, the biomedical one (Bracken et al., 2012; Cohen, 1993; Rose, 2003). In this way it presented diagnosis and classification in terms of discoveries grounded on hard measurements. Through the position of the DSM's discourse in this scientific framework, the APA increased the authority of its own system of classification, because it place the DSM "in the truth" (Foucault, 1970/1981, p.60) of its own historical time. Inside this perspective, disorders are characterised in terms of symptoms that could be elicited by patient report, direct observation and measurement. Reflections about etiological origins of distress are avoided, because it was presumed that, as in general medicine, the phenomenon of symptom could be explained by a common underlying aetiology (APA, 2002). Moreover, as Foucault suggests, a discipline is "a domain of objects, a set of methods, a corpus of preposition considered be true" (Foucault, 1970/1981, p. 59). According to Mayes & Horwitz (2005): "psychiatry reorganized itself from a discipline where diagnosis played a marginal role to one where it became the basis of the speciality" (p. 250). Hence, what is recognised as the true knowledge brings whit it the effect of the power and, at the same time, the exercise of the power generate new forms of knowledge.

In conclusion, the reconstruction of the historical evolution of the DSM discourse allowed to clarify the framework of the power relations in which this peculiar knowledge about mental disorders was allocated. This aspect was being necessary in order to examine the relationship between power and knowledge in conjunction with the recent review of the DSM system of classification. Indeed, the role of the APA in the definition of the boundaries between normality and pathology through DSM-5 was the core of the second study.

In the second step, I investigated the scientific debate evolved from the proposal of deletion of narcissistic personality disorder (NPD) in order to reconstruct and deconstruct the decisional process through which the APA established whether narcissism should be included among mental disorders or not. The aim of this study was

to “try to grasp subjection in its material instance as a constitution of subjects” (Foucault, 1980, p.97) through the analysis of discursive practices that objectify and subjugate the individual. Objectification acts as a locating device that formulates how a “group is seen or known as a problem” (Scheurich, 1997, p.107). Indeed, the debate originates from an interrogation about how much people diagnosed with NPD represented a *problematic zone* inside the society. The analysis highlighted the existence of 2 groups, the first included authors of psychodynamic and psychoanalytic tradition; and second, most numerous and varied, involved authors form different theoretical perspectives and APA members (especially members of the PDWT). The authors of the first group are left out and the second group seemed to animate the debate. The debate revolved around the definition and the operalization of the criteria and the evidence-based data used to arrive at the proposed exclusion made by the PDWT in 2010 and to the finale decision of retention made by the APA at the end of decisional process. Moreover, the *consensus* appeared as the main criterion in the decisional process. The specificities of the argumentations, for or against the deletion of the NPD, used by the different social actors involved in the debate and what kind of implications they brought with them are discussed in the details in the sections 3.6 and 3.7. Here, I would like to put attention on how the decisional process was strictly influenced by the social, political and cultural values that characterise the current historical moment. Indeed, the deconstruction of the debate on NPD highlighted how the biomedical model, defined in terms of objectivity and self-evidence knowledge, was not sufficient to discern if NPD could be considerate as a mental disorder, and so to include it in the last edition of DSM-5. In this perspective, the retention of NPD in the DSM system of classification was more influenced by these aspects that by scientific discoveries. Even if, the final decision of retention could appear as a sign of openness by the APA, in my view this decision was better understood through the logic of political authority. Indeed, according to Foucault (1982), power relations are exercised “over free subject” (p. 790), but also compliant. In other words, the APA as dominant group had to take into consideration the interests and tendencies of the groups over which hegemony has to be exercised. In this perspective, this concession to other social actors involved in the psychiatric domain it was publicised (i.e., through the website: www.dsm5.org) in order to demonstrate the ruling class’s probity and hence to justify and reinforce its moral and political leadership.

In conclusion, the reconstruction and the deconstruction of the debate on NPD allowed to clarify the strategies through which the APA managed the controversy. These strategies entailed another consequence. In the light of the scientific progress the APA appeared able to shape and administere individual and collective conducts, promoting its own knowledge. Indeed, the APA, as shown with the first study, appeared able to exerting an influence not only on the health and mental-health domain, but also on social practices, for instance in the insurance and legal fields. In this vein, the decision to delete or retain NPD, or whatever other mental disorders, would have effects on social practices. Moreover, it contributed to divide subjectivities making decisions about whether or not an individual is "normal" or "abnormal" and whether or not particular behavioural patterns must be regarded as ''functional'' or "dysfunctional". Finally, through the process of objectification, individuals not only come to occupy spaces in the social hierarchy but, through their continual subjugation, come to know and accept their place (Foucault, 1982-1983/2008).

The third step, I continued to analyse the role of DSM system of classification in shaping subjectivity. Leaning on the relational structure of the discourses presented by Lacan (Lacan, 1969-1970/2007), I underlined the relationship between the discourse of the DSM over time and the discourse of other social actors, in particular dissenter movements in order to examine their effects in shaping subjectivity. The specificities of the four different discourses, and the fundamental identifications (and the concomitant desires) that are promoted by them are broadly discussed in the sections 4.4 and 4.5. Here, I would like to summarise the effects on subjectivity of: patients, mental-health professionals and members of dissenter groups.

First, in DSM-I (1952) and DSM-II (1968), the APA leaning on the discourse of the Master and presented itself as a social actor able to uniform the communication in the psychiatric domain, and so able to create a univocal way in which to considerate what was normality or not. Given that every mastery position is grounded on a structural function in itself empty and devoid of meaning (Lacan, 1969-1970/2007), the APA had to fill this lacking of meaning. In my analysis, I underlined how the medical discourse, on which the APA desired to shape the discourse of DSM, is the classic example of a discourse that functions as a discourse of the Master (Bracher et al., 1994; Clavreul, 1978; Zizek, 2004; Clemens & Grigg, 2006). Through it mastery position it reduces "the patience

to an object of its knowledge" (Verhaeghe, 1995a, p. 109) turning subjectivity experience of suffering into a norm.

Second, In DSM-III (APA, 1980), DSM-IV (APA, 1994) and DSM-5 (APA, 2013), the APA leaning on the discourse of University conveying the idea that its own system of knowledge is neutral and objective, and consequently all mental-health professionals can embrace it. In other words, it was reinforced the idea that around the DSM discourse it was possible to identify and recognise a community of people. Hence, the discourses of the last three edition of DSM functioned as a point of reference that can provide to produce particular form of the ego ideal. Moreover, this point of reference shapes an ideal image that functions as identification with a movement and it can provide to individual professionals with a sense of collective purpose. In this perspective, the discourse of the APA shaped also the subjectivity of the people who are supposed to be active agents in this process. Instead, they are "used" to reproduce and enact the DSM system of knowledge.

Finally, the APA discourse influenced also collective responses of protest. In this peculiar case, leaning on the discourse of Hysteric, the subjectivity of the members of dissenter movements was shaped by a radical rejection of the identifications promoted by the APA discourse. Indeed, all dissenter groups analysed in this study called into question the *uniformity* and the presence of a *univocal perspective* through which mental disorders are understood. The aim of these groups was to challenges the authority of the hegemonic discourse in the psychiatry and to open some space to alternative perspectives.

In conclusion, connecting intersecting what has been said so far with the WHO definition of health, according to which health is "a state of complete physical, mental, and social well-being" (World Health Organization, 2003), it is possible to infer that what is related to the *mental health* (i.e. mental well-being or, at the opposite side, the mental distress), emerges as measurable, quantifiable, and hence objectively assessable, only in behavioural and in normative terms. The mind, or the psyche, eventually disappears within the very frame of *mental health*, which becomes a matter of behaviours, rather than mental states, and, what is more, it becomes a matter of the generalisation of human being's behaviours, rather than an expression of subjective, and so peculiar,

sufferance. In this way, the discourse about the *mental health* has been used to objectify individuals as the patterns of *symptoms*, to sets normative standards which allow professionals to undertake *dividing practices* to make decisions about whether or not an individual is normal or abnormal and whether or not particular behavioural patterns must be regarded as functional or dysfunctional. In this perspective, once constituted as an object of a particular form, individuals can be dispersed into disciplinary spaces within that "grid of social regularity" (Scheurich, 1997, p.98) and from there, they become subject to particular discourses and practices that result in what Butler (1997) describes as, "the 'on-going' subjugation that is the very operation of interpellation, that (continually repeated) action of discourse by which subjects are formed in subjugation" (pp. 358-359).

In this dissertation I proposed, inside a broad and general theoretical framework (Critical Psychology), two principal theoretical and methodological references (Critical Discourse Analysis and Semiotic Analysis) that share the interest on the relationship between discourse and power, and the effects of this relation on the construction of the concept of mental disorders. These references offered analytical tools and conceptualizations root in several disciplines (psychology, linguistics, structuralism, logic, psychoanalysis and philosophy) intertwined with critical social psychology about the subject-to-society relation and the emerge of certain forms of authority and social identification (Hook, 2008). I used all these instruments to better deconstruct and highlight the matrix of relations and dynamics in which the current assumption about mental health and mental distress are historically, socially and politically constructed in the contemporary Western context and of the effects product on subjectivity by this assumption. The main limitation of the study was represented by the nature of the data sets, which all are constituted by archive data. Indeed, I'm aware that the lack of the mental-health professionals voice, and the patients voice is the major limitation of the study. Notwithstanding, I hope that this dissertation can contribute to a more articulated understanding of the construction of the otherness, and of the relations between power and knowledge, in the *psy* field. For this reason, I wish that it will inform future reflections and stimulate additional research aim to investigate these relations involved directly mental-health professionals and patients, or to examine the relations between discursive

practices and non-discursive practice, possibly integrating the critical discourse perspectives with the ethnography observation.

APPENDIX

Data set of the study about NPD and DSM-5

Alarcon, R. D., & Sarabia, S. (2011). Debates on the Narcissism Conundrum: Trait, Domain, Dimension, Type or Disorder? *The Journal of Nervous and Mental Disease*, *200*(1), 16–25.

American Psychiatric Association. (2013a). From Planning to Publication : Developing DSM-5. Retrieved September 24, 2013, from http://www.psych.org/File Library/Practice/DSM/DSM-5/DSM-5-Development.pdf.

American Psychiatric Association. (2013b). Personality Disorders. Retrieved September 24, 2013, from www.dsm5.org

Blashfield, R. K., & Reynolds, S. M. (2012). An invisible college view of the DSM-5 personality disorder classification. *Journal of personality disorders*, *26*(6), 821–9. doi:10.1521/pedi.2012.26.6.821

Bornstein, R. F. (2011). Reconceptualizing personality pathology in DSM-5: limitations in evidence for eliminating dependent personality disorder and other DSM-IV syndromes. *Journal of personality disorders*, *25*(2), 235–47. doi:10.1521/pedi.2011.25.2.235

Clarkin, J. F., & Huprich, S. K. (2011). Do DSM-5 personality disorder proposals meet criteria for clinical utility? *Journal of personality disorders*, *25*(2), 192–205. doi:10.1521/pedi.2011.25.2.192

Hopwood, C. J., Thomas, K. M., Markon, K. E., Wright, A. G. C., & Krueger, R. F. (2012). DSM-5 personality traits and DSM-IV personality disorders. *Journal of abnormal psychology*, *121*(2), 424–32. doi:10.1037/a0026656

Karterud, S., Øien, M., & Pedersen, G. (2011). Validity aspects of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, narcissistic personality disorder construct. *Comprehensive psychiatry*, *52*(5), 517–26. doi:10.1016/j.comppsych.2010.11.001

Keith Campbell, W., Miller, J. D., & Buffardi, L. E. (2010). The United States and the “Culture of Narcissism”: An Examination of Perceptions of National Character. *Social Psychological and Personality Science*, *1*(3), 222–229. doi:10.1177/1948550610366878

Kendler, K., Kupfer, D., Narrow, W., Phillips, K., & Fawcett, J. (2009). *Guidelines for Making Changes to DSM-V*. American Psychiatric Association.

Krueger, R. F., Eaton, N. R., Clark, L. A., Watson, D., Markon, K. E., Derringer, J., … Livesley, W. J. (2011). Deriving an empirical structure of personality pathology for DSM-5. *Journal of personality disorders*, *25*(2), 170–91. doi:10.1521/pedi.2011.25.2.170

Kupfer, D. J., First, M. B., & Regier, D. A. (2004). *A research agenda for DSM-V*. (D. J. Kupfer, M. B. First, & D. A. Regier, Eds.). American Psychiatric Association.

Lilienfeld, S. O., Watts, A. L., & Smith, S. F. (2012). The DSM revision as a social psychological process: a commentary on Blashfield and Reynolds. *Journal of personality disorders*, *26*(6), 830–4. doi:10.1521/pedi.2012.26.6.830

Livesley, W. J. (2010). Confusion and Incoherence in the Classification of Personality Disorder: Commentary on the Preliminary Proposals for DSM-5. *Psychological Injury and Law*, *3*(4), 304–313. doi:10.1007/s12207-010-9094-8

Livesley, W. J. (2012). Disorder in the Proposed DSM-5 Classi fi cation of Personality Disorders, *368*(July), 364–368. doi:10.1002/cpp.1808

Miller, J. D., & Keith Campbell, W. (2011). *The Handbook of Narcissism and Narcissistic Personality Disorder: Theoretical Approaches, Empirical Findings and Treatments*. Hoboken: John Wiley & Sons Inc.

Miller, J. D., Widiger, T. a, & Campbell, W. K. (2010). Narcissistic personality disorder and the DSM-V. *Journal of abnormal psychology*, *119*(4), 640–9. doi:10.1037/a0019529

Morey, L. C., & Stagner, B. H. (2012). Narcissistic pathology as core personality dysfunction: comparing the DSM-IV and the DSM-5 proposal for narcissistic personality disorder. *Journal of clinical psychology*, *68*(8), 908–21. doi:10.1002/jclp.21895

Mullins-Sweatt, S. N., Bernstein, D. P., & Widiger, T. a. (2012). Retention or deletion of personality disorder diagnoses for DSM-5: an expert consensus approach. *Journal of personality disorders*, *26*(5), 689–703. doi:10.1521/pedi.2012.26.5.689

Pies, R. (2011). How To Eliminate Narcissism Overnight: DSM-V and the Death of Narcissistic Personality Disorder. *Innovations in clinical neuroscience*, *8*(2), 23–7. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3071092&tool=pmcentrez&rendertype=abstract

Pilecki, B. C., Clegg, J. W., & McKay, D. (2011). The influence of corporate and political interests on models of illness in the evolution of the DSM. *European psychiatry : the journal of the Association of European Psychiatrists*, *26*(3), 194–200. doi:10.1016/j.eurpsy.2011.01.005

Pincus, A. L. (2011). Some comments on nomology, diagnostic process, and narcissistic personality disorder in the DSM-5 proposal for personality and personality disorders. *Personality Disorders: Theory, Research, and Treatment*, *2*(1), 41–53.

Ronningstam, E. (2010). Narcissistic personality disorder: a current review. *Current psychiatry reports*, *12*(1), 68–75. doi:10.1007/s11920-009-0084-z

Ronningstam, E. (2011). Narcissistic personality disorder in DSM-V--in support of retaining a significant diagnosis. *Journal of personality disorders*, *25*(2), 248–59. doi:10.1521/pedi.2011.25.2.248

Ronningstam, E. (2013). An update on narcissistic personality disorder. *Current opinion in psychiatry*, *26*(1), 102–6. doi:10.1097/YCO.0b013e328359979c

Shedler, J., Beck, A., Fonagy, P., Gabbard, G. O., Gunderson, J., Kernberg, O., … Westen, D. (2010). Personality disorders in DSM-5. *The American journal of psychiatry*, *167*(9), 1026–8. doi:10.1176/appi.ajp.2010.10050746

Skodol, A. (2011a). Proposed Changes in Personality and Personality Disorder Assessment and Diagnosis for DSM-5 Part I: Description and Rationale. *American Psychiatric Association*. Retrieved from www. dsm5.org

Skodol, A. (2011b). Personality Disorder Types proposed for DSM-5. *American Psychiatric Association*. Retrieved from www.dsm5.org

Skodol, A. E., Bender, D. S., Morey, L. C., Clark, L. A., Oldham, J. M., Alarcon, R. D., … Siever, L. J. (2011). Personality disorder types proposed for DSM-5. *Journal of personality disorders*, *25*(2), 136–69. doi:10.1521/pedi.2011.25.2.136

Verheul, R. (2012). Personality disorder proposal for DSM-5: a heroic and innovative but nevertheless fundamentally flawed attempt to improve DSM-IV. *Clinical psychology & psychotherapy*, *19*(5), 369–71. doi:10.1002/cpp.1809

Zimmerman, M. (2012). Is there adequate empirical justification for radically revising the personality disorders section for DSM-5? *Personality disorders*, *3*(4), 444–57. doi:10.1037/a0022108

Zimmerman, M., Chelminski, I., Calrymple, K., & Martinez, J. (2012). Impact of Delating 5 DSM-IV Personality Disorders on Prevalence, Comorbidity, and the Association Between Personality Disorder Pathology and Psychosocial Morbidity. *Journal of Clinical Psychiatry,*, *73*(2), 202–207.

BIBLIOGRAPHY

Adorno, T. W. (1998). *Critical Models: Interventions and Catchwords*. (H. W. Pickford, Ed.). New York: Columbia University Press.

Alarcón, R. D. (2009). Culture, cultural factors and psychiatric diagnosis: review and projections. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *8*(3), 131–9.

Alarcon, R. D., & Sarabia, S. (2011). Debates on the Narcissism Conundrum: Trait, Domain, Dimension, Type or Disorder? *The Journal of Nervous and Mental Disease*, *200*(1), 16–25.

Albee, G. W., & Joffe, J. M. (2004). Mental Illness Is NOT “ an Illness Like Any Other .” *Journal of Primary Prevention*, *24*(4), 419–436.

Althusser, L. (1971). Ideology and Ideological State Apparatuses. In *Lenin and Philosophy and Other Essays* (pp. 121–176). Lodon: NBL.

Alvesson, M., & Karreman, D. (2000). Varieties of Discourse: On the Study of Organizations through Discourse Analysis. *Human Relations*, *53*(9), 1125–1149. doi:10.1177/0018726700539002

Alvesson, M., & Karreman, D. (2011). Decolonializing discourse: Critical reflections on organizational discourse analysis. *Human Relations*, *64*(9), 1121–1146. doi:10.1177/0018726711408629

American Psychiatric Association. (1952). *Diagnostic and Statistical Manual of Mental Disorders*.American Psychiatric Association

American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders. Second Edition*. American Psychiatric Association.

American Psychiatric Association. (1973). *Homosexuality and Sexual Orientation Disturbance : Proposed Change in DSM-II*. *Change*. American Psychiatric Association.

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders. Third Edition*. American Psychiatric Association

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders. Third Edition Revised*. American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition*. *Text*. American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition.Text Revision*. *Text*. American Psychiatric Association

American Psychiatric Association. (2002). *A Research Agenda for DSM-V*. (D. J. Kupfer, M. B. First, & D. A. Regier, Eds.). American Psychiatric Association.

American Psychiatric Association. (2006). *Dimensional Models of Personality Disorders. Refining the Research Agenda for DSM-V*. (T. A. Widiger, E. Simonsen, P. J. Sirovatka, & D. A. Regier, Eds.). American Psychiatric Association.

American Psychiatric Association. (2012a). History. Retrieved April 10, 2013, from http://www.psychiatry.org/about-apa--psychiatry/more-about-apa/history-of-the-apa

American Psychiatric Association. (2012b). Practice. Retrieved April 10, 2013, from http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual

American Psychiatric Association. (2012c). DSM-5 Development. Retrieved January 02, 2014, from http://www.dsm5.org/MEETUS/Pages/TaskForceMembers.aspx

American Psychiatric Association. (2013a). *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Association.

American Psychiatric Association. (2013b). From Planning to Publication : Developing DSM-5. Retrieved September 24, 2013, from http://www.psych.org/File Library/Practice/DSM/DSM-5/DSM-5-Development.pdf.

Antaki, C. (Ed.). (2011). *Applied conversation analysis*. Palgrave Macmillan.

Atkin, A., & Richardson, J. (2007). Arguing about Muslims: (Un)Reasonable argumentation in letters to the editor. *Text and Talk*, *27*(1), 1–25.

Atkinson, P., & Hammersley, M. (2007). *Ethnography* (3rd ed.). London & New York: Routledge.

Ayd, F., & Blacwell, B. (1971). *Discoveries in Biological Psychiatry*. Philadelphia: J.B. Lippincott & Co.

Baker, M. (2006). *Translation and Conflict: A Narrative Account*. London & New York: Routledge.

Banister, P., Bunn, G., Burman, E., Daniels, J., Duckett, P., Goodley, D., … Runswick-Cole, K. Sixsmith, J., Smailes, S., Tindall, C. and Whelan, P. (2011). *Qualitative Methods in Psychology*. Buckingham: Open University Press.

Baquedano-Lopez, P. (1997). Creating Social Identities through Doctrina Narratives. *Issues in Applied Linguistics*, *8*(1), 27–45.

Barthes, R. (1957). *Mythologies*. Seuil: Paris.

Barton, W. E. (1987). *The History and Influence of the American Psychiatric Association*. Washington, D.C.: American Prychiatric Press.

Basaglia, F. (1967). *Che cos'è la psichiatria*. Torino: Einaudi.

Basaglia, F. (1971). *L'istituzione negata* (Quinta edi.). Torino: Einaudi.

Baszanger, I., & Dodier, N. (1997). Ethinography. In D. Silverman (Ed.), *Qualitative Research* (pp. 8–23). London: Sage.

Bazerman, C. (1994). System of Genres and the Enactment of Social Intentions. In A. Freedman & P. Medway (Eds.), *Genre and the new rhetoric* (pp. 67–85). Taylor & Francis.

Bazerman, C. (2004). Speech acts, genres, and activity systems: how texts organize activity and people. In C. Bazerman & P. Prior (Eds.), *What writing does and how it does it: An introduction to analyzing texts and textual practices* (pp. 309–339). Lawrence Erlbaum, Mahwah, NJ.

Bazerman, C. (2011). Genre as Action. In J. Gee & M. Handford (Eds.), *The Routledge handbook of discourse analysis* (pp. 226–238). Routledge, London.

Benjamin, L. S. (1996). *Interpersonal Diagnosis and Treatment of Personality Disorders* (2nd ed.). New York, Guildford.

Bernardelli, A., & Ceserani, R. (2005). *Il testo narrativo*. Il Mulino.

Bigwood, L. (1986). ECT: the conscience clause. *Asylum*, *1*, 7–8.

Bilic, B., & Georgaca, E. (2007). Representation of “mental illness” in Serbian newspapers: A critical discourse analysis. *Qualitative Research in Psychology*, *4*, 167–186.

Binet, A. (1887a). Le féticisme dans l’amour (I). *Revue Philosphique de la France et de l’Etranger*, *août*, 143–167.

Binet, A. (1887b). Le féticisme dans l’amour (II). *Revue Philosphique de la France et de l’Etranger*, *septembre*, 252–274.

Blashfield, R. K. (1984). *The Classification of Psychopathology. Neo-Kraepelinian and Quantitative Approaches*. New York: Plenum.

Blashfield, R. K., Blum, N., & Pfohl, B. (1992). The effects of changing Axis II diagnostic criteria. *Comprehensive psychiatry*, *33*, 245–252.

Blashfield, R. K., & Reynolds, S. M. (2012). An invisible college view of the DSM-5 personality disorder classification. *Journal of personality disorders*, *26*(6), 821–9. doi:10.1521/pedi.2012.26.6.821

Bonnafous-Boucher, M. (2001). *Un libéralisme sans liberté. Du terme “libéralisme” dans la penseé de Michel Foucault*. Paris: L’Harmattan.

Bornstein, R. F. (1992). The dependent personality: developmental, social and clinical perspectives. *Psychological_Bulletin*, *112*, 3–23.

Bornstein, R. F. (1998). Reconceptualizing personality disorder diagnosis in the DSM-V: the discriminant validity challenge. *Clinical Psychology: Science and Practice*, *5*, 333–343.

Bornstein, R. F. (2011). Reconceptualizing personality pathology in DSM-5: limitations in evidence for eliminating dependent personality disorder and other DSM-IV syndromes. *Journal of personality disorders*, *25*(2), 235–47. doi:10.1521/pedi.2011.25.2.235

Bourdieu, P. (1977). *A Theory of Practice*. Cambridge: Cambridge University Press.

Bracher, M. (1993). *Lacan, Discourse and Social Change. A psychoanalytic cultural criticism*. Cornell Univerity Press.

Bracher, M., Alcorn, M. W., Corthell, R. J., & Massardier-Kenney, F. (1994). *Lacanian Theory of Discourse*. (M. Bracher, M. W. Alcorn, R. J. Corthell, & F. Massardier-Kenney, Eds.). New York University Press.

Bracken, P. (2003). Postmodernism and psychiatry. *Current opinion in psychiatry*, *16*(6), 673–677.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., … Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British journal of psychiatry : the journal of mental science*, *201*(6), 430–4. doi:10.1192/bjp.bp.112.109447

Bröckling, U., Krasmann, S., & Lemke, T. (2010). *Governmentality: Current Issues and Future Challenges*. Routledge & Kegan Paul.

Brown, P. (1995). Naming and Framing : The Social Construction of Diagnosis and Illness. *Journal of Health and Social Behavior*, *35*(Extra Issue), 34–52.

Brown, T. (2008). Lacan, subjectivity and the task of mathematics education research. *Educational Studies in Mathematics*, *68*(3), 227–245. doi:10.1007/s10649-007-9111-3

Burchell, K. (2007). Empiricist selves and contingent “others”: the performative function of the discourse of scientists working in conditions of controversy. *Public Understanding of Science*, *16*, 145–162.

Butler, J. (1997). Sovereign Performatives in the Contemporary Scene of Utterance. *Critical Inquiry*, *23*(2), 350–377.

Caplan, P. J. (1991). How do they decide who is normal? The bizarre, but true, tale of the DSM process. *Canadian Psychology*, *32*(2), 162–170.

Caplan, P. J. (1995). *They Say You’re Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Perseus Books.

Cermele, J. a., Daniels, S., & Anderson, K. L. (2001). Defining Normal: Constructions of Race and Gender in the DSM-IV Casebook. *Feminism & Psychology*, *11*(2), 229–247. doi:10.1177/0959353501011002011

Chandler, D. (2007a). *Semiotics the Basics* (Second.). London & New York: Routledge.

Chandler, D. (2007b). *Semiotics the Basics* (Second.). London & New York: Routledge.

Chilton, P., & Schaffner, C. (2002). *Politics as Text and Talk*. John Benjamins Publishing Company.

Clark, L. (1992). Resolving taxonomic issues in personality disorders. *Journal of personality disorders*, *6*, 360–378.

Clarkin, J. F., & Huprich, S. K. (2011). Do DSM-5 personality disorder proposals meet criteria for clinical utility? *Journal of personality disorders*, *25*(2), 192–205. doi:10.1521/pedi.2011.25.2.192

Clavreul, J. (1978). *L'ordre médical*. Seuil: Paris.

Clemens, J., & Grigg, R. (2006). *Jacques Lacan and the Other Side of Psychoanalysis*.

Cloninger, C. R. (1987). A systematic method for clinical description and classification of personality variants. *Archives of General Psychiatry*, *44*, 573–588.

Cloninger, C. R. (1993). A psychobiological model of temperament and character. *Archives of General Psychiatry*, *50*, 975–990.

Cohen, C. I. (1993). The Biomedicalization of Psychiatry. *Community Mental Health Journal*, *29*(6), 509–521.

Conrad, P., & Schneider, J. W. (1992). *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple University Press.

Cromby, J., & Harper, D. J. (2009). Paranoia: A Social Account. *Theory & Psychology*, *19*(3), 335–361. doi:10.1177/0959354309104158

Crowe, M. (2000). Constructing normality: a discourse analysis of the DSM-IV. *Journal of psychiatric and mental health nursing*, *7*(1), 69–77.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, *20*(1), 44–63.

Decartes, R. (2000). *Discourse on Method and Related Writings*. London: Penguin Classic.

Di Pardo, A. (1990). Narrative Knowers, Expository Knowledge: Discourse as a Dialectic. *Written Communication*, *7*(1), 59–95. doi:10.1177/0741088390007001003

Diaz-bone, R., Bührmann, A. D., Rodríguez, E. G., Schneider, W., Kendall, G., & Tirado, F. (2007). The Field of Foucaultian Discourse Analysis: Structures, Developments and Perspectives. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *8*(2), Art.30. Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs0702305

Dolar, M. (1998). Where does power come from? *New Formations*, (35), 78–91.

Eco, U. (1976). *A Theory of Semiotics*. London: Macmillan.

Edwards, D., & Potter, J. (1992). *Discursive Psychology*. SAGE Publications.

Ellis, H. (2008). *The Nationalisation of the Health*. Kessinger Publishing.

Eysenck, H. J. (1970). *A dimensional system of psychodiagnostics, in New Approaches to Personality Classification*. (A. R. Mahrer, Ed.). New York: Columbia University Press.

Eysenck, H. J. (1987). The definition of personality disorders and the criteria appropriate for their description. *Journal of personality disorders*, *1*, 211–219.

Fairclough, I, & Fairclough, N. (2012). *Political discourse analysis: A method for advanced students*. Routledge, London

Fairclough, Isabela, & Fairclough, N. (2013). Argument, Deliberation, Dialectic and the Nature of the Political: A CDA Perspective. *Political Studies Review*, *11*(3), 336–344. doi:10.1111/1478-9302.12025

Fairclough, N. (1992). *Discourse and Social Change*. Polity Press, Cambridge.

Fairclough, N. (2003b). *Analysing Discourse: Texual Analysis for Social Research*. Routledge, London.

Fairclough, N., Mulderring, J., & Wodak, R. (2011). Critical discourse analysis. In T. A. van Dijk (Ed.), *Discourse Studies: a multidisciplinary introduction* (pp. 357–378). SAGE Publications.

Fairclough, N., & Wodak, R. (1997). Critical discourse analysis. In T.A. van Dijk (Ed.), *Discourse Studies. A multidisciplinary introduction. Vol.2* (pp. 258–284). London: Sage.

Felman, S. (2009). Madness and Philosophy or Literature's Reason. *Yale French Studies*, (52), 206–228.

Fink, B. (1996). *The Lacanian Subject*. Princeton University Press.

First, M. B., Pincus, H. A., Levine, J. B., Williams, J. B. W., Ustun, B., & Peele, R. (2004). Clinical utility as a criterion for revising psychiatric diagnoses. *American Journal of Psychiatry*, *161*, 946–954.

Foucault, M. (1965). *Madness and Civilization. A History of Insanity in the Age of Reason*. New York: Pantheon Books.

Foucault, M. (1972). *The Archaeology of Knowledge*. New York: Pantheon Books.

Foucault, M. (1976). *The Birth of the Clinic*. London & New York: Routledge.

Foucault, M. (1977a). *Discipline and Punish*. New York: Vintage Books.

Foucault, M. (1980a). Truth and Power. In C. Gordon (Ed.), *Power/Knowledge selected interviews and other writings 1972-1977*. Hemel Hempstead: Harvester Wheatsheaf.

Foucault, M. (1980b). Question of Method. In *Michel Foucault: Power* (pp. 223–238). New York: The New Press.

Foucault, M. (1980c). Two lectures. In C. Gordon (Ed.), *Power/Knowledge selected interviews and other writings 1972-1977* (pp. 78–108). New York: Pantheon Books.

Foucault, M. (1980d). The Confession of the Flesh. In Colin Gordon (Ed.), *Power/Knowledge selected interviews and other writings 1972-1977*. New York: Pantheon Books.

Foucault, M. (1981). The order of discourse. In R. Young (Ed.), *Untying the text: A Post-Structuralist Reader* (pp. 48–79). Routledge & Kegan Paul.

Foucault, M. (1982). The Subject and Power. *Critical Inquiry*, *8*(4), 777–795.

Foucault, M. (1994). La politique de la santé au XVIII siecle. In *Dits and Écrits* (p. vol. III). Paris:Gallimard Seuil.

Foucault, M. (2000). The Subject and Power. In J. D. Faubion (Ed.), *Power* (pp. 326–348). New York: The New Press.

Foucault, M. (2008). *Le gouvernement de soi et des autres: Cours au Collège de France (1982-1983)*. Paris:Gallimard Seuil.

Fox, D., Prilleltensky, I., & Austin, S. (Eds.). (2009). *Critical Psychology: An Introduction* (Second Edt.). SAGE Publications.

Frances, A. (1982). Categorical and dimensional systems of personality diagnosis: a comparison. *Comprehensive psychiatry*, *23*, 516–527.

Freud, A. (1992). *The Ego and the Mechanism of Defence*. London: Karnac Books.

Freud, S. (1977a). *Tre saggi sulla sessualità*. Torino: Bollati Boringhieri.

Freud, S. (1977b). *Introduzione al narcisismo*. Torino: Bollati Boringhieri.

Freud, S. (2002). L'interpretazione dei sogni. In *Opere*. Torino: Bollati Boringhieri.

Freud, S. (2006). L'Io e l'Es. In *Opere*. Torino: Bollati Boringhieri.

Freud, S. (2012). Il presidente Schreber: Osservazioni psicoanalitiche su un caso di paranoia (dementia paranoides) descritto autobiograficamente. In *Casi Clinici - 6*. Torino: Bollati Boringhieri.

Funtowicz, M. N., & Widiger, T. a. (1999). Sex bias in the diagnosis of personality disorders: an evaluation of the DSM-IV criteria. *Journal of abnormal psychology*, *108*(2), 195–201.

Georgaca, E. (2013a). Social constructionist contributions to critiques of psychiatric diagnosis and classification. *Feminism & Psychology*, *23*, 56–62.

Georgaca, E. (2013b). Discourse analytic research on mental distress: A critical overview. *Journal of mental health (Abingdon, England)*, *Jan 16*, 1–11. doi:10.3109/09638237.2012.734648

Georgaca, E., & Avdi, E. (2012). Discourse Analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research in Mental Health and Psychoterapy* (pp. 147–161). Wiley-Blackwell.

Glynos, J., & Stravakakis, Y. (2002). *Lacan and Science*. H. Karnac.

Grabe, W. (2002). Narrative and expository macro-genres. In A. Johns (Ed.), *Genre in the classroom: Multiple perspectives* (pp. 249–267). Mahwah, NJ: Lawrence Erlbaum.

Gramsci, A. (1975). *Quaderni dal carcere*. Torino: Einaudi

Gramsci, A. (2001). *Selections from the Prison Notebooks of Antonio Gramsci*. Electric Book Company.

Hare-Mustin, R., & Marecek, J. (1994). Asking the right questions: Feminist psychology and sex differences. *Feminism & Psychology*, *4*, 531–537.

Hegel, G. W. F. (2000). *Fenomenologia dello spirito*. Milano: Bompiani.

Hirshbein, L. (2009). The American Psychiatric Association and the history of psychiatry. *History of psychiatry*, *22*(3), 302–314.

Hodge, R., & Kress, G. (1988). *Social Semiotics*. Ithaca, NY: Cornell University Press.

Hook, D. (2007). Foucault, Psychology and the Analytics of Power. doi:10.1057/9780230592322

Hook, D. (2008). Absolute other: Lacan's "big Other" as adjunct to critical social psychological analysis? *Social and Personality Psychology Compass*, *2*(1), 51–73.

Hook, D., Kiguwa, P., Mkhize, N., Collins, A., Burman, E., & Parker, I. (2004). *Critical Psychology*. Juta Academic.

Hopwood, C. J., Thomas, K. M., Markon, K. E., Wright, A. G. C., & Krueger, R. F. (2012). DSM-5 personality traits and DSM-IV personality disorders. *Journal of abnormal psychology*, *121*(2), 424–32. doi:10.1037/a0026656

Horkheimer, M. (1974). *Teoria critica. Scritti 1932-1941*. (A. Schmidt, Ed.). Torino: Einaudi.

Horkheimer, M. (1992). Traditional and Critical Theory. In D. Ingram & J. Simon-Ingram (Eds.), *Critical Theory: The Essential Readings* (pp. 188–243). Paragone House.

Horkheimer, M., & Adorno, T. W. (1999). *I seminari della Scuola di Francoforte*. (F. Riccio, Ed.). Milano: Franco Angeli.

Howarth, D. (2000). *Discourse*. Open University Press.

Hull, D. L. (1988). *Science as a process: An evolutionary account of the social and conceptual development of science*. Chicago: University of Chicago Press.

Ieţcu-Fairclough, I. (2008). Legitimation and Strategic Maneuvering in the Political Field. *Argumentation*, *22*(3), 399–417. doi:10.1007/s10503-008-9088-9

Ihnen, C., & Richardson, J. (2011). On combining pragma-dialectics with critical discourse analysis. In E. Feteris, B. Garssen, & F. Snoeck Henkemans (Eds.), *Keeping in touch with Pragma-Dialectics* (pp. 231–245). John Benjamins Publishing Company.

Ingleby, D. (1979). Professionals as socializers. The `psy complex'. *Research in law, deviance and social control*, *7*, 79–109.

Ingleby, David. (1981). Understanding “Mental Illness.” In David Ingleby (Ed.), *Critical Psychiatry: The Politics of Mental Health* (pp. 23–71). London: Penguin.

Jorgensen, M., & Phillips, L. J. (2002). *Discourse Analysis as Theory and Method*. SAGE Publications.

Karterud, S., Øien, M., & Pedersen, G. (2011). Validity aspects of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, narcissistic personality disorder construct. *Comprehensive psychiatry*, *52*(5), 517–26. doi:10.1016/j.comppsych.2010.11.001

Keith Campbell, W., Miller, J. D., & Buffardi, L. E. (2010). The United States and the “Culture of Narcissism”: An Examination of Perceptions of National Character. *Social Psychological and Personality Science*, *1*(3), 222–229. doi:10.1177/1948550610366878

Kendell, R. (1975). *The Role of Diagnosis in Psychiatry*. London: Blackwll Scientific.

Kendler, K., Kupfer, D., Narrow, W., Phillips, K., & Fawcett, J. (2009). *Guidelines for Making Changes to DSM-V*. American Psychiatric Association.

Kernberg, O. (1970). Factors in the Psychoanalytic Treatment of Narcissistic Personalities. *Journal of the American Psychoanalytic Association*, *18*(1), 51–85. doi:10.1177/000306517001800103

Kernberg, O. (1975). *Borderline Conditions and Pathological Narcissism*. New York. Aronson.

Kiesler, D. J. (1986). The 1982 Interpersonal Circle: an analysis of DSM-III personality disorders. In T. Milton & G. Klerman (Eds.), *Contemporary Directions in Psychopathology: Toward the DSM-IV* (pp. 571–597). New York, Guildford.

Kohut, H. (1966). Forms and Transformations of narcissism. *Journal of the American Psychoanalytic Association*, *14*(2), 243–272.

Kohut, H. (1968). The Psychoanalytic Treatment of Narcissistic Personality Disorders. *The Psychoanalytic Study of the Child*, *23*, 86–113.

Kress, G., & Hodge, R. (1979). *Language and Ideology*. Routledge & Kegan Paul.

Kristeva, J. (1977). *Polylogue*. Seuil: Paris.

Kristeva, J. (1986). *The Kristeva Reader*. (T. Moi, Ed.). New York: Columbia University Press. doi:10.1037/027283

Kristeva, J. (1998). The Subject in Process. In *The Tel Quel Reader* (pp. 133–178). New York: Routledge.

Kupfer, D. J., First, M. B., & Regier, D. A. (2004). *A research agenda for DSM-V*. (D. J. Kupfer, M. B. First, & D. A. Regier, Eds.). American Psychiatric Association.

Lacan, J. (1976a). Sovversione del soggetto e dialettica del desiderio nell'incoscio freudiano. In *Scritti, vol.2* (pp. 795–831). Torino: Einaudi.

Lacan, J. (1976b). Lo stadio dello specchio come formatore della funzione dell'io. In *Scritti, vol. 1* (pp. 87–94). Torino: Einaudi.

Lacan, J. (2006a). *Il Seminario. Libro II 1954-1955*. (J.-A. Miller, Ed.). Torino: Einaudi.

Lacan, J. (2006b). *Le Séminaire. Le livre XVI 1968-1969*. (J.-A. Miller, Ed.). Paris: Seuil.

Lacan, J. (2007). *The Seminar of Jacques Lacan: The Other Side of Psychoanalysis. Book XVII*. W.W. Norton & Company.

Lacan, J. (2008). *Il Seminario. Libro VIII 1960-1961*. (J.-A. Miller, Ed.). Torino: Einaudi.

Laclau, E. (2005). *On Populist Reason*. London: Verso.

Laclau, E., & Mouffe, C. (2001). *Hegemony and Socialist Strategy*. Verso.

Langston, D. (2011). Medieval Theories of Conscience. *Standford Encyclopedia of Philosophy*. Retrieved February 25, 2013, from http://plato.stanford.edu/entries/conscience-medieval/

Lasch, C. (1979). *The Culture of Narcissism: American Life in an Age of Diminishing Expectations*. W.W. Norton & Company.

Lemke, J. (1995). *Texual Politics*. London: Taylor Francis.

Levy, K. N., Chauhan, P., Clarkin, J. F., Wasserman, R. H., & Reynoso, J. S. (2009). Narcissistic Pathology: Empirical Approaches. *Psychiatric Annals*, *39*(4), 203–213. doi:10.3928/00485713-20090401-03

Lewis, B. (2006). Postempiricism: Imagin a Successor Science for Psychiatry. In *Moving Beyond Prozac, DSM & the New Psychiatry* (pp. 143–165).

Lewis, W. (2009). Althusser. *Standford Encyclopedia of Philosophy*. Retrieved October 13, 2013, from http://plato.stanford.edu/entries/althusser/

Lilienfeld, S. O. (1994). A critical examination of the use of the term "comorbidity" in psychopathology research. *Clinical Psychology: Science and Practice*, *1*, 71–83.

Lilienfeld, S. O., Watts, A. L., & Smith, S. F. (2012). The DSM revision as a social psychological process: a commentary on Blashfield and Reynolds. *Journal of personality disorders*, *26*(6), 830–4. doi:10.1521/pedi.2012.26.6.830

Livesley, W. J. (2003). Diagnostic dilemmas in classifying personality disorder, in Advancing DSM: Dilemmas. In K. A. Phillips, M. B. First, & H. A. Pincus (Eds.), *Psychiatric Diagnosis* (pp. 153–190). Washington, D.C.: American Prychiatric Association.

Livesley, W. J. (2010). Confusion and Incoherence in the Classification of Personality Disorder: Commentary on the Preliminary Proposals for DSM-5. *Psychological Injury and Law*, *3*(4), 304–313. doi:10.1007/s12207-010-9094-8

Livesley, W. J. (2012). Disorder in the proposed DSM-5 classification of personality disorders. *Clinical psychology & psychotherapy*, *19*(5), 364–8. doi:10.1002/cpp.1808

Macherey, P. (1986). Aux sources "de l'histoire de la folie." *Critique*, *471-472*, 753–774.

Martin Rojo, L., & van Dijk, T. (1997). "There was a problem, and it was solved!" Legitimating the expulsion of "illegal" immigrants in Spanish parliamentary discourse. *Discourse and Society*, *8*(4), 523–567.

Mayer, A. (1950). *The Collected Papers of Adolf Mayer*. (E. E. Winters, Ed.) (vol. 4.). Baltimore: The John Hopkins University Press.

Mayes, R., & Horwitz, A. V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the history of the behavioral sciences*, *41*(3), 249–67. doi:10.1002/jhbs.20103

McCann-Mortimer, P., Augoustinos, M., & Lecouteur, A. (2004). "Race" and the Human Genome Project: Constructions of Scientific Legitimacy. *Discourse & Society*, *15*(4), 409–432. doi:10.1177/0957926504043707

McKenna, B., & Graham, P. (2000). Technocratic discourse : A primer. *Journal of Techinical Writing and Communication*, (3), 219–247.

Migone, P. (1993a). Il concetto di narcisismo (I). *Il Ruolo Terapeutico*, *63*, 37–39. Retrieved from http://www.psychomedia.it/pm/modther/probpsiter/ruoloter/rt63-64.htm

Migone, P. (1993b). Il concetto di narcisismo (II). *Il Ruolo Terapeutico*, *64*, 32–36.

Miller, G., & Fox, K. J. (1997). Building Bridges. In David Silverman (Ed.), *Qualitative Research. Theory, Method and Practice* (pp. 35–56). SAGE Publications.

Miller, J. D., & Keith Campbell, W. (2011). *The Handbook of Narcissism and Narcissistic Personality Disorder: Theoretical Approaches, Empirical Findings and Treatments*. Hoboken: John Wiley & Sons Inc.

Miller, J. D., Widiger, T. a, & Campbell, W. K. (2010). Narcissistic personality disorder and the DSM-V. *Journal of abnormal psychology*, *119*(4), 640–9. doi:10.1037/a0019529

Miller, P., & Rose, N. (2008). *Governing the Present. Administering Economic, Social and Personal Life*. Cambridge: Polity.

Millon, T., Davis, R. D., Millon, C. M., & et al. (1996). *Disorders of Personality: DSM-IV and Beyond*. New York: Wiley & Son.

Morey, L. C., & Stagner, B. H. (2012). Narcissistic pathology as core personality dysfunction: comparing the DSM-IV and the DSM-5 proposal for narcissistic personality disorder. *Journal of clinical psychology*, *68*(8), 908–21. doi:10.1002/jclp.21895

Mulkay, M., & Gilbert, G. N. (1984). *Opening Pandora's Box*. Cambridge: Cambridge University Press.

Mullins-Sweatt, S. N., Bernstein, D. P., & Widiger, T. a. (2012). Retention or deletion of personality disorder diagnoses for DSM-5: an expert consensus approach. *Journal of personality disorders*, *26*(5), 689–703. doi:10.1521/pedi.2012.26.5.689

Narrow, W., Rae, D. S., Robins, L. N., & et al. (2002). Revised prevalence estimates of mental disorders in the United States: using a clinical significance criterion to reconcile 2 surveys' estimates. *Archives of General Psychiatry*, *59*, 115–123.

Neill, C. (2013). Breaking the text: An introduction to Lacanian discourse analysis. *Theory & Psychology*, *23*(3), 334–350. doi:10.1177/0959354312473520

Nietzsche, F. (2012). *Genealogia della morale*. Newton Compton.

Nikander, P. (2006). CONSTRUCTIONISM AND DISCOURSE ANALYSIS. *Discourse*, *2006*(November).

Nunberg, H., & Federn, E. (1973). *Dibattiti della Società Psicoanalitica di Vienna, 1906-1908*. (H. Nunberg & E. Federn, Eds.). Torino: Bollati Boringhieri.

Nystrand, M. (1989). A Social-Interactive Model of Writing. *Written Communication*, *6*(1), 66–85. doi:10.1177/0741088389006001005

Ouvry, O. (2001). Le Féminin comme nouveauté pubertaire. In *Le féminin: un concept adolescent?* (pp. 49–74). Eres.

Parker. (2007). *Revolution in Psychology. Alienation to Emancipation* (Pluto Pres.).

Parker, I. (1987). Social representations: Social psychology's (mis)use of sociology. *Journal for the Theory of Social Behaviour*, *17*(4), 447–469. doi:10.1111/j.1468-5914.1987.tb00108.x

Parker, I. (1997). Discourse Analysis and Psycho-Analysis. *British Journal of Social Psychology*, *36*, 479–495.

Parker, I. (1999). Critical psychology: critical links. *Annual Review of Critical Psychology*, *1*, 3–18.

Parker, I. (2005a). Lacanian Discourse Analysis in Psychology: Seven Theoretical Elements. *Theory & Psychology*, *15*(2), 163–182. doi:10.1177/0959354305051361

Parker, I. (2005b). Lacanian Discourse Analysis in Psychology: Seven Theoretical Elements. *Theory & Psychology*, *15*(2), 163–182. doi:10.1177/0959354305051361

Parker, I. (2005c). Lacanian Discourse Analysis in Psychology: Seven Theoretical Elements. *Theory & Psychology*, *15*(2), 163–182. doi:10.1177/0959354305051361

Parker, I. (2008). Constructions, Reconstructions and Deconstruction of Mental Health. In A. Morgan (Ed.), *Being Human: Reflections on Mental Distress in Society* (pp. 40–53). PCCS Books, Ross-on-Wye.

Parker, I. (2013a). Discourse Analysis : Dimensions of Critique in Psychology. *Qualitative Research in Psychology*, (October). doi:10.1080/14780887.2012.741509

Parker, I. (2013b). Qualitative Research in Psychology Discourse Analysis : Dimensions of Critique in Psychology Discourse Analysis : Dimensions, (October), 37–41. doi:10.1080/14780887.2012.741509

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing Psychopatology*. SAGE Publications.

Pavon-Cuellar, D. (2010). *From the Conscious Interior to an Exterior Unconscious: Lacan, Discourse Analysis and Social Psychology*. (D. Carlo & I. Parker, Eds.). London: Karnac Books.

Pies, R. (2011). How To Eliminate Narcissism Overnight: DSM-V and the Death of Narcissistic Personality Disorder. *Innovations in clinical neuroscience*, *8*(2), 23–7

Pilecki, B. C., Clegg, J. W., & McKay, D. (2011). The influence of corporate and political interests on models of illness in the evolution of the DSM. *European psychiatry : the journal of the Association of European Psychiatrists*, *26*(3), 194–200. doi:10.1016/j.eurpsy.2011.01.005

Pincus, A. L. (2011). Some comments on nomology, diagnostic process, and narcissistic personality disorder in the DSM-5 proposal for personality and personality disorders. *Personality Disorders: Theory, Research, and Treatment*, *2*(1), 41–53.

Pincus, A. L, & Wiggins, J. S. (1990). Interpersonal problems and conceptions of personality disorders. *Journal of personality disorders*, *4*, 342–352.

Pincus, A. L, & Wilson, M. (2001). Interpersonal variability in dependent personality. *Journal of personality disorders*, *69*, 223–251.

Pincus, A. L, McQueen, L. E., & Elison, L. (2003). Subthreshold mental disorders: nosological and research recommendations. In K. Phillips, M. B. First, & H. A. Pincus (Eds.), *Advancing DSM: Dilemmas in Psychiatric Diagnosis* (pp. 129–144). Washington, D.C.: American Prychiatric Association.

Popper, K. (2002). *The Logic of Scientific Discovery*. Routledge, London.

Potter, J. (1996). *Representing Reality. Discourse, Rhetotic and Social Construction*. SAGE Publications.

Potter, J., & Wetherell, M. (1987). *Discourse and Social Psychology*. SAGE Publications.

Presly, A. S., & Walton, H. J. (1973). Dimensions of abnormal personality. *British Journal of Psychiatry*, *122*, 269–276.

Prilleltensky, I. (1994). *The Morals and Politics of Psychology: Psychological Discourse and the Status Quo*. New York: SUNY Press.

Radley, A. (1994). *Making sense of illness: The social psychology of health and disease*. SAGE Publications.

Reisigl, M., & Wodak, R. (2001). *Discourse and Discrimination. Rhetorics of Racism and Antisemitism*. London & New York: Routledge.

Richardson, J. (2001). “Now is the time to put an end to all this”: Argumentative discourse theory and letters to the editor. *Discourse and Society*, *12*(2), 143–168.

Rivas, L. A. (2001). Constroversial Issues in the Diagnosis of Narcissistic Personality Disorder: A Review of the Literature. *Journal of Mental Health Counseling*, *23*(1), 22–35.

Ronningstam, E. (1991). Narcissistic Personality Disorder: A Review of data on DSM-III-R descriptions. *Journal of personality disorders*, *5*(2), 167–177.

Ronningstam, E. (2009). Narcissistic Personality Disorder : Facing DSM-V. *Psychiatric Annals*, (March), 111–121.

Ronningstam, E. (2011). Narcissistic personality disorder in DSM-V--in support of retaining a significant diagnosis. *Journal of personality disorders*, *25*(2), 248–59. doi:10.1521/pedi.2011.25.2.248

Ronningstam, E. (2013). An update on narcissistic personality disorder. *Current opinion in psychiatry*, *26*(1), 102–6. doi:10.1097/YCO.0b013e328359979c

Rose, N. (1985a). The psychological complex : mental measurement and social administration, 5–68.

Rose, N. (1985b). *The psychological complex: psychology, politics and society in England 1869-1939*. Routledge & Kegan Paul.

Rose, N. (1986). Psychiatry: The Discipline of Mental Health. In P. Miller & N. Rose (Eds.), *The Power of Psychiatry* (pp. 43–84). Cambridge: Polity Press.

Rose, N. (1999a). Power and Subjectivity: Critical history and psychology. In C. Graumann & K. Gergen (Eds.), *Historical Dimensions of Psychological Discourses* (pp. 103–124). Cambridge: Cambridge University Press.

Rose, N. (1999b). *Powers of Freedom. Reframing political thought*. Cambridge: Cambridge University Press.

Rose, N. (2000). Government and control. *British Journal of Criminology*, *40*, 321–339.

Rose, N., & Novas, C. (2003). Biological citizenship. In A. Ong & S. J. Collier (Eds.), *Global Assemblages. Technology, Politics, and Ethics as Antropological Problems* (pp. 439–464). Blackwell Publishing Ltd.

Rosenhan, D. L. (1973). On being sane in insane place. *Science*, *179*, 250–258.

Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language*, *50*, 696–735.

Samson, C. (1995). Madness and Psychiatry. In B. S. Turner (Ed.), *Medical Power and Social Knowledge, 2nd ed.* (pp. 55–83). SAGE Publications.

Saussure, F. (2009). *Corso di linguistica generale*. Bari: Laterza.

Scheurich, J. J. (1997). *Research Method in the Postmoderm*. London: Falmer Press.

Schneider, K. (1923). *The Psychopathic Personalities*. Vienna, Austria, Deuticke.

Schroeder, J. L. (2008). *The Four Lacanian Discourses or turning law inside-out*. Birkbeck Law Press.

Shedler, J., Beck, A., Fonagy, P., Gabbard, G. O., Gunderson, J., Kernberg, O.,Westen, D. (2010). Personality disorders in DSM-5. *The American journal of psychiatry*, *167*(9), 1026–8. doi:10.1176/appi.ajp.2010.10050746

Shorter, E. (2005). *A historical dictionary of psyhciatry*. Oxford University Press.

Skodol, A. E., Bender, D. S., & Morey, L. C. (2013). Narcissistic Personality Disorder in DSM-5. *Personality disorders*, 0–6. doi:10.1037/per0000023

Skodol, A. (2011a). Proposed Changes in Personality and Personality Disorder Assessment and Diagnosis for DSM-5 Part I: Description and Rationale. *American Psychiatric Association*. Retrieved from www. dsm5.org

Skodol, A. (2011b). Personality Disorder Types proposed for DSM-5. *American Psychiatric Association*. Retrieved from www.dsm5.org

Skodol, A. E., Bender, D. S., Morey, L. C., Clark, L. A., Oldham, J. M., Alarcon, R. D., … Siever, L. J. (2011). Personality disorder types proposed for DSM-5. *Journal of personality disorders*, *25*(2), 136–69. doi:10.1521/pedi.2011.25.2.136

Smith, D. (2012). Gilles Deleuze. *Standford Encyclopedia of Philosophy*. Retrieved March 30, 2013, from http://plato.stanford.edu/entries/deleuze/

Sturrock, J. (1986). *Stucturalism*. London:Paladin.

Tarizzo, D. (2012). Biopolitics and the Ideology of “Mental Health.” *Filozofski vestnik*, *XXXII*(2), 135–149.

Timimi, S. (2002). *Pathological Child Psychiatry and the Medicalization of Childhood*. Brunner-Routledge, Hove, UK.

Tyler, P., & Alexander, J. (1979). Classification of personality disorder. *British Journal of Psychiatry*, *135*, 163–167.

Tyrer, P. (1988). What’s wrong with DSM-III personality disorders? *Journal of personality disorders*, *2*, 281–291.

Van Dijk, Teun A. (1998). *Ideology: A multidisciplinary approach*. London: Sage.

Van Eemeren, F. H. (2009). Democracy and argumentation. In D. C. Williams & M. J. Young (Eds.), *Discourse, Debate and Democracy* (pp. 37–54). New York: Idebate Press.

Van Eemeren, F. H., & Grootendorst, R. (2004). *A Systematic Theory of Argumentation; The Pragma-Dialectical ApproachNo Title*. Cambridge: Cambridge University Press.

Van Eemeren, F. H., Grootendorst, R., Jackson, S., & Jacob, S. (1993). *Reconstructing Argumentative Discourse*. AL: The University of Alabama Press.

Van Eemeren, F. H., & Houtlosser, P. (1999). Strategic maneuvering in argumentative discourse. *Discourse Studies*, *1*, 479–497.

Van Eemeren, F. H., & Houtlosser, P. (2002). *Dialectic and Rhetoric: The Wrap and Woof of Argumentation Analysis*. (F. H. van Eemeren & P. Houtlosser, Eds.). Dordrecht:Kluwer Academic Publisher.

Van Leeuwen, T. (1995). *The grammar of legitimation*. London School of Printing, School of Media.

Van Leeuwen, T. (2007). Legitimation in discourse and communication. *Discourse & Communication*, *1*(1), 91–112. doi:10.1177/1750481307071986

Van Leeuwen, T., & Wodak, R. (1999). Legitimizing immigration control: A discourse historical perspective. *Discourse Studies*, *1*, 83–118.

Van Rees, M. a. (2007). Discourse analysis and argumentation theory: The case of television talk. *Journal of Pragmatics*, *39*(8), 1454–1463. doi:10.1016/j.pragma.2007.04.005

Verhaeghe, P. (1995a). From ipossibility to inability: lacan's theory on the four discourses. *The Letter. Lacanian Perspectives on Psychoanalysis*, *3*, 91–108.

Verhaeghe, P. (1995b). Psychoanalysis is the science of the particular., 1–14.

Verheul, R. (2012). Personality disorder proposal for DSM-5: a heroic and innovative but nevertheless fundamentally flawed attempt to improve DSM-IV. *Clinical psychology & psychotherapy*, *19*(5), 369–71. doi:10.1002/cpp.1809

Walton, H. J. (1986). The relationship between personality disorder and psychiatric illness. In T. Millon & G. Klerman (Eds.), *Contemporary Directions in Psychopathology: Toward the DSM-IV* (pp. 553–569). New York, Guildford.

Wermuth, L., Donzelot, J., & Hurley, R. (1981). *The Policing of Families. Contemporary Sociology* (Vol. 10, p. 414). doi:10.2307/2067358

White, H. (1981). The Value of Narrative in the Representation of Reality. In W. Mitchell (Ed.), *On Narrative* (pp. 5–27). University of Chicago Press.

Widiger, T. A., & Frances, A. (1985). The DSM-III personality disorders: perspectives from psychology. *Archives of General Psychiatry*, *42*, 615–623.

Widiger, T., & Clark, L. (2000). Toward DSM—V and the classification of psychopathology. *Psychological bulletin*, *126*(6), 946–963.

Wolfe, T. (1976). The “Me” Decade and the Third Great Awakening. *New York Magazine*. Retrieved from http://nymag.com/news/features/45938/

World Health Organization. (2003). WHO definition of Health. *World Health Organisation*. Retrieved January 01, 2014, from http://www.who.int/about/definition/en/print.html

Young, R. (1981). *Untying the texts: A Post-structural Reader*. (R. Young, Ed.). Routledge & Kegan Paul.

Zimmerman, M. (2012). Is there adequate empirical justification for radically revising the personality disorders section for DSM-5? *Personality disorders*, *3*(4), 444–57. doi:10.1037/a0022108

Zimmerman, M., Chelminski, I., Calrymple, K., & Martinez, J. (2012). Impact of Delating 5 DSM-IV Personality Disorders on Prevalence, Comorbidity, and the Association Between Personality Disorder Pathology and Psychosocial Morbidity. *Journal of Clinical Psychiatry,*, *73*(2), 202–207.

Zizek, S. (1989). *The Sublime Object of Ideology*. London: Verso.

Zizek, S. (1998). *Cogito and the Unconscous*. Duke University Press: Durham and London.

Zizek, S. (2002). *Benvenuti nel deserto del reale*. Meltemi Editore. Roma.

Zizek, S. (2004). The Structure of Domination Today: A Lacanian View. *Studies Eastern European Thought*, *56*, 383–403.