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American Insanity: The Demise of the Elite and a Critical/ Historical Analysis of the DSM

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AMERICAN INSANITY: THE DEMISE OF THE ELITE AND A CRITICAL/HISTORICAL ANALYSIS OF THE DSM

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By

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I HEREBY RECOMMEND THAT THE THESIS PREPARED UNDER MY SUPERVISION BY Tiffany B. Hunter ENTITLED American Insanity: The Demise of the Elite and a Critical/Historical Analysis of the DSM BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF Master of Arts.

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Abstract

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The International Classification of Diseases, Sixth Edition (ICD-6; World Health Organization, 1949) is a universal health care management tool for examining the pathology of diseases and how to properly diagnose and treat said diseases. The birth of the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I; American Psychiatric Association, 1952) is the product of the ICD and the American Medico-psychological Association and first delivered shortly after the end of the Second World War. As per request of the American Armed Forces, which were ill-equipped to manage the surge of mental disorders after the war, the need for a uniform classification system to diagnose the rising number of disorders classified as numerous names and symptoms, or inexistent in medical nomenclature, was perceived to be undoubtedly dire.

Unlike the ICD, the DSM was constructed particularly for American classifications of mental disorders and psychosis, both organic and inorganic, which would in the course of over 60 years expand its diagnosis to thousands of American civilians. Since the first publication of the DSM, there have been six additional publications that essentially define what is ñnormalò and ñdeviantò as it relates to social behavior and function. The purpose of this research is to examine the trend of Axis II

personality disorders within DSM-I through V (APA, 1952 & 2013) in regards to its continually revised definition of the boundaries of American normalcy and the ñotherò[1]; its impact on social behavior, economic disparity; the implications of corralling the masses through medicalization; and an ideation of political dominance that presumes to know what is best for the general population. By utilizing the seven editions of the DSM to examine the literature within the manuals, it will assist in guiding through the trends of personality disorder classifications per edition in comparison to a necessity for controlling maladaptive behaviors. With this information in hand, it will facilitate in the evaluation of how compartmentalized human behavior has become in relation to a limited knowledge of the social spectrum.

[1] The ñotherò, as it relates to the argument, represents an established prototype of ñnormalò (i.e. ethnic, racial, and behavioral) by articulating what is abnormal within a society structured by a class system. Likewise, the ñotherò relates to citizens of nations abroad, both racially and ethnically, that do not adhere to American values.

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To Susan A. Brown.

Thank you for saving my life.

I. Chapter One

Introduction and Goals Statement

Shortly after the end of the Second World War, the United States would find itself fighting another war ï an internal conflict of discipline between the approach and practices of professional psychology. Ill-equipped to manage the surge of mental disorder prevalence after the war, the perceived or felt need for a uniform classification system to diagnose the rising number of disorders known under numerous names and symptoms (or inexistence thereof) became perceivably dire. The birth of the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I; APA, 1952) was the product of the International Classification of Diseases (ICD-6; WHO, 1949) and the American Medico-psychological Association, shared and guided by the American Armed Forces. Unlike the ICD, the DSM was constructed particularly for American classifications of mental disorders and psychosis, both organic and inorganic, which would in the course of over 60 years expand its diagnosis to thousands of American civilians.

By researching Axis II[2] personality disorders within the American Psychological Associationôs DSM-I through DSM-V (APA, 1952 & 2013), peer reviewed articles, commentaries, and scholarly publications, I have developed two hypotheses. First, the

[2] The use of Axes in the DSM did not begin until the DSM-III (APA, 1980).

transition from psychoanalysis to psychiatry in the DSM-III (American Psychiatric Association, 1980) ï a discipline of psychology that was previously associated strictly with institutionalization (Strand, 2011) ï resulted in an expected increase in the average amount of personality disorder classifications. Second, since the introduction of psychiatry as the dominant discipline of professional psychology, the anticipated revisions and refinement of published personality disorder classifications correlates in a political manner which separates American behavior from the ñotherò as well as from one another.

The construction of American normalcy as the standard is based on shared, pre-existing, and non-critically examined cultural constructs. Using a critical theoretical approach, I posit that the DSM is best understood as generated by a political conflict for dominance of disciplines and rationality, as well an elitist dominance of the subservient and the ñotherò. Congruent with the aforementioned, the DSM defines a standard of ñnormalò by structuring what is not normal; that is, behavior that displays symptoms outside of normative expectations for behavior. Disorder, as it relates to psychiatry, is a slight-to-radical deviation from the manifestation of what is prescribed as acceptable behavior. Disorder, in turn, compromises the authority of the elite by compromising its self-worth. Therefore, the power and significance of an autonomous (elitist) authority is only affirmed in such a position so long as the subservient population under its regime experiences it as meaningful without force or contradiction. However, immediate attention and uprising against Democratic *unfreedom* is distracted by a ñsatisfaction of ófalse needsô, which are themselves created by the system of mass consumption and popular culture,ò (Yar, 2012, p. 55).

Since the DSM is an American publication posing to examine and deconstruct social behavior of Americans, it cannot be applicable to other nations or cultures, which is both its benefit and Achillean weakness. Unlike biomedical practices, non-Western cultures do not view personality disorders in the same regard as Western cultures (and more specifically, American culture). Instead, their beliefs assume that personalities are not deviant or maladaptive, but simply reveal an individualôs different path and perception of life (Nikelly, 1992). I aim to explore the assumption that standardization of normal behavior is secondary to the creation of prototypical constructions of deviant behavior, which are instruments in methods of social control and preservation of political power by corralling and subduing the masses.

In light of this assumption, an overarching medical jurisdiction may be to the benefit of pharmaceutical, biomedical and technological industries in the capitalist setting of the United States by collaborating in multiple venues which will reap profit and control, while covertly encouraging dependence. I will supplement this assumption by introducing the theory of medicalization in Chapter Four (Conrad, 2007), followed by comparing the classification specificity and numerical expansion in volume size within Axis II personality disorders from DSM-I to DSM-III, where there is a transition of discipline from psychoanalysis to psychiatry. Furthermore, I will be reviewing the actual number of personality disorders published per edition (DSM-I through V; Chapter Four) and searching for shared characteristics in classifications within each publication (Chapter Three).

To comprehend what defines truth, it is imperative to historically deconstruct current confines of facts from a skeptical approach in order to question knowledge. To

mute irrationality, the popular approach in America is to remedy with institutionalization either through clinics, imprisonment, medicalization, social sedation (discussed in Chapter Three) or any combination of the aforementioned. With the recent release of the newest edition of the DSM in 2013, the importance of the current research is to rationalize that the DSM is not perfect and dependence on this particular instrument may cause more harm than benefit to American civilians. To begin, the current chapter will provide background insight to the historical conception and reproduction of the DSM. Likewise, a politico-economical examination of the ever-advancing technological lifestyle that enchants and controls the subservient American population will demonstrate a manipulated extravagance of alienated patterns of behavior and thought. In light of the opening chapter, I pose this question: Did the creation of the DSM exist to explain deviant behavior (*a posteriori* justification), or were deviant behaviors *a priori* knowledge to its construction?

Historical context of the ICD and DSM

Despite the publication year of the sixth edition of the ICD in 1949, five earlier editions made production through the International Statistical Institute[3]. During a conference in Vienna in 1891, a committee was formed where Jacques Bertillon[4] was

[3] World Health Organization. *Date of publication is unknown.*

[4] (1851-1922), Chief of Statistical Services of the City of Paris, whose position detailed the classification of causes of death. ñThe classification prepared by Bertillon's committee was based on the classification of causes of death used by the City of Paris, which, since its revision in 1885, represented a synthesis of English, German, and Swiss classifications,ò World Health Organization, retrieved from History of the development

named chairman. The Bertillon Classification of Causes of Death would be first introduced to the Americas in the mid-1890s in Mexico, and later introduced to the United States at the end of the 1890s (WHO). The responsibility of the Bertillon Classification of Causes of Death was to publish statistics pertaining to the causes of death as those classifications applied to the specific country every ten years, which would prove a difficult feat to accomplish in later editions. The World Health Organization would replace the Bertillon Classification of Causes of Death with the International Classification of Diseases (ICD; WHO, 1949), a healthcare management tool for examining the epistemology of diseases and how to properly diagnose and treat said diseases.

The benefit of the ICD was its universal utility, but the United States began their excursion for an American classification system by the end of the roaring clamor in the 1920s. In 1917, through the formulation and adoption of a ñuniform statistics in hospitals for mental disease,ò (DSM-I; APA, 1952, p. *v*) psychology managed to situate itself in a more favorable position in comparison to a ñlarge body of American medicineò (p. *v*) as it pertains to standardized nomenclature. Despite the instrumentation of a classification plan designated as ñprimarily a statistical classificationò (p. *v*), the Committee on Statistics of the American Psychiatric Association (previously known as the American Medico-psychological Association) employed such a plan for limited classification of mental disorders for *nomenclature* as well. Problematic in its own construction, nomenclature differed from institution to institution, as each educational facility

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of the ICD (http://www.who.int/classifications/icd/en/HistoryOfICD.pdf) on September 29, 2013. Note: date of publication is not established in the document.

ñemployed a system of its own origination,ò (p. *v*) that fulfilled their local, immediate needs.

By 1932, the first National Conference on Nomenclature of Disease composed a trial edition of proposed nomenclature to distribute to a selection of hospitals. By the following year, the first edition of the Standard Classified Nomenclature of Disease was published and largely implemented within two years. The changes in the section regarding Mental Disorders of the Standard Nomenclature of Diseases and Operations remained relatively consistent during the two revised editions in 1933 and 1942, but the original nomenclature from 1933 remained the official diagnostic nomenclature for medical records and standardizing. When America entered into WWII, civilian and military psychiatry were utilizing nomenclature ñdeveloped primarily for the needs and case loads of public mental hospitals,ò (DSM-I; APA, 1952, p. *vi*) which would soon prove problematic.

Psychiatric caseloads increased as mobilization during the Second World War ensued and the need for accurate accounts of morbidity required an appropriate diagnosis by a psychiatrist, but it was not practiced among civilians. The classification and diagnoses of active duty military personnel became very important, but lacked a standard for nomenclature and criteria, which is imperative. Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists utilized a separate system of nomenclature from one another, resulting in different diagnoses for one individual per system. As stated in the foreword of the first edition of the DSM (APA, 1952), ñOnly about 10% of the total cases seen fell into any of the categories ordinarily seen in public mental hospitals,ò (p. *vi*) thereby restricting nomenclature to an expanding caseload.

Consequentially, psychosomatic disorders were classified by a gastroenterologist or cardiologist and incorporated into wartime nomenclature. For example, men who were reacting to considerable amounts of immediate stress were categorized as ñpsychoneuroticò, and minor personality disturbances were classified as ñpsychopathic personalityò (DSM-I; APA, 1952).

Nevertheless, many of these soldiers who were once labeled as ñpsychoneuroticò or ñpsychopathicò did not match the contingencies of either label in subsequent studies. Therefore, during this time of heavy attention to psychiatric evaluation regarding reactive stress to combat experienced by soldiers in the war, terms were invented by medical professionals to satisfy classification standards. Thus, the previous system of nomenclature previously utilized became archaic and futile. Continuing with this trend in makeshift adjustments, by 1944, the Navy altered some of the nomenclature from the Mental Disorders of the Standard Nomenclature of Diseases and Operations to fit the disturbances mentioned above, while striving to stay within the limitations of the Standard. By 1945, the Army made further revisions with disregard for the Standard, ñattempting to express present day concepts of mental disturbance,ò (DSM-I; APA, 1952, p. *vii*) a trend which was eventually incorporated by all of the branches of the American Armed Forces.

During the following year, the Veterans Administration adopted a similar style of nomenclature. By 1948, a similar rubric of classified mental disorders was revised and categorized in the International Statistical Classification. Likewise, the standards of nomenclature set in 1942 were obliterated to a pile of confusion and at least three separate standards of nomenclature were utilized, including the Standard Classified

Nomenclature of Disease, Armed Forces, and Veterans Administration ï none of which coincided with the International Statistical Classification. As highlighted in the foreword of the first edition of the DSM (APA, 1952), ñOne agency found itself in the uncomfortable position of using one nomenclature for clinical use, a different one for disability rating, and the International for statistical work,ò (p. *vii*). Aside from the modifications previously implemented in teaching intuitions, psychiatrists returning from military duty in the Armed Forces introduced an assortment of nomenclature modifications, and then incorporated them into many clinics and hospitals (DSM-I; APA, 1952).

The successes and shortcomings of the various systems of nomenclature provided by the Army and Veterans Administration were used as examples by the National Committee of Mental Hygiene for revision considerations of the current Standard. Along with the material utilized from the aforementioned agencies, psychiatric teaching quarters were probed for ideas regarding diseases and nomenclature ï including organic brain disorders. The efforts that were made to acquire any possible information from experts in American psychiatry, and literature concerning such, were incorporated into brainstorming for the newest revision. Statistical aspects, something not previously utilized, facilitated the conception of a trial revision of official psychiatric nomenclature that was distributed to 10% of the members in the American Psychiatric Association by April 1950[5]. This included membersô addresses selected from geographical listings, 10%

[5] American Psychiatric Association (1952). Note: The Foreword explains that the selection of members was attributed to the position that was held to provide complete coverage to each aspect of psychiatry in order to receive fair sampling from the included

from each state and Canada, whom would receive a trial revised copy and an additional nine-page questionnaire for the purposes of opinions and suggestions (APA, 1952).

Given that each member received a 3-month deadline to review the revision and complete the questionnaire, it is not surprising that out of the 520 copies distributed only 241 were returned prior to July, 1950. From the returned questionnaires, 224 (93%) expressed approval, 11 (5%) expressed disapproval, and 6 (2%) of respondents expressed neutrality towards the proposed revision (DSM-I; APA, 1952). Albeit that more than half of the reviewers left specific suggestions and recommendations in their comments, the lowest rating of approval for any section did not sink below 72% (DSM-I; APA, 1952). A short period of time for completion of the questionnaire may skew the perception of the revised edition in a favorable light. The members of the American Psychiatric Association who did not receive follow-up notifications concerning their absent questionnaires may have directly contributed to the biased statistics for approval of the first trial edition.

A large proportion of reviewers claimed to address the revision in discussions with colleagues and meetings with staff members of mental hospitals, clinics, and other administrative groups. The fraction of returned questionnaires began another round of revisions in 1950, using the same method as before to obtain authorization by Council to

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groups: American Neurological Association, American Psychoanalytic Association, Academy of Neurology, American Psychopathological Association, to name a few.

ñMembers of the staffs of State Departments of Mental Health were included in order to obtain an expression of opinion from such departments concerning the statistical and clinical impact of the proposed revision,ò (p. *ix*).

the Standard Nomenclature for the edition written in 1951 (APA, 1952) with the goal of publication by the American Psychiatric Association. In the fashion of an epic heroic tale, the foreword of the first edition of the DSM (American Psychiatric Association, 1952) details how involved the federal government has been in regards to the collection of etiology of mental disorders. As it details, ñDelegated from year to year on a fiscal basis to the Bureau of the Census, morbidity statistics in this most important area perhaps would never have been collected had it not been for the untiring efforts of former Committees on Statistics of the American Psychiatric Association and the National Committee on Mental Hygiene,ò (DSM-I; American Psychiatric Association, 1952, p. *x*).

The birth of the first edition of the DSM was the product of collaborative effort between the ICD, National Committee of Mental Hygiene, and American Medico-psychological Association, which was delivered shortly after the Second World War. The Committee on Nomenclature and Statistics, a section of the American Psychiatric Association, collaborated with the National Committee for Mental Hygiene (renamed the National Association for Mental Health) for the publication of the DSM. After receiving approval by the Committee on Nomenclature and Statistics and agreement with the National Association for Mental Health, the Mental Hospital Service of the APA received authority for publishing future publications of the DSM. However, the first publication of the DSM represents the nomenclature of the section concerning Diseases of the Psychobiologic Unit within the Standard Nomenclature of Diseases and Operations, Fourth Edition (American Psychiatric Association, 1952).

In the following chapter, an application of Herbert Marcuseôs (1964) concepts of one-dimensionality, falsified rationality and dialectical thought will assist in analyzing

the characteristics of capitalism, the elitist classô construction of standardized behavior, and its effect on the general population. Specifically, the pattern of change within each publication of the DSMôs personality disorders is adaptive as it relates to the cultural beliefs of what is deviant behavior. Moreover, the introduction of the Five-Factor Model (FFM)[6], described by McCrae and Costa (1999) as ña dimensional model that consists of five broad domains [é] that can be further differentiated into more specific facetsò (*see* Widiger, 2005, p. 495) of human behavior will assist in the deconstruction of a contradictory continuum.

[6] Costa & McCrae (1992). NEO Personality Inventory ï Revised (Neo-PI-R)

Chapter Two

> ñThe major change, of course, was the substitution of the newly accepted terminology for the old. Many of the new terms were broader in scope than the old to conform to the basic thinking among psychiatrists that some disorders or reactions formerly considered as separate clinical entities are really expressions of a single disease,ò (DSM-I; American Psychiatric Association, 1952, p. 103).

Herbert Marcuseôs one-dimensional theoretical approach in *One-Dimensional Man* (1964) strongly coincides with Veblenôs critique of the leisure class, where the desires and needs of the laborer are represented as identical in necessity. The presented desires are conspicuous consumptions of the dominant class and their specific politico-economic interests to impose as rational and purposeful. The allure of the desires, known as ñfalse needsò (Marcuse, 1964), maintain a status quo manifesting itself as materialistic values in an object-fueled society. The concept of ñfalse needsò represents a superimposed need or desire upon the individual by particular social interests; in turn, this masks an individualôs *true* or basic needs (those of which are necessary to survive) for distraction of an assumed internal drive to belong to a group or society as a whole. As a result,

individuals in a technologically-advanced, capitalist society quantify their worth and satisfaction by the quantity and quality of their possessions. Therefore, by assuming that an individualôs needs and desires are one in the same, an individualôs needs are based on the needs of dominant conception (Kertzer, 1979), or what is socially accepted, yet not articulated, as common sense. More specifically, they are the needs which render servitude and rationalism via control of societal institutions and their interests. As Marcuse (1964) argues,

> ñThe distinguishing feature of advanced industrial society is its effective suffocation of those needs which demand liberation ï liberation also from that which is tolerable and rewarding and comfortable ï while it sustains and absolves the destructive power and repressive function of the affluent society,ò (p. 7).

Imagine a healthy cell of the human body; it is serving its function of sustaining the bodyôs normal functions, laboring through debris and toxins in order to maintain the ultimate goal of sustaining the body. As this particular cell begins to enlarge, its organelles separate and replicate its purpose and functionality in a matter of seconds. Moments later, the cell cleaves and its innards are appropriating to their assigned positions until one cell separates itself from the other. Ultimately, one cell will die but its premise for existence prevails in the essence of its offspring, which may encounter different scenarios and adjust accordingly. Similarly, the same argument for the process of mitosis can serve macroscopically to the behavior of the individual and their role within society. The presence of each individual in a capitalist society is apparently classless and identical in desires and needs, through which their *raison d'être* is to serve the ultimate function of sustaining the existence of society and assimilate to change.

ñThe government of advanced and advancing industrial societies can maintain and secure itself only when it succeeds in mobilizing, organizing, and exploiting the technical, scientific, and mechanical productivity available to industrial civilizations. And this productivity mobilizes society as a whole, above and beyond any particular individual or group interests,ò (Marcuse, 1964, p. 3).

Through absolving the perception of class differences and emphasizing a perceived ñsamenessò of individuals in technologically-advanced and advancing industrial societies, assimilation to one common denominator has become the prioritized goal. This idea of faux ñequalization of class distinctionsò (p. 8) serves a competitive function in which the needs and satisfactions of the underlying population are shared via preservation of the Establishment (Marcuse, 1964), or dominating class. In turn, this perceptual sameness transposes the self by externalizing the Ego and internalizing a generic identity, which is reinforced by observation and immediate, automatic identification with the object world. However, cultural classifications prove to be purposeful because it defines a certain reality which affects the groupôs thoughts and behaviors. Therefore, the entirety of subservient human behavior and alienation is mimetically reinforced through obligation; the individualôs desires and identity appear to be one within the individual and between their (proximal and metaphorical) neighbors.

As exclusive goods become available to more social classes, their existence becomes a means for a better quality of life. One-dimensional thought thrives in the industrially advanced, capitalist mindset because it ñé is systematically promoted by the makers of politics and their purveyors of mass information,ò (Marcuse, 1964, p. 14). As the quality of life appears to improve by the aggregation of exclusive goods, the behavior of materialistic individuals reduces

to ñideas, aspirations, and objectives [that]é are redefined by the rationality of the given system and of its quantitative extension,ò (Marcuse, 1964, p. 12, brackets added). Evidentiary influence in the forms of propaganda, weaponry, art, music, television, films, and advertising provided by the media are powerful tools which reinforce the efficacy of control over the individual; a demonstration of power which continuously reproduces higher expectations for human behavior and status quo by supplying choices through imposition.

The concept of American liberty is counterintuitive by which its practices make a powerful instrument in domination (Marcuse, 1964) and sustaining alienation. By acknowledging that American democracy provides liberties, it also emphasizes negations regarding individual *unfreedom*, or restrictions to human freedom. Social controls make necessities out of deceptive liberties through what has been optioned to the individual. More specifically, freedoms of competition, speech, and choice represent *degrees* of human freedom; that is, what choices are given to individuals (what *can* be chosen) and what *is* chosen from these options by the individual (Marcuse, 1964).

Ironically, Marxian theories of the laboring class are applicable to the practice of capitalism; however, Americans desire to be drastically separate from communism because American Exceptionalism represents qualitative differentiation from communism. During the Cold War, the political war between two superpowers targeted each other as the great enemy; so to admit that the ends of human and instrument productivity to both political means are material goods would be perceived as illogical and dogmatically self-destructive. Furthermore, the cohesion of a nationôs citizens are astronomically boosted when, ñIt is a cohesion on materialistic grounds; mobilization against the enemy works as a mighty stimulus of production and employment, thus sustaining the high standard of living,ò (Marcuse, 1964, p. 21). Individuals are

viewed as instruments with limitless depths of productivity with rigid standards of possibility; compliance inhibits their potential to perceive alternative modes of true satisfaction, instead encouraging materialism and competition. Thus, the standard of living correlates with the amount of human productivity, separatism from the ñotherò and social alienation from each other.

With continuous refinement and increased production speed, technology has incorporated its utility within the private sphere of the individual, whom slowly sacrifices privacy until it is virtually nonexistent. For this practice to survive and cohesion as a medium of control prevail, a change in the *technical structure itself* (Marcuse, 1964) must universally engulf privacy within publicity. This change would prompt that the subservient class is conditionally alienated from individuality and internalize productivity as a matter of survival and quantitative change. Productivity as a means of survival is presupposed as logical to survival with an expanding population, a majority of which comprise the laboring class, and a rapidly disappearing middle class. The acquisition of objects and materials is gluttonous by which an individual will never find total satisfaction in their quantity, and thus never reach actualization of their self-worth. Their self-worth in turn is an end to their laborious means, which encourage objects as necessities to survival in lieu of existing as leisurely goods.

A promising lifestyle of comfort for those unable to imagine alternatives and a ñcapacity to contain and manipulate subversive imagination and effort,ò (Marcuse, 1964, p. 23) maintains the lubrication of mechanical productivity. However, is the price of overexertion of the laboring class worth the ends of a never-ending desire for objects? Michel Foucaultôs dissection of the origins, adjustment, and allocation of penalizing the body in *Discipline and Punish* (1975) emphasizes the process of appropriating penalty upon the deviant and insane. The dominant class

reinforces their power of cohesion by corralling bodies to fulfill expectations of their behavior and punishing outliers either physically, psychologically, economically, or any combination of the three methods. Punishment has likewise transitioned from translating a committed crime with the severity of physical pain, to utilizing the body as a means of reform, where the individual is the embodiment of punishment. Therefore, the consequences of nonconformity yield participation in an artistic refinement of punishment, which has changed alongside the technical structure of an industrially advanced society.

> ñThe names of things are not only óindicative of their manner of functioning,ô but their actual manner of functioning also defines and óclosesô the meaning of the thing, excluding other manners of functioning,ò (Marcuse, 1964, p. 87).

Rationality is constructed to define what a concept is as well as what it is not, implying that what is rational is also factual and cannot be repudiated. Marcuseôs concept of rationality is jointly associated with advancements in technology, which serves as a cohesion of power and social control for the general population where individuals and nature are viewed strictly as objects, or means to an end (overproductivity and goods). Reality, as it pertains to industrially-advanced nations, is implicitly interwoven with technology in a way that individuals may perceive objects, experiences, and even themselves solely in present-tense. Under such circumstances of existing in an object-world, both individual and machine are viewed as malleable, alienated, and willing instruments. Individuals, like machines, are given predetermined possibilities (a technical *raison d'être*) which inhibit their abilities to perform in

an alternative fashion and are thusly equivalent to their worth among each other and against technological commodity.

Linguistics in a technologically-advanced society is functional in that its structure may absolve abstract thinking and repel conflicting interpretations in order to dismiss historical reference and eliminate challenge. Two-dimensional thought incorporates actuality with appearance; an opposition of dimensions where abstract, critical thinking (Marcuse, 1964, p. 97) exists in reality and contradiction. Dialectical language, Marcuse (1964) argues, contains elements of both reality and history; in its absence, a suppression of history is politically motivated to distort language and its content. By successfully accomplishing a stunted vocabulary of context and discourse, the purpose of anti-dialectical language (p. 97) serves to direct and control the general population to live and exist in the present (Marcuse, 1964). Furthermore, an abridgment of opposing concepts that would previously signal contradiction, now elicits truth in its falsification. The logical purposes for erasing the past eliminate future self-destruction: ñRemembrance of the past may give rise to dangerous insights, and the established society,ò (Marcuse, 1964, p. 98) may become disenchanted from an associative power that promises a better (materialistic) way of life.

As anti-dialectical language relates to the theme of the seven editions of the DSM and the opening quote (p. 15) within the first edition of the DSM (DSM-I; APA, 1952), a special focus of consideration should consider the nomenclature utilized in describing human personality traits and their alleged disorders. An individualôs personality *as a whole* is socialized and internalized; the wide range of observed personality traits and the manner from which they are formed are based upon societal interactions and the dominating classôexpectations of what is considered acceptable behavior. Personality traits exist within every individual; it is what shapes the

perception of experiences, the ability to relate and contemplate the existence of the environment and the self. The expectations from the dominant class, as it pertains to the laboring classô interactions with one another, insist that criteria accepted as fact sustains the subservient class as ñrational to an unprecedented degree,ò (Marcuse, 1964, p. 84). In developing a system of linguistic control that confines an individualôs ability to develop abstract interpretations, anti-dialectical language limits their very ability to communicate and develop an abstract imagination, or *higher thought*. Consequentially, the laboring classôability to oppose and consider alternative measures remains incredibly limited, if nonexistent.

The "Big Five" and its Contradictory Continuum

Human behavior has undergone decades of research and experimentation, with the primary goal to understand the expression of observable actions, with contributions made by possible by federal funding. In 1961, two U.S. Air Force researchers by the names of Tupes and Christal (1961/1992) began to examine common language (i.e. American English) in order to produce a comprehensive set of personality traits (McCrae & Costa, 2005). Utilizing a set of 16 proposed personality factors (Sixteen Personality Factor Questionnaire; Cattell, 1946) (e.g. warmth, reasoning, dominance, and liveliness) first described by Cattell in 1946 (*see* McCrae & Costa, 2005), Tupes and Christal (1961/1992) condensed a model of five observable factors taken from several samples. In turn, those findings were replicated by Norman (1963) and described as ñan adequate taxonomy of personality traits,ò (McCrae & Costa, 2005, p. 35). However, research in personality factors would not be revived until Goldberg (1981; *see* McCrae & Costa, 2005) analyzed the origin of personality trait synonyms in order to apply them to his own research, thereby replicating the Five-Factor Model (FFM) of human disposition (McCrae & Costa, 2005).

McCrae and Costa (2005) describe traits and a method for observation as, "[é] generalized dispositions, so [we know] we must look for evidence of consistent patterns of behavior or reactions across a range of situations," (p. 37, brackets added). The patterns of behaviors or reactions that produced consistent results ultimately comprised the elements of the Neuroticism, Extraversion, and Openness (to experience) Personality Inventory (NEO-PI; McCrae & Costa, 1985) and its revised version, which contains Agreeableness and Conscientiousness (NEO-PI-R; McCrae & Costa, 1992). The NEO-PI-R (McCrae & Costa, 1992) is a survey consisting of 240 items adapted for self-administration or observational evaluation, and the purpose of this inventory is to categorize behavior by attributing a numerical value (between 1-5) to associate with a characteristic (McCrae & Costa, 2005). Furthermore, contained within each domain is a subset of six scales, or *facets*, that specifically measure the overall concept of its given domain.

The "Big Five" – Five-Factor Model (FFM) of Personality			
Domain	**Facets**		**Constituents**
Openness (to experience)	Artistic Curious Imaginative	Insightful Original Wide interests	Wide range of interests, Introspective, Unusual thought processes, Values intellectual matters, Judges in unconventional terms, Aesthetically reactive.
Conscientiousness	Efficient Organized Planful	Reliable Responsible Thorough	Dependable/responsible, Productive, Able to delay gratification, Not self-indulgent, Behaves ethically, Has high aspiration level.
Extraversion	Active Assertive Energetic	Enthusiastic Outgoing Talkative	Talkative, Skilled in play/humor, Rapid personal tempo, Gregarious, Facially/gesturally expressive.
Agreeableness	Appreciative Forgiving Generous	Kind Sympathetic Trusting	Not critical/skeptical, Behaves in giving way, Arouses liking, Warm/compassionate, Sympathetic/considerate, Basically trustful.
Neuroticism	Anxious Self-pitying Tense	Touchy Unstable Worrying	Thin-skinned, Brittle ego defenses, Self-defeating, Basically anxious, Concerned with adequacy, Fluctuating moods.

Table 2.1, The Five-Factor Model (FFM) of human personality, adapted from McCrae & John (1992, p. 178-179).

As shown above in Table 1.1, the FFM consists of Openness to experience, Conscientiousness, Extraversion, Agreeableness, and Neuroticism. The above table also lists the six facets associated with each domain and its constituents, or elements that conceptualize and differentiate one factor from the others. Further elaboration of each domainôs contradictory continuum and factors will be achieved in the following table (*Table 2.2*), but for now, each domain will be explained as it is described by McCrae and Costa (2005). *Openness to experience* refers to a ñreceptiveness to new ideas, approaches, and experiences,ò (McCrae & Costa, 2005,

p. 46). *Neuroticism* refers to an individualôs proneness ñto experience unpleasant and disturbing emotionsò and for their actions to correspond to their emotions (McCrae & Costa, 2005, p. 46). *Extraversion* represents ñdifferences in preference for social interaction and lively activityò (McCrae & Costa, 2005, p. 46). *Agreeableness* represents a ñselfless concern for others and in trusting and generous sentimentsò (McCrae & Costa, 2005, p. 46). Lastly, *Conscientiousness* represents a ñdimension of individual differences in organization and achievement,ò (McCrae & Costa, 2005, p. 46).

Named categories elicit emotions and motives; they can elicit a call to action for service to the country, or to endure exhaustive hours of labor in order to maintain the functioning of the system during a time of economic dependence. Marcuse (1964) argues, ñIt is the word that orders and organizes, that induces people to do, to buy, and to accept,ò (p. 86). Inasmuch the very limited nouns and concepts restricts the subservient populationôs ability to formulate meaning (ñhabits of thoughtò; Marcuse, 1964, p. 85), it also stunts their ability to communicate and furthermore, *interact*. The functionality of words and concepts in the current capitalist, industrially-advanced society are the product of the system itself; that is, their concepts are operationalized through science and technology (Marcuse, 1964) to accommodate the elimination of privacy and autonomous dependence. Thus, by rigidly structuring concepts to fit observed behaviors, the subservient populationôs interactions, beliefs, and attitudes can be standardized; traits that do not adhere to standardized preconceptions of behavior are therefore seen as disordered in its formation and execution.

Marcuseôs (1964) analysis of dialectical thought and behavior utilizes the perspective of what is socially *normal*, as well as its cohesion with contradictions along a lexical continuum. More specifically, by adjoining opposing nouns and adjectives to describe behavior and

observable concepts to the current American English language resembles Orwellian (1949) Newspeak. When it is possible to classify behaviors by justifying what it is not (i.e., not healthy, not desirable), the cohesion of control to unify opposites exhibits them as one in the same, which validates its truth and eliminates cognitive ambiguity. As Marcuse (1964) remarks, ñThe syntax of abridgement proclaims the reconciliation of opposites by welding them together in a firm and familiar structure,ò (p. 89). Therefore, by placing opposing concepts along the same continuum, the structure of current ñNewspeakò conditions the human mind to perceive and function along such a rationale of behavior.

The Five-Factor Model -- Human Personality Continuum		
Domain	**Continuum**	
Openness (to experience)	Down-to-earth -- Imaginative	Prefer routine -- Prefer variety
	Uncreative -- Creative	Uncurious -- Curious
	Conventional -- Original	Conservative -- Liberal
Conscientiousness	Negligent -- Conscientious	Aimless -- Ambitious
	Lazy -- Hardworking	Quitting -- Persevering
	Late -- Punctual	Disorganized -- Well-organized
Extraversion	Reserved -- Affectionate	Passive -- Active
	Loner -- Joiner	Sober -- Fun-loving
	Quiet -- Talkative	Unfeeling -- Passionate
Agreeableness	Ruthless -- Softhearted	Antagonistic -- Acquiescent
	Suspicious -- Trusting	Critical -- Lenient
	Stingy -- Generous	Irritable -- Good-natured
Neuroticism	Calm -- Worrying	Comfortable -- Self-conscious
	Even-tempered -- Temperamental	Unemotional -- Emotional
	Self-satisfied -- self-pitying	Hardy -- Vulnerable

Table 2.2, The Five Factor Model (Human Personality Continuum), adapted from McCrae & Costa (2005, p. 4; 1986).

As shown above in Table 1.2, the Five-Factor Model (FFM) of human behavior exemplifies the current argument that the human personality spectrum is located along a continuum of contradictions. As it relates to Orwellian conception of Newspeak, combining

nouns and adjectives that are otherwise oppositional unifies a conceptôs meaningfulness within the individual mind and cuts off circulation to creativity. Albeit their attributes are supposed to range in strength of presence, each factorôs continuum are ultimately dichotomous in nature and represent a scale of characteristics that are weighed as either ñdesirableò or ñnot desirableò, ñhealthyò or ñnot healthyò. Through repetition of such conditioned behaviors, the individual creates a fixed image of a prototypical being, a *status quo* of identification adjoined with false familiarity.

The subservient class is expected to associate and abide by its given contradictions, as they are delivered as facts and rationality. By fusing contradictions along a continuum, repetition creates a sense of familiarity which lacks true understanding or application of its meaning. Furthermore, an association with social ideals structures a fixated representation which assimilates to context, and perpetuates a sense of timelessness and static presence all at once. As it relates to behavior and personality, a trait along a continuum encourages prototypical compliance, continues the social need for common identification, and validates the cohesion of power within adjoining contradictions. When a behavior fails to coincide with normalcy, the function, physical features, and habits of the individual or a group of individuals, ñé leaves no space for distinction, development, differentiation of meaning; it moves and lives only as a whole,ò (Marcuse, 1964, p. 93). Therefore, a collection of negative attributes creates a monstrous entity of fear and an overemphasized negation from normalcy. Thus, a scaffold is erected; what is seen as ñnot desirableò and ñnot healthyò is the ultimate fear, and results in an alienation from the master as well as the subservient.

According to Widiger (2003), ñAll of the fundamental symptomatology of the personality disorders can be understood as maladaptive variants of personality traits evident within the

normal population,ò (p. 132). In the first and second editions of the DSM (APA, 1952 & 1968), personality disorders are categorized in the same axis as clinical disorders. However, personality disorders first appear in the third edition of the DSM (DSM-III, APA, 1980) within a separate axis[7] in large response to ñaccumulating evidence that the quality and quantity of preexisting personality disturbance may influence the predisposition, manifestation, course, and response to treatment of various Axis I conditions,ò (Frances, 1980; *see* Widiger, 2003, p. 131). In more recent editions of the DSM (APA; DSM-IV, 1994; DSM-IV-TR, 2000; & DSM-V, 2013) mental retardation (also called *intellectual disabilities*) is in the same axis as personality disorders, which one may infer shares relatedness to maladaptive personalities. Assumedly, dysfunctions in behavior and disabilities of intellect may be attributed to (or contribute to) the prevalence of clinical disorders such as (but not limited to) depression, anxiety, delirium, and obsessive-compulsive disorder (OCD).

Deviations from normal personality that may disrupt the structured, rational behavior of the general population are viewed as dysfunctional, and its constituents are contextually-based and readjusted as shared beliefs qualitatively shift. As elaborated by the second edition of the DSM, personality disorders are biologically characterized as ñdeeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms,ò (DSM-II; APA, 1968). ñIt is only when *personality traits* are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute *Personality Disorders*,ò (DSM-III; APA, 1980). For an example of fluctuation on views of maladaptive traits, personality disorders classified sexual

[7] Personality disorders (Axis II) belong to a separate category from clinical disorders (Axis I) as of the publication of the DSM-III (1980).

deviation, alcoholism, and drug dependence were viewed as dysfunctional behaviors in the DSM-I (Widiger, 2003)[8].

Personality traits are usually not viewed as problematic by the individual, whose characteristics may be assumed to be a product of interaction and refinement of the Ego. The DSM-IV-TR (APA, 2000) explains a personality *trait* as ñé enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts,ò (p. 686). Widiger (2003) argues, ñPersonality traits are integral to each personôs sense of self, as they include what people value, how they view themselves, and how they act most every day throughout much of their lives,ò (p. 131). The DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000) extend the conceptualization of personality disorders to one that implies a societal recognition of maladaptive behavior, not just an individual-based conception. Therefore, what the individual may not see as problematic or deviant can radically be contrasted to societal observation. Between the six-year gap in publication between the DSM-IV and DSM-IV-TR, there are no visible adjustments made to what constitutes as a *disorder* of personality:

ñA Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment,ò (DSM-IV; APA, 1994, p. 26).

[8] Sexual and gender identity disorders (known as sexual deviation in DSM-I) are currently associated with Axis I disorders. Alcoholism and drug dependence are currently part of the section regarding substance-related disorders (DSM-IV; APA, 1994)

Axis II: Personality Disorders in the DSM-IV-TR (2000).

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder

Cluster A

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder

Cluster B

- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

Cluster C

- Personality Disorder Not Otherwise Specified

Table 2.3, Axis II personality disorders and clusters, as listed in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition revised (APA, 2000).

Table 2.3 highlights the current personality disorders classified in the DSM-IV-TR (2000)[9] and their designated clusters. According to their clusters, Clusters A, B, and C describe an observable characteristic in their classification, ñbased on descriptive similaritiesò (DSM-IV; APA, 1994, p. 629). Cluster A, which includes paranoid, schizoid, and schizotypal personality disorders, is often manifested as odd or eccentric behavior in individuals. Cluster B, which includes antisocial, borderline, histrionic, and narcissistic personality disorders, manifests itself as individuals often appearing ñdramatic, emotional, or erratic,ò (DSM-IV; APA, 1994, p. 630).

[9] The current personality disorders listed in Axis II from the DSM-IV-TR (APA, 2000) are identical to the publication of classifications in the DSM-IV (APA, 1994), so either publication may be used.

Cluster C, which includes avoidant, dependent, and obsessive-compulsive personality disorders, is often characterized as anxious or fearful behavior in individuals (DSM-IV; APA, 1994). Ironically, below the description of what each cluster entails, the DSM-IV (APA, 1994) states, ñIt should be noted that this clustering system, although useful in some research and educational situations, has serious limitations and has not been consistently validated,ò (p. 630). Furthermore, co-morbidity of illnesses from different clusters may make it impossible (and improbable) to ascribe one personality disorder from one specific cluster to one specific individual.

In conclusion of the chapter, Marcuse (1964) has laid the groundwork for explaining the compliance of normal behavior subliminally reinforced to the subservient population. A sense of satisfaction by acquiring materials insists that the concept of ñfalse needsò replaces alternative routes of thinking, as well as eliminates time, both retrospective and projective, as well as conceptual ambiguity. By assuming that an individualôs needs and desires are one in the same, an individualôs needs render servitude and rationalism via control of societal institutions and their interests. By presuming that the subservient class shares a virtual sameness compared to each other, an assumption of class distinctions as nonexistent serves as a competitive function of preserving the federal government, or dominant class. On the other hand, the cultural classifications presented in the DSM act as a mode of social control for the subservient class by articulating maladaptive or incorrect modes of otherwise obligatory behavior and thought based on class and societal position. Moreover, the entirety of subservient human personality and behavior is said to be conceptualized within five domains: Openness to experience, Conscientiousness, Extraversion, Agreeableness, and Neuroticism.

Given the historical background covered in Chapter One and the groundwork covered in Chapter Two regarding critically analyzing American society, the cornerstone for social alienation and insanity has been set. Albeit Marcuseôs critical examination of technologically advanced and advancing societies offers a purpose for standardizing normal behavior, it still does not satisfy the social pariah of the alienated, subservient population ï the *abnormal*. In the following chapter, Michel Foucaultôs perspective of the abnormal in *Madness and Civilization: A History of Insanity in the Age of Reason* (1964) and *The Birth of the Clinic: An Archaeology of Medical Perception* (1963) will facilitate in further elaborating on the five domains of human personality traits, their contradicting disorders, as well as what insanity entails.

Chapter Three

ñMadness deals not so much with truth and the world, as with man and whatever truth about himself he is able to perceive,ò (Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, 1964, p. 27).

To explain the concepts of Western concern, one should begin the journey by excavating the premises of the past and apply its essential contingencies to current subjectivity. As discussed in the previous chapter, Marcuse depicts the separation of classes within a ñclassless societyò to symbolize an adhesive division of labor and its stupefying, futile effect on fulfilling desires against the structure of false needs. Moreover, by promoting an ideology of generic needs and an apparent equalization of class distinctions, it technically generates more problems in lieu of pacifying most concerns. Immediate attention should be drawn to the first contradiction of error ï how is it possible to exist in a society that is both divided by social worth and equilibrated in their distinctions? An obvious answer would be through heavy sedation, but not through routes of pharmaceutical sedation (which takes place at higher levels of a heuristic hierarchy) inasmuch as primarily social sedation, competition, and alienation.

In the current chapter, the discussion opens by providing a brief introduction to a new critique of social control in order to demonstrate the framework of the themes previously explained in the last chapter. The purpose of the following figure (*Figure*

3.1) is to visually demonstrate the malleability of human motivation based upon the manipulation by the dominant class and how its priorities are structured along five rungs, where each level cannot be triumphed without conquering the ones below it. After briefly discussing the lower three ñlevelsò of achieving social control ï *social sedation, assimilation, desire* and *competition* ï it will be possible to illustrate in further detail the social construction and function of the mentally insane, the examining gaze, and their placement within society.

Following the discussion of the social function that encompasses alienation and ostracism of the mentally ill, the chapter will conclude by reviewing the contextual revision of abnormal behavior as it pertains to Axis II personality disorders within DSM-I (APA, 1952) through DSM-V (2013). Instead of elaborating first about the revisions present per edition of the DSM, it is with strongest confidence that providing an alternative, critical perspective will make it possible to defend the position of the current research as well as its integrity. By discussing the abnormal as it is documented in an American diagnostic tool towards the conclusion of this chapter, the goal is to first, demonstrate that American Exceptionalism is flawed; and secondly, absolute faith in a militaristic tool for diagnosing abnormalities is the origin for conditioning acceptable, normal American behavior.

Hunter's Hierarchy of Social Adhesion (2014)

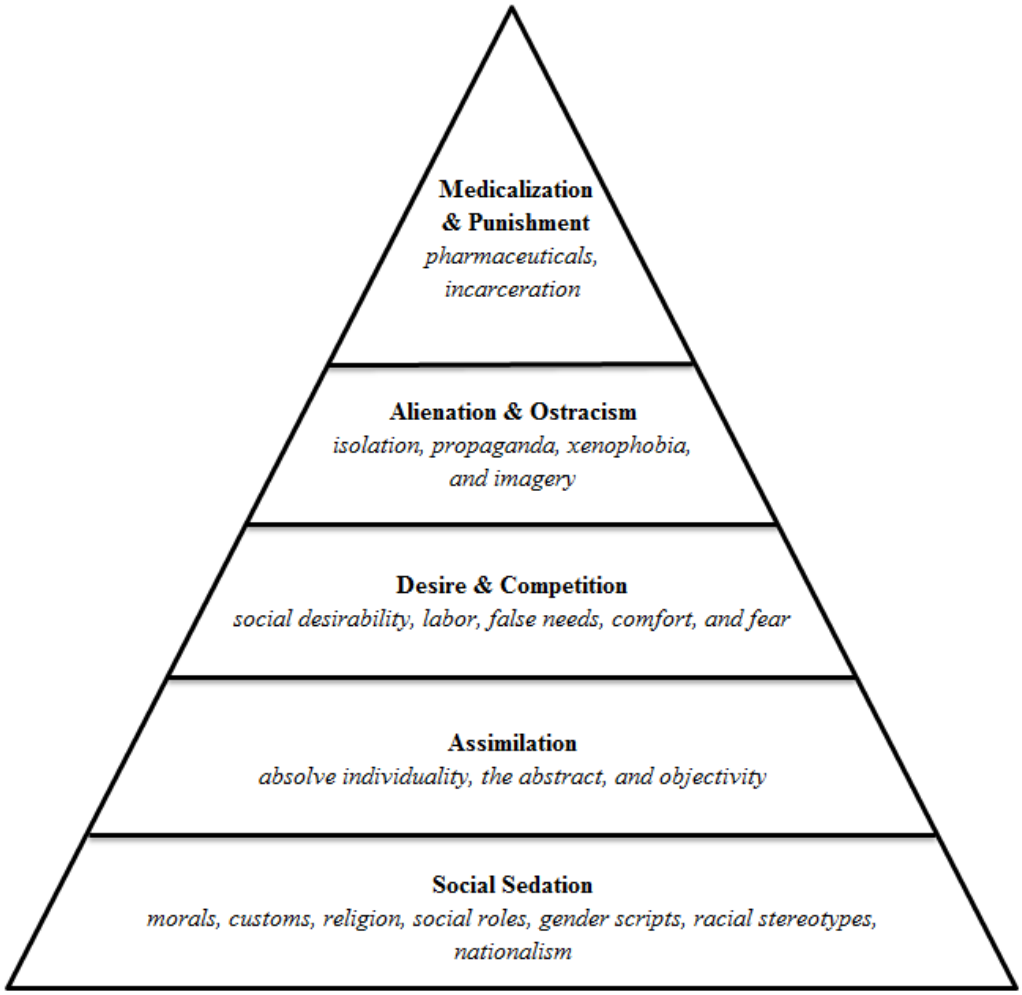

Figure 3.1, Hunterôs hierarchy of social adhesion (2014).

To understand the DSM in real-life circumstances as it relates to social sedation, it must be brought to explanation with a heuristic device. As displayed above in Figure 3.1, a critical analysis of the hierarchy of social adhesion (Hunter, 2014) demonstrates a pyramidal construction of the elitist classô solution to the irrational contradiction within social worth and the equalization of social distinctions. Social sedation is the groundwork and the *adhesive* of a developing society; more specifically, to equalize social distinctions, said distinctions have to first be created. To clarify, the above device

describes a purely empirical model of lower level social adhesion, an analytical contrast between the natural and functional, which systematically conforms to maintain seamless contextual synchronicity. Likewise, Figure 3.1 aims to materialize the rationale of the subservient classôreality (i.e., obligatory thoughts and behaviors) by demonstrating how it is shaped at each rung as well as its impact on the following rungs. As a precursor first and foremost, the above diagram is merely an intermediate set of actions which occur between the time of social construction, the division of social worth, and the equalization of social distinctions. Moreover, the above device is utilized to critically analyze a possible conception of uniform behavior and its functional outliers.

Social Sedation, Assimilation, Desire and Competition. Before the Greeks of Classical history would perceive one another as nationally Greek, Greece would take the threat of Darius I and Xerxesôtyrannical Persian invasion to bind Athens, Sparta, Megara, Corinth, and Aragon into a single force and notion. All of the conflict occurring between city-states appeared quite trivial against the threat of bondage by a larger, foreign enemy; ergo, their differences no longer appeared as flaws based on location (e.g., Spartan brute force, Athenian navy). However, there were a contradictive set of standards by ancient Greeks, who acquired many slaves as a result of war. However, under the presumption of a free democracy, the Greeks are fundamentally above the notion of bondage. However, against the massive Persian Empire, an Achillean rage cried out ñI am Greek!ò in a seismic clamor and victory was achieved in the early 500 B.C. era. As a product of preservation, the birth of nationalism entered the stage of social sedation and Greeks were unified.

In Western society, specifically American society, it is a civilization blended

with hundreds of ethnicities, as its infamous nickname ñThe Great Melting Potò depicts. For the sake of self-preservation however, a notion of Americanism first survives within us all, resisting tyrannical bondage. America was founded on the basis of escaping religious persecution, but there is a contradiction within that venture to escape persecution: a chance to create political and religious dominance. A chance of freedom to dominate is the fresh canvas to a painterôs brush; anything is possible to illustrate, given the proper tools are present. Cultural values encourage American citizens to embrace the meaning of being separate from other nations. Moreover, variables that adhere to customs and tradition (such as social roles, gender scripts, and racial stereotypes) are forever present yet contextually different to meet the demands of a developing landscape moving temporally forward.

In order for the seed to sprout roots, the ground it impregnates must be able to sustain the seed during this fragile period of germination. The assimilation of a group requires that its members do not conflict and splinter, which means that eccentric individuality and objectivity have to be suffocated before it flickers. Marcuseôs (1964) postulation of one-dimensionality clearly regards the elimination of the abstract as a compromise of living in comfort and confidence in exchange for alternative, independent thinking (p. 23). Therefore, by limiting creativity within the bounds of utility and rationality as a whole under the guise of security, the dominant class is exercising power with minimal force.

Much of what can be said for desire and competition is discussed in the previous chapter but in summation, it is the driving force behind maintaining lubrication within the malleability of the laboring class. With distractions provided by vanity (social

desirability) and false needs, hours of stupefying labor scaffolds the silhouetted image of comfort and the fear of being without. In technologically-advanced countries, oneôs worth is displayed by tangible items, titles, education, and physical appearance. Fear of the unknown is quite powerful and expends minimal energy; fear maintains that labor will persist in order to avoid decay of self-esteem and therefore, labor sustains pleasure. Furthermore, fear of the unknown, or the ñotherò, and its questionable implications of inquiry mobilize the dynamic alterations of desire and competition to persist.

As pouring sand into a basket filled with holes is quite ludicrous in retrospect, the ideation of an American Exceptionalism is constantly under objectification for exactly this reason. Nietzscheôs nihilistic denunciation of a present and living God, civil rights, womenôs liberation, Sartreôs illusion of an existential hell[10], and the ever-changing (yet contradictory) diagnostic materials that serve as a trajectory for stabilizing behavioral abnormalities only represent minimal examples in the plethora of tremors which represent revolt of traditional Western adherence and therefore, its rationality.

Alienation and Ostracism. Michel Foucaultôs classic analysis of the arrangement and social function of the insane in *Madness and Civilization: A History of Insanity in the Age of Reason* (1964) clears the smoke of disillusioned fear regarding the imagery associated with the dark recesses of the mind. Concurrently, Foucaultôs (1964) arrangement and social function prove to facilitate the following description of the fourth level of social adhesion (Figure 3.1, p. 32) and therefore will be utilized to

[10] In the play ñNo Exitò (1944), Jean-Paul Sartre demonstrates an alternative perspective of hell -- a customizable eternal suffering contoured to the individualôs fears and their ultimate demise.

demonstrate its practicality.

> ñTo inhabit the reaches long since abandoned by the lepers, they chose a group that to our eyes is strangely mixed and confused,ò (Foucault, 1964, p. 45).

Prior to the alienation of the insane during the Classical period (which Foucault regards as the period between 1660 and the end of the 19th century), leprosy was the scapegoat of the largest social fear and religious sacrifice. Lepers were collected from their village and driven to colonies located on the outskirts of the perimeter, where their lives would only remain in the company of the like until their deteriorative demise. Their infliction is both the largest social fear and religious sacrifice because it is a direct form of lifelong suffering by reason of moral evilôs flaw and fault. Therefore, to assist the leper is to alleviate the load of their mortal suffering of all men ï a direct sin against a monotheistic God, which threatens the survival of man. As it relates to the hierarchy, fear is associated with religion to eliminate contestation of the unknown, or from feeling sympathy towards the outcast, out of a stronger innate drive of self-preservation and social responsibility.

> ñHe did not come from the solid land, with its solid cities; but indeed from the ceaseless unrest of the sea, from those unknown highways which conceal so much strange knowledge, from that fantastic plain, the underside of the world,ò (Foucault, 1964, p. 12).

Foucault describes a ñship of foolsò (e.g. *Narrenschiff*; p. 8) during the late 1600s through the eighteenth century which collected and housed the villageôs insane and then cast them off to meander the seas and foreign lands. A league of abandoned cargo, unaware of their own being and void of reason and contribution, is cast to eternal drifting as a symbol of what could become of man. In this way, the crew of the ships could be within tangible sight ï an ever-present threat ï while remaining at a distance. Their lifestyle and behavior became the distinction of alien; identical to their land dwellers, yet alien in what represents truth and rationality. The identification of a leper was visually obvious, whereas the identification of the insane became a struggle, and the biggest fear, in and of itself. The struggle to differentiate the difference between man of moral and rational merit and their mentally defective, unrational neighbor became a fear of identification because the distinction worthy of ostracism was not immediately and physically present during the transition of taboo. Moreover, this transition from physical to spiritual, and eventually psychological, flaw and fault rejects past distinctions in exchange for an affliction that may possess anyone without discrimination or presumption.

An intriguing transition of placement (and therefore *function*) of the social pariah takes place during the Classical period -- a migration to the *center*. The fear associated with the leper penetrated the physical and spiritual gambit while it simultaneously dulled the edge of mercy within individuals and society. The association with leprosy means a sentence of lifelong alienation; leprosy represents a diseased body. The leperôs function within society remains along the outskirts, an outlier in the construction of social

adhesion, but as its presence declined so did the underlying fear. Furthermore, the Renaissance signaled a birth of sophistication not previously acquired by society -- a cultural progression where death no longer perpetually loomed ominous concern, so it likewise must become a covert concept and concern.

The folly of the madman was paramount in tales and fables as he represented the realization of the ever-present concept of death and apocalypse. Prior to the Renaissance, insanity served a purposeful function within society; as Foucault (1964) describes, ñMadness is the great tromp lôoeil in the tragic structures of preclassical literature,ò (p. 34). In regards to the underlying message detailed through folly, the madman knew the unavoidable, ominous truth of innate darkness and demise. However, only through illusory could the truth be accepted while contextual reality is regarded as ña new madness that had just come into [*man's*] head,ò (Foucault, 1964, p. 31-32, brackets added). The cultural development of thought that followed the Renaissance demonstrates a deviation from ominous death and survival; folly was abandoned and the madman directly represented death and the darkness of man. As a result, the impugned madman begins to take over center stage but cannot replace the leper, so it must *supersede* the leper as social concerns shift; therefore, the function of death and the bestial demise within man and society must coincide with placement, ergo centralization.

This centralization of the spectacle of insanity serves more than one function: immediacy of fear, dehumanization (discussed later), and a physical representation in relation to the human anatomy. The latter is quite philosophical in its explanation and differentiation, but it should be introduced firstly to demonstrate the comparison of the

human body to totem. In short, the situation of mortal fault and ailment is located accordingly to its anatomy, physically and geographically; moreover, the effectiveness of analogy demands parallel contingencies that are likewise perpendicular (the importance of nature, which Foucault describes as orderliness). Foucault explains that ñHe [*the madman*] is put in the interior of the exterior, and inversely,ò (1964, p. 10, brackets added); or more specifically, the individuals who are believed to be mad are made spectacles within the publicôs protected interior. A leper is visually identifiable by their symptoms of a diseased body, which cannot be tamed or controlled; moreover, the layout of the village placed the lepers along the perimeter, or the exterior.

Concurrently, the attempts to alienate the madman from society originally underwent a similar process until the differentiation between madness and unrationality demonstrated that dominance via policing can tame madness. The inflammatory organization of words and imagery (i.e., ñship of foolsò) along with the success of taming insanityôs bestial behavior, repurpose curious fear into social utility (Foucault, 1964); thus, the placement of the madman migrates to the center of villages, towns, and cities. The madman, whose inflictions wary from within, make him perceivably different from all others by his innate essence of being ï from his *core*. Therefore, inasmuch as there is a need for the insane to effectively replace the leper, the need for proximal relocation is just as important. In essence, madness surrounds society and engulfs it in fearful curiosity because the madness of man could be tamed for utility and observation. Ergo, demonstrating the strength of nature[11] and authority of rational man in the face of

[11] Nature, as it is regarded by Foucault (1964), is understood to encompass order and rationality ï which appears quite contradictory to chaotic unruliness that results in an

perceived threat is quite a powerful tool of security.

Madness is feared because it threatened the preservation of life and contested rationality; it is a reminder of the Dark Ages, which functions as moral detest for the past and the greatest cultural coagulant towards progression. Furthermore, the seismic transition from concern about diseased bodies to a diseased mind reveals the changing dynamics of social consciousness, culture, and the importance of normal behavior.

The Construction and Transition of Madness

> ñThere must have formed, silently and doubtless over the course of many years, a social sensibility, common to European culture, that suddenly began to manifest itself in the second half of the seventeenth century; it was this sensibility that suddenly isolated the category destined to populate the places of confinement,ò (Foucault, 1964, p. 45).

The underpinnings of Marcuseôs (1964) analysis of dimensionality align quite well with Foucaultôs (1964) analyses of the economic utility of idle bodies. To be specific, idleness is ñthe mother of all evils,ò (Foucault, 1964, p. 53) ï it is the inability to follow civil law and abide by what is accepted to be sacred by the majority of society. Marcuse explains the overall utility of competitively laboring, malleable bodies that lubricate the gears of productivity and persist the social importance of a prosperous

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absence of human intervention. However, society depicts nature as orderly and rational; a direct contribution of human intervention and social consciousness for self-preservation.

work ethic. Self-worth is associated with the moral obligation of employment and those individuals who appear incapable of absorbing that responsibility are labeled as social deviants. Foucault (1964) posits that the notion of confinement begins in the mid-17th century as an economic solution to the problem of idle bodies; confinement forces productivity and prosperous contribution by those who would otherwise refute moral obligation while reducing labor costs. Idleness becomes of specific social concern during the Classical period due to the imperative nature behind economic growth and sophistication, and it is here where the concept of productivity and power becomes the great social bond towards advancement.

The Classical period is a time in which society aims to define the contingencies and existence of normalcy while attempting to separate those viewed as abnormal. It is possible to parallel Marcuseôs (1964) and Foucaultôs (1964) perspectives of incongruence with social expectations and its consequences with the abstract thinking of the social deviants who apparently contest the myopic choices given to them. A more likely possibility is that their position and function within society is resituated based on the context of social importance and concern. ñTo inhabit the reaches long since abandoned by the lepers,ò Foucault remarks, ñthey chose a group that to our eyes is strangely mixed and confused,ò (1964, p. 45). Under the façade of the *Hospital General*, which ñhad nothing to do with any medical concept,[12]ò (p. 40), the first established workhouse in France was associated with a condemnation of idle behavior in lieu of

[12] Foucault continues that the Hospital General ñé was an instance of order, of the monarchical and bourgeois order being organized in France during [*the Classical*] period,ò (Foucault, 1964, p. 40, brackets added).

ailing ñall contagious invalids,ò (p. 44). Instead, the individuals who would find themselves under the thumb of authoritarian constraint were the unemployed, the poor, libertines, and the mad.

Handling civil disobedience became a problem of the city during the Classical period, and their solution became confinement. Confinement, under the rouse of a medical facility, held ñeconomic significanceò (p. 50) by forcing civil law upon those who would not accept it. In these workhouses, the beast-like quality of madness is policed to instill a notion of morality and religious abidance while concealing the cityôs shame into a single infrastructure. By creating a ñsafe havenò to house the mad (amongst other social deviants), society is able to standardize the constituents of ñnormalcyò through what it is not. The question then becomes, how did the cityôs shame become associated with the mad? The function of the madman shifts from one of utility in folly to deviance and fear; confinement becomes an establishment to which the desire for control, the construction of concrete borders for normative behavior, and an exemplification of elitist control becomes paramount in the awakening of a new age of sophistication.

The Dehumanizing "Gaze". The notion of confinement is related to a refinement of technologies, taxation, and a stabilized government. By registering a cityôs inhabitants, the elitist class has an accessible route within privacy and a commodity of power by exclusion. Likewise, the ability to confine a population of ostracized individuals reflects an expanding population, an expanding army and an overall societal vanity. The contradiction to highlight within this assumption is what Foucault (1964) defines as a ñmadness of vain presumptionò (p. 29), which infects all men. If this specific sector of

madness is ñé a delusive attachment that enables him to grant himself all the qualities, all the virtues or powers he lacks,ò (Foucault, 1964, p. 29), how then, is the ñnormalò population of society any different than the madman who is caged? At first glance, it would appear impossible to confine an entire society but upon closer inspection, it is already enacted. By defining one groupôs stereotypes and perceived inadequacies, it indeed isolates the ñotherò through constriction and vanity.

> ñMadness had become a thing to look at: no longer a monster inside oneself, but an animal with strange mechanisms, a bestiality from which man had long since suppressed,ò (Foucault, 1964, p. 70).

The fascination with the madman during the Classical period concerned the resilience and tolerance to what destroyed established men; the madmanôs animalistic qualities supersede his own humanity, therefore making the possibility of perceiving the madman as a beast justifiable. Confinement hid most scandals, but it ñexplicitly drew attention to madness, pointed to it,ò (p. 70); this spectacle of organizing madmen within the facility of the workhouse made it possible to perform public exhibitions. However, by utilizing public exhibition as a spectacle, it defined and controlled not only the social sphere of the madman, but that of its observers. The scandal behind confining and displaying the mad to the public sparks curiosity; to see the fragile line between nature and the ultimate human demise is frightening yet seductive. In a way, the madman represents a fear of the past and a fear of reprimand, and curiosity embodies a drive to seek its derivative.

Madness appears to shift from a civil disobedience, to a disease of the body, and ultimately a disease of the mind. The solution to the contradiction of madness within confinement represents itself in the form of the asylum beginning at the dawn of the nineteenth century. The madman has absolute freedom because he does not live by the same laws and morals that are contextually-based and accepted by the majority of society; the concerns and pains of the madman are not the same as the modern man. The madman is an anarchist and the anti-Christ, which therefore makes him dangerous to the preservation of modernity and temporal progression. The period of Enlightenment however, encourages curiosity to seek rationality by organizing the madman to observe and explain that which is diseased (i.e., the mind), but it still makes the madman quasi-invisible in its symptomology.

A concern has to be recognized as such by examining its disruption in society and enforcing the control via intervention; its threat to comfort and life as it is known at any point in time has to be made an imperative by stating its purpose. In order to understand the transition from fear to curiosity and knowledge, a broader range of its formulation must be examined. Foucaultôs (1963) publication titled *The Birth of the Clinic: An Archaeology of Medical Perception* gives way to the introduction of scientifically investigating madness by first unearthing the mysterious prestige of the medical field. The sophistication which accompanied the Classical period, along with a growing population and army, obsesses over the contingencies of normalcy and segregating that which is not. This segregation, however, occurs on numerous levels and the gaze of the medical practitioner initiates from within and spreads throughout.

The ñrational order of diseasesò (Foucault, 1963, p. 7) is botanical in nature. The

anatomy of the human body is essentially transformed into a rationale of developmental order, and it allows the physician to communicate with the development of the disease without interacting with the patient. The gaze of the physician lifts the veil of the uncertainty behind diseases and it is the gaze that reveals the truth of order. Moreover, the human body becomes a means to an end in the form of manifested symptoms and experimentation; the patient becomes a transparent translator for that which cannot speak. The patient and their human qualities are therefore dissolved, much like the abolishment of humanity in the madman, and thus becomes a ñrediscovered portrait,ò (p. 15) of a familiar ailment.

The patient becomes secondary to the disease, but an unavoidable disturbance which must be tolerated and parenthesized (Foucault, 1963). The truth lies within the disease because it can be observed within the nature of the human body; it follows a path, insofar as it does not mutate, which is recognizable to the physician whereas the patient is not. Moreover, the patient becomes a trivial, external fact during the gaze which prompts to preserve their life. ñThe rationality of life,ò Foucault remarks, ñis identical with the rationality of that which threatens it,ò (1963, p. 7). More specifically, the knowledge of diseases works in conjunction with the recognition of health because it is from one rationale that the other can be understood. It is here that the disease and physician share the scaffold and spectacle; it is here where diseases can be organized and life can be monitored.

The Containment of Madness. The context of the word ñhospitalò has transitioned quite dramatically since the seventeen century and so has its specific population, but the theme of concealment is still tangible. During the Classical period, hospitals were not

geared towards the rehabilitation of ill patients; moreover, illness was turned away from admission within their guarded fortresses. The best environment for a disease to be controlled was within the home where it cannot perpetuate and spread, but this rationale is somewhat contradictory for both diseases and madness. Contradictions geared towards the condemnation of housing diseases, which are to be eradicated from the body and population, would make the relationship between the physician and their gaze a short-lived relationship throughout the entire span of human existence. The knowledge obtained through the observation of that which threatens life would be trivial and archaic, but that knowledge appears to be far from its truth and utility. In fact, the knowledge of diseases expands into numerous disciplines that claim the same purpose ï to manage life and examine its antithesis.

Society maintains contextual truths as such by accepting the premises of its contingencies, which is dependent upon who delivers those contingencies as truths (e.g., expertise and wisdom). Contrary to the condemnation of institutionalizing diseases, the institutionalization of insanity poses to eradicate its existence among the general population and organizes its role within society. As previously mentioned, the scope of insanity within the social sphere contextually migrates from a dark secret of man, to a disease of the body, and ultimately a disease of the mind. Concurrently, the body of the madman shifts from the figure of social utility of truths (i.e. tales and fables), to civil disobedience (i.e., confinement), to covert force within the asylum. As the role of the gaze expands to an expertise of the mind, there appears to be a transition from the movement of humors, to a tension of nerve fibers, to ultimately a psychological explanation of truths (Foucault, 1964).

The Seven Still-Frames

ñData from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions suggest that approximately 15% of the U.S. adults have at least one personality disorder,ò (DSM-V; APA, 2013, p. 646).

DSM-I (APA, 1952) Personality Disorders			
"The Personality pattern disturbances are considered deep seated disturbances, with little room for regression. Personality trait disturbances and Sociopathic personality disturbances under stress may at times regress to a lower level of personality organization and function without development of psychosis," (American Psychiatric Association, 1952, p. 34-35).			
Personality pattern disturbances	**Personality trait disturbances**	**Sociopathic personality disturbances**	**Special symptom reaction**
Inadequate personality	Emotionally unstable personality	Antisocial reaction	Learning disturbance
Schizoid personality	Passive-aggressive personality	Dyssocial reaction	Speech disturbance
Cyclothymic personality	Compulsive personality	Sexual deviation	Enuresis
Paranoid personality	Personality trait disturbance, other	Addiction (Alcoholism, Drug addiction)	Somnambulism
			Other
Transient situational personality disorders			
"This general classification should be restricted to reactions which are more or less transient in character and which appear to be an acute symptom response to a situation without apparent underlying personality disturbance," (American Psychiatric Association, 1952, p. 40).			
Transient situational personality disturbance		Adjustment reaction of childhood *I. Habit disturbance* *II. Conduct disturbance* *III. Neurotic traits*	
Gross stress reaction			
Adult situational reaction			
Adjustment reaction of infancy			
Adjustment reaction of late life		Adjustment reaction of adolescence	

Table 3.1, Personality disorders listed in the DSM-I (APA, 1952).

Albeit the intended purposes of the new diagnostic manual are aimed towards active duty and veteran military personnel, it manages to become a sophisticated, sovereign gaze of the twentieth century. Trivial words such as ñadequateò, ñsocialò, and ñstableò, which naturally hold a mundane position in the English vernacular, begin to take on a derogatory connotation to anyone labeled as such when they are accompanied by a negative prefix. The Second World War left unanswered questions regarding shared insanity by a nation and a backwash of its shell-shocked troops returned to their homes, garlanded with albatrosses. The consequences of war, however, would leave its impressions upon a civilization long after the extravagant pride of congregated Allied forces finalized sanctions. The publication of the first DSM in 1952 (American Psychiatric Association) marks the first consensus of Americanized sensationalism through behavioral reprimand, but it would surely not be the last.

Personality disorders, the American Psychiatric Association (1952) assumes, ñé are characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress,ò (p. 34). Specifically, at the time of publication, personality disorders are not attributed to external variables or oneôs internal interpretation. Similar to the attribution of insanity provided by the family, which Foucault (1964) describes about the inspection of diseased minds, personality disorders are attributed to be particular to the individual and their family. The first group of disorders, *personality pattern disorders*, describes a reluctance of the individualôs personality to ever be altered or alleviated, with its only direction being a downward slope into psychosis. The second group, *personality trait disturbances*, encompasses disorders where individuals have an inability to manage their ñemotional

equilibrium and independence under minor or major stress,ò (DSM-I; APA, 1952, p. 36) due to an interruption during emotional development.

Individuals classified with personality trait disturbances are diagnosed according to a ñfixation and exaggeration of certain character and behavior patterns,ò (DSM-I; APA, 1952, p. 36) or increasingly simplify in behavior due to external (environmental) or internalized stress. Moreover, evidence of ñphysical immaturityò (p. 36) tends to supplement an indication of an underlying personality impediment. The third group, *sociopathic personality disturbances*, posits that individuals are unable to socialize and conform to ñthe prevailing cultural milieuò (p. 38). Unable to find comfort in their own skin or in relationships with others, individuals diagnosed with sociopathic personality disorders are perceived more often to have a high comorbidity rate with both personality trait and pattern disturbances. *Transient situational personality disorders* appear to be a set of diagnoses likewise known as *defense mechanisms*; their acute reactions are responsive to scenarios and ñtransient in characterò (p. 40). Furthermore, experience to similar situations is a means of adapting and thus, symptoms will recede as stress declines.

During a conversation with a trusted mentor, it became abundantly clear that this style of accompanying words and their observed symptoms can be aptly known as *objectivity with a vengeance*. Objectivity with a vengeance positions objectivity as negative by nature, but the physicians who define the contingencies of personality disorders observe its symptoms from a distance. In methodological research, this ñdistanceò is justified as observational ï where the natural discourse of events remains pure of influence. The physicians assume a point of view that is ñneutralò, yet the physician never wants to know what the lived experience is in order to deviate from any

positive outcome. In this way, the primitive dichotomy of ñhealthy/not healthyò and ñnormal/abnormalò is sustained and culturally preserved over the course of more than sixty years within arbitrary text. Furthermore, this dichotomy is elaborated in more depth within the course of eighteen years, and personality disorders begin to form an entity separate from sexual deviancies and addictions.

DSM-II (APA, 1968) Personality Disorders		
"This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns, often recognizable by the time of adolescence or earlier." (American Psychiatric Association, 1968, p. 41). ***"In DSM-I 'Personality Disorders' also included disorders now classified under Sexual deviation, Alcoholism, and Drug dependence,"* (American Psychiatric Association, 1968, p. 42)		
Paranoid personality	Obsessive compulsive personality ((Anankastic personality))	Passive-aggressive personality
Cyclothymic personality ((Affective personality))	Hysterical personality (Histrionic personality disorder)	Inadequate personality
Schizoid personality	Asthenic personality	Other personality disorders of specified types (Immature personality)
Explosive personality (Epileptoid personality disorder)	Antisocial personality	[Unspecified personality disorder]

Table 3.2, Personality disorders listed in the DSM-II (APA, 1968).

A few notable differences exist between the first and second editions of the diagnostic manual, particularly the addition of new diagnoses, the elimination of clustered categories, as well as the relocation of sexual deviation, alcoholism, and drug dependence into a new classification. New diagnostic additions in the second edition include explosive personality disorder, hysterical/histrionic personality disorder, asthenic personality disorder, immature personality, and those personality disorders that cannot be specified.

Moreover, compulsive personality disorder tends to teeter with obsession throughout the history of the diagnostic manualôs existence. In the DSM-I, compulsive personality disorder is described as a ñchronic, excessive, or obsessive concern with adherence to standards of conscience or of conformity,ò (APA, 1952, p. 37) which renders an individual unable to easily relax and may be the result of behavioral patterns first introduced during their adolescence. By 1968, the disorder is coupled with an ñobsessiveò element yet remains contextually similar in symptomology as its predecessor.

> ñé The idea of hysteria is a catchall for the fantasies, not of the person who is or believes himself ill, but of the ignorant doctor who pretends to know why,ò (Foucault, 1964, p. 139).

Contrary to the first edition of the DSM, the second edition includes hysterical personality disorder, more popularly known as histrionic personality disorder. The symptoms, as stated by the DSM-II (APA, 1968), are characterized by ñexcitability, emotional instability, over-reactivity, and self-dramatization [é] ...immature, self-centered, often vain, and usually dependent on others,ò (p. 43, brackets added). In Foucaultôs (1964) analysis of madness, there are four core aspects of madness: mania, melancholy, hysteria, and hypochondriasis. The transition of attributing madness from one of movement of animal spirits, to a movement of humors, to nerve fiber tensions and ultimately a disorder of the psyche dedicated long hours to creating rationality for its occurrence. In specific, hysteria (which translates to ñwandering uterusò) afflicted individuals (particularly women) with ñsoft bodiesò (Foucault, 1964, p. 121), a condition

associated with idle bodies which perspire less and therefore contain toxins (i.e., heat, animal spirits, and humors) which must be equilibrated or expelled. As a result of the soft bodyôs exposure to excitation or trauma, it has a seismic effect upon the body and thus more difficult to recover, if ever.

Attention should also be directed towards the transience of homosexuality as a mental disorder, which prior to the publication of the first DSM, was religiously condemned as a mortal evil (i.e., sodomy) worthy of an express ticket to hell. Moreover, homosexuality (and sexual deviancies in general) is previously classified by physicians as ñpsychopathic personality with pathologic sexuality,ò (DSM-I; APA, 1952, p. 39). By the time of the first publication of the DSM, homosexuality is classified as a priority sexual deviance under the category of sociopathic personality disturbances. In the second edition of the DSM, sexual deviation is separated from personality disorders and houses a set of diagnoses within its own identity. However, there is not a set of symptoms available to assist in diagnosing an individual with such a sexual deviation. Instead, the broader classification of sexual deviation implies that albeit the deviant behaviors are considered grossly bizarre by many, the individual is ñunable to substitute normal sexual behavior for them,ò (DSM-II; APA, 1968, p. 44). More specifically, by deviating from normal sexual behavior, one believably forfeits their gender and thus contesting culturally-based values. Considering the background of hysteria and homosexuality, the continued transience of the latter and the addition of hysterical personality disorder within the second edition of the DSM is thus an insult and a sexist method of preserving primitive gender scripts.

After reviewing contextual differences between DSM-I (APA, 1952) and DSM-II (APA, 1968), one thing becomes abundantly clear ï the word ñindividualò transitions to

ñpatientò within its diagnostic definitions. By placing the individual within a set of parenthesis, it becomes easier to depersonalize the human being and all of their qualities from the disorder, in order to further distance experience from neutrality. For example, the sophistication of context between DSM-I and DSM-II in their description of antisocial personality disorder paints an image of an individual with political undertones appropriate to their era ï dusking of WWII and McCarthyism (i.e., ñRed Scareò, and Cold War). The imagery and context associated with fascists, communists, and Nazis has somehow been boiled down into behaviors that encapsulate an entire civilization and work against American civilians: trouble-making, callous, pleasure-seeking, selfish, and an inability to learn from experience or punishment. Furthermore, the depth of specificity from one definition to its successor reveals a normative belief structure that condemns ñsignificantò deviations from standardized (or *normal*) behavior and its potential threat to the general population.

To briefly transition before discussing the third edition of the DSM, an important chain of political events, followed by an equally important document, deserves to be brought to attention. In June of 1968, the United States experienced an uproar from the lesbian, gay, bisexual, transgender, and queer community: Stonewall riots in the Greenwich Village (The Leadership Conference, 2009). As a result of police officers harassing a few patrons attending a popular gay bar, a riot broke out and continued for several days after. Following the anniversary of this event, a band of gay pride parades occurred in several major cities, including San Francisco, and the liberation ensued. The voice of an oppressed group began to gain amplification, which grabbed the attention of

the American Psychiatric Association. Between the second and third editions of the DSM, the American Psychiatric Association released a statement of revision:

Homosexuality and Sexual Orientation Disturbance:
Proposed Change in DSM-II, 6th Printing, page 44

302.0 Sexual orientation disturbance (Homosexuality)

This category is for individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder. Homosexuality per se is one form of sexual behavior and, like other forms of sexual behavior which are not by themselves psychiatric disorders, is not listed in this nomenclature of mental disorders.

Figure 3.2, Opening statement for the rationale regarding a proposed change of homosexuality and revision of APA nomenclature for the DSM-II (Document Reference No. 730008; Washington, D.C.: APA, 1973).

Dr. Robert Spitzer, a member of the APA Task Force on Nomenclature and Statistics, formulates the rationale in response to rising controversy regarding homosexuality as a ñpathological deviation of normal sexual development or as a normal variant of the human potential for sexual response,ò (p. 1). The argument for the inverse is that the classification of homosexuality under any regards as a psychiatric disorder is ñscientifically incorrectò and that it manipulates the relationship between the homosexual community and the discipline of psychiatry, as well as justifying non-professional denial of any and all civil rights. The counterarguments made by those who wish to maintain its discriminatory classification insist that by succumbing to the persuasion that homosexuals are not sick, it would discourage imperative treatment. What is critically paramount within this five-page document is that the American Psychiatric Associationôs members have finally agreed upon a solid definition of what is homosexuality:

> ñHomosexuality refers to an interest in sexual relations or contact with members of the same sex. Some experts in our field believe that predominant or exclusive homosexuality is pathological; other experts believe it a normal variant,ò (Spitzer, 1973, p. 2).

Furthermore, the following points of agreement made by the APA insist that while a significant proportion of homosexuals are content with their orientation and show no signs of psychopathology, a significant proportion of homosexuals are in conflict with their orientation and desire to change it (Spitzer, 1973). Prior to the above, neither editions of the DSM have a definition of what homosexuality is clinically symptomized to be. However, by creating this definition, it has likewise given life to an entity from which to express condemnation, judgment, and hate. Conversely, the APA describes that the hate towards homosexuality is internalized by the individual who is in conflict with their identity and feelings in lieu of its inverse. Yet the question remains ï how can an individual hate themselves without the cue and expectations of their cultural environment primarily leaning its preferences?

DSM-III (APA, 1980) Personality Disorders		
"It is only when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute Personality Disorders. The manifestations of Personality Disorders are generally recognizable by adolescence or earlier and continue throughout most of adult life, though they often become less obvious in middle or old age." (American Psychiatric Association, 1980, p. 305). ***"The diagnosis of a Personality Disorder should be made only when the characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness."* (American Psychiatric Association, 1980, p. 305)		
Cluster I	***Cluster II***	***Cluster III***
Paranoid	Histrionic	Avoidant
Schizoid	Narcissistic	Dependent
Schizotypal	Antisocial	Compulsive
	Borderline	Passive-aggressive
Atypical, Mixed, or Other Personality Disorder		
"If an individual qualifies for any of the specific Personality Disorders, that category should be noted even if some features from other categories are present," (DSM-III; APA, 1980, p. 329).		
Atypical	Mixed	
Other Personality Disorder		

Table 3.3a, Personality disorders listed in the DSM-III (APA, 1980).

The third edition of the DSM (1980), which coincides with the ICD-9-CM (WHO, 1979)[13], receives a makeover and augmentation; the third edition contains a staggering

[13] The ICD-9-CM (WHO, 1979) is specifically intended for classifications for hospital coding in the United States, which appears to be somewhat incongruent with classifications from the ICD-9 and further supplementing the argument of a possible American Exceptionalism (Scientific Data Documentation; International Classification of Diseases-9-CM, 1979).

494 pages, of which 25 pages discuss personality disorders[14]. Concurrently, personality disorders are coded as Axis II disorders[15] and schizotypal, narcissistic, borderline, and dependent personality disorders are formally introduced and replace disorders such as explosive and cyclothymic personality disorders. Upon further examination, there appears to be an interchangeable relationship between compulsive personality and obsessive-compulsive personality disorder among the first three editions. Likewise, there is a refinement within the description and classification of histrionic personality disorder (formerly known as hysterical personality disorder and must be distinguishably different from *hysterical neurosis*).

During the 1960s, an investigation of the primary facets of human personality is investigated with the hopes of confining the abyss of human behavior within a continuum and its findings lend great utility for personifying personality abnormalities by route of clustering and external perception. The clustering of personality disorders may appear trivial at first, but its justification positions that each cluster possesses a specific theme: ñóoddôor eccentric,ò (*Cluster I*), ñdramatic, emotional, or erratic,ò (*Cluster II*), and ñanxious or fearfulò (*Cluster III*) (DSM-III; APA, 1980, p. 307). Both personality disorders specifically discussed below, as well as those not mentioned but present in the DSM-III, are making a shift from a diagnosis to a perceivable illness; the nosology of personality disorders are in and of themselves *developing* a personality. By supplementing

[14] Table 4.1 (p. 88) in Chapter Four covers the total number of classifications, the total number of personality disorder classifications, and the total number of pages per version of the seven DSMs.

[15] In the first two editions of the DSM, the utilization of Axes did not exist.

symptoms with perceivable differences from normalcy (e.g., ñstiffò, stubborn, indecisive, ñprincessò, femininity), it justifies nonprofessional observation and ultimately, ostracism. The third edition of the DSM manages to take symptomology a step further; it is apparent that by elaborating on a personality disorder with more specificity, it parenthesizes the individual (whom literally transitions to a ñpatientò in the second edition) and engulfs their entire life within a derogatory diagnosis.

Dramatic, emotional, erratic personalities appear to make an abrasive impact on others due to the individualôs perceived inability to conform to rational thinking, with egocentricism demanding a large part of their identity. Narcissistic personality disorder makes its formal introduction within the third edition of the DSM (APA, 1980) and is characterized as a ñgrandiose sense of self-importance or uniqueness,ò (p. 315). Furthermore, narcissism is the only negative personality attribute featured in the catalogue of personality factors[16] and it becomes the easiest of the objective traits to impugn. Foucault (1964) explains that the understanding behind passions is that it drives men to madness, but passion also directs to mastering human expression through the arts. In assuming this relationship of passion and madness, an element of narcissism must be present as an intermediate towards the drive of continued success. However, in regards to 20th century perception of narcissism, it may appear quite irritating to others within the gambit of absolved social distinctions.

Histrionic personality disorder, formerly known as hysterical personality disorder, remains quite gender specific ï or more realistically, sexist ï in its symptomology. In the

[16] Narcissism is accompanied with openness to experience, agreeability, conscientiousness, and extraversion.

DSM-II, hysterical (*histrionic*) personality disorder characterizes individuals as emotionally instable, immature, perpetually attention-seeking and seductive, as well as prone to self-dramatization (APA, 1968, p. 43). By the publication of the third edition of the DSM, histrionic personality disorder is explained in more depth (or justified with more specificity), and describes patients as often assuming the role of the ñvictimò or ñprincessò (DSM-III; APA, 1980, p. 313). However, the most incriminating evidence relating to sexism lies within this sentence: ñFlights into romantic fantasy are common; in both sexes overt behavior often is a caricature of femininity,ò (DSM-III; APA, 1980, p. 314). As previously mentioned, there is a concrete persistence by the members of the association to solidify and maintain gender scripts, which likewise impugns the female sex and relates to the assumption of a higher prevalence for the affliction of ñsoft bodiesò (Foucault, 1964) as a scientific fact.

The interchangeable relationship between compulsive and obsessive compulsive personality disorder (and within the disorder, characterized with hyphenation not present until the fourth edition in 1994) appears to show a conflicting set of standards and therefore the identity of the disorder is more inconsistent than the affected individual. In the first edition of the DSM, compulsive personality disorder characterizes individuals as suffering from a ñchronic, excessive, or obsessive concern with adherence to standards of conscience or of conformity,ò (APA, 1952, p. 27). Albeit their behavior may be ñoverinhibited, overconscientious, and may have an inordinate capacity for work,ò (p. 27), their hyperanalytical behavior and its characterizations are not viewed as an ñinvariable consequenceò (p. 27) within a product-driven society. However, in the DSM-II (1968), the elimination of any benefit within hypervigilant behavior is compensated by augmenting its

deteriorative aspects: rigidity, hyper-inhibition, hyper-conscientiousness, hyper-dutiful, and an inability to relax (p. 43). In the third edition of the DSM (1980), a more in depth description of compulsive personality disorder provides specific characteristics of the disorder as well as how the general population may perceive such symptoms.

Disorders of Childhood or Adolescence →	**Personality Disorders**
Schizoid Disorder of Childhood or Adolescence	Schizoid Personality Disorder
Avoidant Disorder of Childhood or Adolescence	Avoidant Personality Disorder
Conduct Disorder	Antisocial Personality Disorder
Oppositional Disorder	Passive-Aggressive Personality Disorder
Identity Disorder	Borderline Personality Disorder

Table 3.3b, Disorders present in children and adolescents, and their manifestation in the form of a personality disorder upon maturation (DSM-III; APA, 1980, p. 305).

In the metaphorical black hole of categorization, it is apparent that once an individualôs behavior is viewed as maladaptive, it remains impossible to escape the parenthetical paradigm. To further justify the imperative nature of personality disorders, the DSM-III (1980) explains the discourse behind the manifestation of personality disorders, which may appear during childhood and adolescence. Above, Table 3.3b is a correspondence of what the DSM-III warrants as personality disorders being a lifelong deviation from normal behavior, by lending credibility to its predecessor during childhood and adolescence. More specifically, if certain features of deviance are present in children or adolescents, it will mature alongside the chronological maturation of the individual onward into adulthood. Conclusively and with all respect, the parentheses

which engulf the patient depersonalize their human qualities and the ellipses within said parentheses disorient an escape route.

DSM-III-R (APA, 1987) Personality Disorders		
"It is only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress that they constitute Personality Disorders. "The manifestations of Personality Disorders are often recognizable by adolescence or earlier and continue throughout most of adult life, though they often become less obvious in middle or old age. The diagnostic criteria for the Personality Disorders refer to behaviors or traits that are characteristic of the person's recent (past year) and long-term functioning since early adulthood. The constellation of behaviors or traits causes either significant impairment in social or occupational functioning or subjective distress," (American Psychiatric Association, 1987, p. 335).		
Cluster A	***Cluster B***	***Cluster C***
Paranoid	Antisocial	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive Compulsive
	Narcissistic	Passive aggressive
Personality Disorder, Not Otherwise Specified (NOS)		

Table 3.4a, Personality disorders listed in the DSM-III-TR (APA, 1987).

In 1983, the American Psychiatric Association arguably begins to revise the third edition of the DSM, upon the context of knowledge and understanding as a single still frame in time. The purposes for revision include inconsistent diagnostic in comparison to findings of new research, as well as unclear, inconsistent, and contradictory criteria between categories (APA, 1987). More importantly, the APA claims that the World Health Organization requests their expertise in contributing to the mental disorders chapter

of the ICD-10 ñwhich is expected to go into effect around 1992,ò[17] (DSM-III-R; APA, 1987, p. *xvii*). Therefore, in order to capture a ñcurrent still frameò (and avoid embarrassment via contradiction from archaic data) that will in turn reflect itself within the ICD-10, assemblies of ñexpertsò organize into committees with the mission to review and make suggestions for the revised edition of the third DSM.

The following question might be, ñWhy is there a revised edition of the third DSM instead of a fourth edition of the DSM?ò The DSM-III-R warrants the defense of coinciding with the future ICD-10; perhaps this is to strengthen its own credibility and practicality, while separating itself from other countries. This particular separation is essential to defining the competing expectations of Western science and research while pinpointing the derivations of American behavior. The United States, which is approaching the horizon of a spring equinox after a long Cold War, consequentially (or beneficially, depending on oneôs stance) does not make the DSM universal but it does develop an ideation of American supremacy based on knowledge. In this way, by continuously redefining itself and seeking confirmation via textual conformity, the DSM is always a present figure living in the future tense.

The introduction of the DSM-III-R states that the ñDSM-III was intended primarily for use in the United States, but it has had considerable influence internationally,ò (APA, 1987, p. *xviii*). However, personality disorders remain strictly applicable to American standards due to differences of definably normal based on social expectations, as well as conflictions with religious interpretation which may translate as

[17] The publication of the ICD-10 occurred in 1992 but the use of the ICD-10 by WHO Member States did not begin until 1994.

normal given the context. Moreover, to objectively observe and thus dictate the constituents of normal behavior among other sociocultural groups, given that the APA cannot harmoniously contend to what is normal behavior for Americans, makes the argument of universality invasive and moot.

In the revised edition of the third DSM, there are a few changes made to the Axis II personality disorders, most of which are philosophical in argument. The first, and most obvious, is the inclusion of personality disorders that are not otherwise specified. Prior to this diagnosis, or a lack of compliance to other diagnoses, the DSM-II (APA, 1968) is the last edition of the DSM to include a ñcatchallò section. Moreover, the DSM-III (APA, 1980) created three categories within its catchall: *atypical*, *mixed*, and *other personality disorders*. *Atypical personality disorder* is assigned to individuals when the clinician perceives a personality disorder to be present, yet cannot decipher which disorder it may be. *Mixed personality disorder* is used for individuals who have features from several designated personality disorders present, yet cannot meet the criteria for any single diagnosis. Lastly, the classification of *other personality disorder* is assigned to an individual at the disposal of the clinician when there is a perceivable personality disorder present but it does not fit within a specific classification, yet deemed as appropriately necessary (e.g., masochistic, or impulsive) (DSM-III; APA, 1980, p. 330).

Similar to the passage (p. 23) by Foucault (1964, p. 139) regarding hysteria, the diagnosis of ñnot otherwise specifiedò is a fantasy for the physician who pretends to hold expertise and knowledge, not for the individual whom believes themselves to be ill. Its conditional diagnosis indicates that an example of the given catchall is, ñfeatures of more than one specific Personality Disorder that do not meet the full criteria for any one, yet

cause significant impairment in social or occupational functioning, or subjective distress,ò (DSM-III-R; APA, 1987, p. 358). More or less, the three diagnoses present in the third edition of the DSM under atypical, mixed, and other personality disorders are combined into a single diagnosis in order to avoid repetition and the likelihood of differential diagnoses for trivial criteria requirements. After all, the DSM is only a tool to guide the clinician but it does not mean that there is consistency from one clinician to the next.

Humans are very social creatures and their identity and behavior is assumed and modified based on the feedback from others. Symbolic interactionism, as pioneered by George Herbert Mead (1934), dictates that reality is a social development provided through interaction with others. Moreover, individuals do not react to objects or one another based on their literal position but rather through their understanding of it. Society and the individual cannot be separated because of its consistent interaction and adjustment to one another, but intermediate variables may act as deciding factors. The social understanding of the dichotomy of ñhealthy/not healthyò or ñnormal/not normalò is the underpinning of ostracism and the DSM is its intermediary. In specific, personality disorders act as the deciding factor between the relationship of symbolic interactionism and ostracism based on the social understanding of what that diagnosis represents.

The opening section of the Axis II personality disorders for both the DSM-III (APA, 1980) and DSM-III-R (APA, 1987) provide three subsections within its introduction that push the envelope a bit further and chirp credence to the concept of objectivity with a vengeance: *associated features*, *age at onset and course*, and *impairment*. *Associated features* of personality disorders positions that individuals with a

personality disorder are frequently ñdissatisfied with the impact his or her behavior is having on others or with his or her inability to function effectively,ò (DSM-III-R; APA, 1987, p. 336). In lay terms, others are dissatisfied with the behavior and their feedback is what creates dissonance within the individual, whom may not regard their behavior as undesirable or is unable to ñmodify them despite great effort,ò (p. 336). *Age at onset and course* relates to the age of recognition of said disorders; ñé Personality Disorders by definition generally are recognizable by adolescence or early adult life and are characteristic of most of adult life,ò (p. 336). *Impairment*, which relates to the severity of infliction upon oneôs ability, positions that ñé impairment in social and occupational functioningò (p. 336) may be markedly present.

In the DSM-III (1980) and DSM-III-R (1987), *associated features* and *impairments* accompany each disorder alongside variables such as *complications*, *predisposing factors*, *prevalence*, *sex ratio*, *familial pattern*, and *differential diagnosis*. Furthermore, based on knowledge of background and research, some disorders may contain more information than others. The irony becomes jam-locked within the repetition or ambiguity of each disorder as the whole is deconstructed into parts; a gestalten conundrum in which the DSM reveals its shortcomings by attempting to provide a strengthening argument of truth. The product of deconstructing a larger entity reveals less value and validity to the overall purpose of predictability, to which truths must be repositioned and accredited to expertise. Below, Table 3.4*b* exemplifies the consequences of accentuating the parts in lieu of the whole; the disorders present in children and adolescents and their manifestation into a personality disorder in adulthood is significantly reduced as a result of inconsistencies and contradictions:

Disorders of Childhood or Adolescence →	Personality Disorders
Avoidant Disorder of Childhood or Adolescence	Avoidant Personality Disorder
Conduct Disorder	Antisocial Personality Disorder
Identity Disorder	Borderline Personality Disorder

Table 3.4b, Disorders present in children and adolescents, and their manifestation in the form of a personality disorder upon maturation (DSM-III-R; APA, 1987, p. 335).

Lastly, Cluster C personality disorders, which encompasses personalities marked by anxious or fearful behavior, appears to undergo yet another cosmetic transition in regards to obsessive compulsive and passive aggressive personality disorder. The former is accompanied and slowly adjoining with an obsessive component and the latter is absent of an essential conjoining. Obsessive compulsive personality disorder remains essentially the same in some regards, but is explained in more depth when accompanied by obsession; the individual feels incompetent despite perfectionism and accomplishments, pervasively inflexible, stubborn, ñstiffò, and poorly manages time given constraints. Concurrently, the concept of conformity is still ever present in the diagnosis yet textually eliminated from the primary criteria and a preoccupation towards rules and trivial details while detaining pleasure distracts the individual from thinking practically. Likewise, the symptomology is explained in regards to actions performed and thought processes in order to lean credibility to the diagnosis and to justify the dichotomy of ñnormal/not normalò by professionals and nonprofessionals alike.

Passive aggressive personality disorder, on the other hand, is slowly disintegrating

by the adjoining seams as research on adolescent behavior demonstrates a diminuendo of the marked characteristics of passive aggressive disorder as an individual matures in age and experience. Furthermore, the knowledge or understanding of the disorder as a whole contains minimal data to support its assumptions. For example, the characteristics of passive aggressive disorder feature ña pervasive pattern of passive resistance to demands for adequate social and occupational performanceé expressed indirectly rather than directly,ò (DSM-III-R; APA, 1987, p. 356). Individuals labeled as passive aggressive are often defiant, critical, irritable, ñargumentative when asked to do something they do not want to do,ò (p. 357), and resentful towards facilitative information regarding productivity. Thus, its diagnosis assumes ñsuch people are passively expressing covert aggression,ò (p. 356), which is quite common among adolescents and their attitudes towards individuals assuming an authoritative role.

DSM-IV (APA, 1994) Personality Disorders		
"A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders," (American Psychiatric Association, 1994, p. 629). ñA Personality Disorder should be diagnosed only when the defining characteristics appeared before early adulthood, are typical of the individual's long-term functioning, and do not occur exclusively during an episode of an Axis I disorder,ò (American Psychiatric Association, 1994, p. 632).		
Cluster A	***Cluster B***	***Cluster C***
Paranoid	Antisocial	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive-Compulsive
	Narcissistic	
Personality Disorder, Not Otherwise Specified (NOS)		

Table 3.5, Personality disorders listed in the DSM-IV (APA, 1994).

The publication of the fourth DSM in 1994 coincides with the release of the ICD-10 (WHO, 1994), as projected within the introduction of the revised edition of the DSM-III (APA, 1987). The DSM-IV aims to be facilitative across many different settings ï ñé inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations,ò (p. *xv*). In the hopes of ñstriving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria,ò (DSM-IV; APA, 1994, p. *xv*) it implicitly made digestibility of otherwise intricate concepts easier to comprehend among the general population. It is questionable, however, to rely so heavily on the congregational brainstorming of thirteen work groups each comprised of approximately five experts whose reports were ñcritiqued by between 50 and 100 advisers, who were also chosen to

represent diverse clinical and research expertise, disciplines, backgrounds, and settings,ò (p. *xv*). Despite the critique by many advisers, it is still perfunctory as the limits of the critique are associated with the breadth and detail given within the reviews.

Once again, personality disorders are characterized as an enduring pattern of maladaptive behavior which definitively deviates from the norms of their culture and social expectations. Moreover, personality disorders are to be diagnosed by an ñobjectiveò outsider, which can be anyone with a basic knowledge of the DSM and a certification degree. According to the preemptive considerations, a diagnosis is sometimes sufficed through a single interview[18], yet more are encouraged in order to decipher what is ego-syntonic[19], age appropriate (e.g., young adulthood), attributable to sudden loss, or not associated with complications as the result assimilation given that the ñindividualôs ethnic, cultural, and social backgroundò (DSM-IV; APA, 1994, p. 631) is one of immigrant status. Considering the supposed neutrality of the expert, the wisdom inscribed within the DSM-IV (APA, 1994) also supplements that personality disorders are often gender-specific in prevalence; antisocial personality disorder being more often diagnosed in men while borderline, histrionic, and dependent personality disorder are diagnosed more often in women (DSM-IV; APA, 1994, p. 631-632). Given that the designation of personality disorder prevalence is related to oneôs gender (i.e., men or women) in lieu of sex (i.e., male, female), it is possible to assume that said maladaptive behaviors are attributed to

[18] The DSM-IV also suggests that several interviews should be conducted and spaced out over time (APA, 1994, p. 630).

[19] Ego-syntonic refers to the individual perceiving their personality or its characteristics as unproblematic (DSM-IV; APA, 1994, p. 631).

social stereotypes related to scripts and roles of both genders and are not in fact biological[20].

It is during this time that interviews become imperative to assessment more so to acquire solid data for future editions of the DSM than to accurately diagnose current afflictions. A pivotal change in the DSM-IV (APA, 1994) is the absence of passive aggressive personality disorder, which, as mentioned above, began to cleave away from its identity and the social understanding of its role or credible existence during the revised edition of the third DSM (APA, 1987). The cross-sectional, mimetic effect of passive aggressive personality with affective and anxiety disorders (while holding the variables of age, gender, and cultural assimilation constant) often results in more uncertainties and contradictions rather than solutions. Additionally, passive aggressive personality disorder potentially may not be distinguishable due to an inability to ñreach the thresholdò (p. 633) for qualification as a personality disorder and inconsistency of appearance throughout oneôs life.

[20] Contrary to the DSM-IV (APA, 1994) advisory against over-diagnosing or underdiagnosing certain disorders for males or females due to ñsocial stereotypes about typical gender roles and behaviorsò (p. 632), the preconceived notion already exists through the use of inflammatory criteria.

DSM-IV-TR (APA, 2000) Personality Disorders		
"A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment," (American Psychiatric Association, 2000, p. 685).		
Cluster A	***Cluster B***	***Cluster C***
Paranoid	Antisocial	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive-Compulsive
	Narcissistic	
Personality Disorder, Not Otherwise Specified (NOS)		

Table 3.6, Personality disorders listed in the DSM-IV-TR (APA, 2000).

While reviewing and examining the differences as it relates to Axis II personality disorders between DSM-IV (1994) and its successor, the DSM-IV-TR (2000), the differences are quite minimal and philosophical at best. Taking into consideration that the temporal distance between the fourth edition and its textual revision (DSM-IV and DSM-IV-TR, respectively) is a mere six years, the elimination or addition of a new classification of personality disorders may appear quite absurd. That is not to say during the revision/critique stages that suggestions were not given by proponents who contend that ñthe new diagnoses were necessary to improve the coverage of the system by including a group of individuals that were undiagnosable in DSM-IV or diagnosable only under the

Not Otherwise Specified rubric,ò (DSM-IV-TR; APA, 2000, p. *xxviii*)[21]. Adding further insult to injury, diagnoses included in the ICD-10 ñwere given somewhat more consideration than those that were being proposed fresh for DSM-IV,ò (p. *xxviii*). That is to say, the diagnostic materials from which the United States desired to separate in decades past now lend more priority than suggestions by proponents critiquing a potential revision, which may create an air of dissonance between work groups and the review boards.

The clustered groups appear to be quite arbitrary and trivial, especially given that the creators of the DSM also question is validity and contend that the system has ñserious limitations,ò (DSM-IV-TR; APA, 2000, p. 686). It is possible then to further assume that the deletion of passive aggressive personality disorder from Cluster C is in part attributable to severe limitations regarding research, and a lack of cohesion with the other disorders within that specific cluster. Despite the elimination of passive aggressive personality disorder, which occurs in the DSM-IV (APA, 1994), it is still ever present under the classification of personality disorders not otherwise specified: ñé the individual's personality pattern meets the general criteria for a Personality Disorder, but the individual is considered to have a Personality Disorder that is not included in the Classification (e.g., passive-aggressive personality disorder),ò (DSM-IV-TR; APA, 2000, p. 685; DSM-IV; APA, 1994, p. 629).

[21] The DSM-IV-TR warrants that, ñWe decided that, in general, new diagnoses should be included in the system only after research has established that they should be included rather than being included to stimulate that research,ò (APA, 2000, p. *xxviii*).

Tables 3.3*b* and 3.4*b* demonstrate the relationship between behavioral disorder diagnoses relating to children and adolescents and their maturation into an inherent and maladaptive set of personality characteristics. However, this relationship is not textually present in the DSM-IV (APA, 1994) or its revised edition, but it is still *contextually understood* by most that adhere to the assumption regarding a relationship trap of parenthetical ellipses. The relationships that are present and documented in the DSM-III (APA, 1980) and the DSM-III-R (APA, 1987), albeit deteriorated due to questionable validity and severe limitations, demonstrate that the damage and preconceptions of social understanding are already set in motion. Ergo, once a concept is embraced as rational, there is little need to alter its social utility until the contingencies of such demand adjustment.

DSM-V (APA, 2013) Personality Disorders		
"A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment," (American Psychiatric Association, 2013, p. 645).		
General Personality Disorder		
Theme Trait Personality Disorders:		
Cluster A	***Cluster B***	***Cluster C***
Paranoid	Antisocial	Avoidant
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Obsessive Compulsive
	Narcissistic	

Other Personality Disorders	
Personality Change Due to Another Medical Condition	
I. Labile type	*II. Paranoid type*
III. Disinhibited type	*IV. Other type*
V. Aggressive type	*VI. Combined type*
VII. Apathetic type	*VIII. Unspecified type*
Other Specified Personality Disorders	
Unspecified Personality Disorder	

Table 3.7, Personality disorders listed in the DSM-V (APA, 2013).

After much anticipation over the span of nearly 20 years, the most recent edition, DSM-V (APA, 2013), appears to take a step back into nostalgia as it resembles classifications of earlier editions of the DSM (particularly the first edition from 1952). One major justification for the long delay of its presentation argues for the goal of

ñharmonizingò the DSM-V (APA, 2013) with the upcoming publication of the ICD[22] produced by the World Health Organization. The reasons for the scientific harmonizing are as follows: 1) ñThe existence of two major classifications of mental disorders hinders the collection and use of national health statistics, the design of clinical trials aimed at developing new treatments, and the consideration of global applicability of the results by international regulatory agencies,ò (DSM-V; APA, 2013, p. 11); 2) Competition creates complications in regards to replication ñacross national boundaries,ò (p. 11); and 3) The DSM-IV and ICD-10 did not always agree in regards to ñidentical patient populations,ò (p. 11). For this reason and others, it is interesting that the creators of the DSM would choose the concept of harmonization in lieu of synchronicity.

Synchronicity would specifically indicate that there is a sound uniformity within and between groups, as well as within and between the context of the DSM and ICD. The entire reason behind developing the DSM and the clinical modifications of the ICD is to *modify* classifications based on American standards of behavioral truths. Obviously, it is difficult to identify a uniform sample of individuals under the assumption of wholly identical features in one location; it is virtually impossible to identify two identical groups across national boundaries. For example, life experiences, gender stereotypes, community and familial structures, belief systems, and the regard held for physicians differ significantly from the United States and abroad. Likewise, the competition between the two major classification systems runs the gambit of ethical concerns, applicability and generalization of research findings and differing cultural interpretations of what is understood as normal and abnormal stimulates more contradiction than consensus. Thus,

[22] Currently, the ICD-11 (WHO, 2017) will not be published for another three years.

instead of collaborating on the issues of current observation, both major classification systems compete in the present in order to continue a function of a future agenda. For this reason and others, it is likewise interesting that the creators of the DSM would choose the concept of harmonization in lieu of dissonance.

Theme trait personality disorders encompass Clusters A, B, and C which are essentially the same as those classified in the DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000), yet the umbrella terminology which encompasses them is unique to the current edition. Each theme is related to a specific cluster, and each cluster has a set of traits which differ from other traits; however, the entire umbrella represents an essential difference of identity from personality changes due to another medical condition and those that do not fit within the criteria of documented personality disorders. Furthermore, the possibility of the co-occurring diagnoses (5.7% for Cluster A, 1.5% for Cluster B, 6.0% for Cluster C, and 9.1% for any of the listed personality disorders; DSM-V; APA, 2013, p. 646) is contradictory given the assumption that each cluster exists in order to differentiate itself from the others. Given the statistics of co-occurrence and the confounding information of differential, clustered traits, it should be understood that deviation lies within the eye of the beholder.

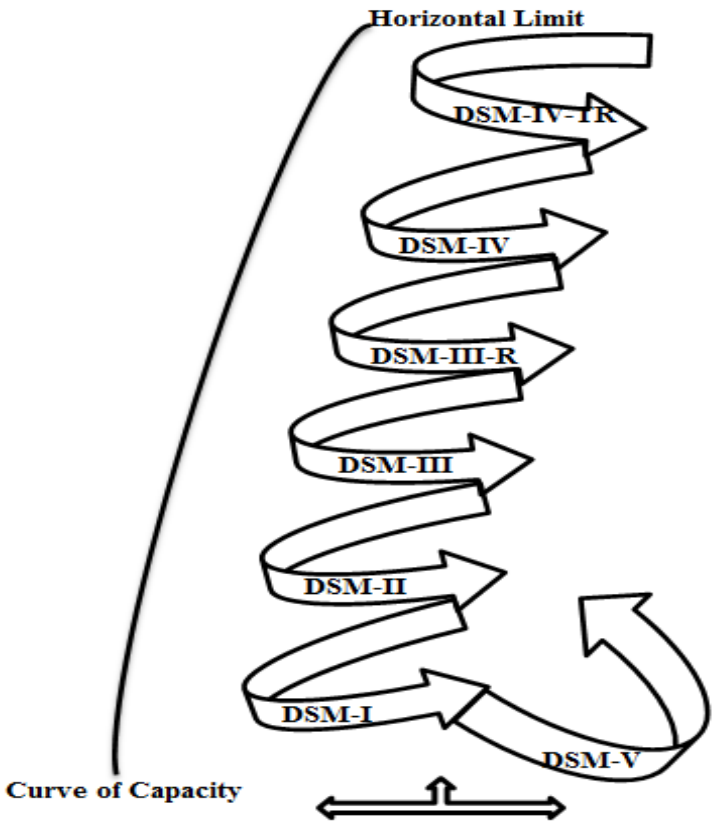

Figure 3.3, Illustrated depiction of cyclical retrograde (Hunter, 2014).

Cyclical Retrograde. The anecdotal phrase ñhistory repeats itselfò may hold an ominous prophecy regarding the relationship between human behavior and society. A significant difference within the Axis II personality disorders listed in the DSM-V (APA, 2013) focuses on the expansion of the lower portion of Table 3.7 ï *personality changes due to another medical condition*, *other personality disorders*, and *unspecified personality disorders*. An expansion of this magnitude is reminiscent of the first edition of the DSM published over sixty years ago, which bears the question of *cyclical retrograde.* As depicted above in Figure 3.2, the concept of cyclical retrograde represents a recycling process of resources, starting from archaic dichotomies, and adjusting their concepts to current context in order to fabricate current growth of understanding towards future

endeavors. The *horizontal limit* represents the ultimate curve capacity of inertia upon reaching a straight line, and the point of which stabilization must compensate from the bottom to support the infrastructure. From this point, the cyclical process will continue upwards until it reaches yet another horizontal limit, and thus expand horizontally from the base once again. Are we as a society approaching the horizontal limit of knowledge in respect to human behavior? At this point in time, has an assumption of normalcy through defining its opponent reached its maximum? What are the future implications of recycling the past?

The addition of personality change due to a medical condition does not follow the usual trend of diagnosing personality disorders; the change must be present for at least one year, it is diagnosable in children, it is not a true disorder, and it is not organic. This grouping of personality changes represents a shift in personality in lieu of a maladaptive trait or set of traits, where assessments conclude that the change is a ñdirect pathophysiological consequence of another medical condition,ò (DSM-V; APA, 2013, p. 682). Moreover, the individual may even recognize the ñdistress or impairmentò which accompanies their change in personality as a result of the medical condition. The description of each subtype is based on observation, which appears quite redundant but is described as such: 1) Labile type represents a predominant feature of affective breakdown or change; 2) Disinhibited type represents a predominant feature of poor or absent impulse control; 3) Aggressive type represents a predominant feature of aggressive behavior; 4) Apathetic type represents a predominant feature of ñmarked apathy and indifferenceò (p. 682); 5) Paranoid type represents a predominant feature of ñsuspiciousness or paranoid ideationò (p. 682); 6) Other type represents a feature which is ñnot characterized by any of

the above subtypes,ò (p. 682); 7) Combined type represents the predominance of more than one feature; and 8) Unspecified type. In reflection, this category of personality changes should be regrouped with affective disorders given the criteria from which it is acquired.

General diagnostic criteria for a Personality Disorder
A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas: (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events. (2) affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response). (3) interpersonal functioning (4) impulse control
B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Table 3.8, General diagnostic criteria for a personality disorder (DSM-V; APA, 2013, p. 646-647).

In Table 3.8, the general diagnostic criteria for a personality disorder is provided in order for the reader to collect their own opinions regarding the description of a new subsection of personality disorders presented in the DSM-V (APA, 2014) and its dissonance in comparison to the above criteria. Even more damaging, and present throughout the entire span of the seven still-frames, is the absence of success rates for

coexistence with or potential cures for personality disorder. Personality disorders are such because they are perceived by others as abnormal and thus brought to the individualôs attention that may remain otherwise unaware. *Post hoc ergo propter hoc*[23] provides justification to the general public and the physician alike, where the consequences of affected individualôs behavior is due to their inability to conform to a prototypical set of standards (as it relates to normal behavior). After the maladaptive trait is located, it is because of this deviation that the individual is abnormal and will remain semi-transparent and therefore ostracized. Moreover, the interaction between the individual, the physician, and society as a whole will adhere to observing and enacting this set of stereotypical behaviors because it is understood as reality. In this respect, the physician has created an infinite liarôs paradox in which a disorder is able to be discovered and understood yet cannot be reversed or minimized.

Michel Foucault dedicated his academic career to examining the historical derivation of social abnormalities, their current function, and possible future implications. By utilizing Michel Foucault (1963, 1964) and borrowing concepts from George Herbert Mead (1934), new critical positions were formulated in order to explain the current argument of contextual madness and potentially open windows to release stale catchalls. In closing this chapter, one may feel a dizzying sensation concerning the questionable reality and the social position of insanity. In the following chapter, the peak of Hunterôs (2014) hierarchy of social adhesion, themed *medicalization and punishment*, will be discussed. Moreover, Peter Conradôs (2007) *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* will lend great utility in

[23] Latin, which translates to ñafter this, therefore because of thisò.

transitioning the focus to medicalizing a nation and its impact on the current social relationship between the population and the medical and pharmaceutical industry. So, just as the chapter began, it will end with this caption:

> ñMadness deals not so much with truth and the world, as with man and whatever truth about himself he is able to perceive,ò (Foucault, 1964, p. 27).

Chapter Four

ñNo man chooses evil because it is evil; he only mistakes it for happiness, the good he seeks,ò (Mary Wollstonecraft, 1790, p. 39).

It appears that the unreason within the madman is steadily consistent while their position within society steadily shifts and the context of abnormality is adaptive. The arrangement of the previous chapter provides a philosophical ensemble of the archaeological layers of madness, a concept which at its core still represents a state of non-being. The madman, or the *insane*, appears to never be aware of their state or civil law ï both of which are used against them in their alienation and ostracism. Furthermore, the approach to the organization and management of the insane adapts at face value, but the ultimate goal of control survives throughout the centuries. Psychoanalysis, and psychology overall, expands its sovereign gaze through and over a larger population; the political and economic spheres of technologically-advanced and advancing Western cultures, specifically American culture, capitalizes on the management of behavior.

In Chapter Three, the introduction of a new heuristic device, Hunterôs hierarchy of social adhesion (2014, p. 34), is an analytical tool that demonstrates lower-level *social adhesion*, which systematically conforms to maintain seamless contextual synchronicity, to portray current concreteness and rationality with a futuristic trajectory. Given that the

device is utilized to critically analyze a possible conception of uniform behaviors and its functional outliers, there must be a succession of levels, or ñrungsò, from the ground-up that are solidified as social truths and rationality. In order to embrace said truths and rationale, they must first be internalized; Chapter Two discusses the first three rungs of the pyramidal device in detail (and revisited in the third chapter) as means to a conformist end. Moreover, those individuals who apparently cannot internalize civil law are ostracized and alienated; every quality that is human-like is parenthesized, ergo their identity and disease is one in the same. Chapter Three utilizes the adjustment of disordered behaviors listed in the seven editions of the DSM (APA) to exemplify the transitive placement of the madman from one of spiritual and religious evils to a diseased mind.

Power is given to those who can define and inhibit the possibility of opposition via monopolization of thought. In this case, power is a very potent form of inhibition because it is based on suppressing the other from being able to create an alternative. More specifically, power is sustained by the ability to repackage the perimeters of old definitions and present them as new by defending that cutting edge research is applied to a moving target. The United States is a grandiose nation of medical enterprise, or more specifically, an example of medical jurisdiction elitism. In turn, the DSM is a moving target within the medical enterprise; it is apparently stable but changes over the course of time to reflect the vulnerability of the American population. The implications of an ever-expanding medical jurisdiction is that it has snowballed into an overarching component of social control, with implications on both the macro (e.g., economics, hospitalization) and micro (i.e., shaping self-definitions) scale of social realities. It is imperative for sociologists to research this growing social concern because the political nature of

diagnostic criteria is the new American ego, where citizens believe that they are both vulnerable and dependent upon medicalization, which in turn serves to reaffirm the position of current composites of knowledge.

In the current chapter, the top of the pyramid ï Medicalization and Punishment ï will first be discussed with the assistance of Peter Conradôs (2007) *The Medicalization of Society* to highlight the interwoven relationship between the physician and the patient. Moreover, a Foucauldian approach will supplement the current argument of politicizing health via discourse provided by a gaze that is both above and throughout society. Upon the brief completion of this multifaceted dependence, the rest of the chapter will highlight the political consciousness of dueling archaic dichotomies and the illusion behind American Exceptionalism. As a note for the reader, you may ask yourself throughout the current chapter, ñHow did we not open our eyes sooner?ò

> ñMedicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of the *healthy man*, that is, a study of the *non-sick man* and a definition of the *model man*,ò (Foucault, 1963, p. 34).

Medicalization and Punishment. The top of the pyramid in Hunterôs (2014) hierarchy of social adhesion describes the final rung of social order and conformity. Medicalization and punishment describes both the social and individual dependence of pharmaceuticals and the control of individuals who cannot internalize the code of self-preservation as it is socially accepted. Foucault (1963) explains that prior to the end of the eighteenth century,

the orientation of medicine ñrelated much more to health than to normality,ò (p. 35); more specifically, a prototype representing normality did not yield the same value in comparison to the restoration from illness. However, by the nineteenth century, the ñprestige of the sciencesò (Foucault, 1963, p. 35) creates a priority for normalcy in those concepts and interventions which function within a standard dichotomy of healthy/not healthy (or normal/not normal). The rationality for this transition lies within the belief of society, not the individual, as one that can excel or decline; succeed or degenerate; a civilization that can make the example or be the example. Indeed, this myopic view is quite cynical but it is what separates ñusò from ñthemò.

The medical gaze is sovereign; it reigns through society as well as above it, and within it contains the knowledge of diseases and their maladies. Moreover, the containment of disease and methods of intervention has become politicized through specialized government departments, pamphlets, inspectors, and statistics. The doctor is a means to an end, an instrument, and the ñpriests of the bodyò (p. 32); the responsibility of the church to the ill has now been replaced by the doctor, whose obligation to treating the sick is a ñsacred taskò (Foucault, 1963, p. 32) to provide to the nation. The doctor merely eliminates the individual in order to inspect the disease and its maladies, from which knowledge will restore the individual back to a state of relative normalcy. It is likewise from this relationship that the doctor and the patient are dependent in both survival and legitimacy; they are the spectacle and the scaffold, from which the particular knowledge of the doctor parallels that of the skilled executioner.

Health and normalcy can only be sustained if managed through control on various scales; regulations for illness prevention are piously implemented and health inspections

function at the local level of supervision. Institutions house the insane (i.e., the mentally ill) while physical illnesses remain domestic, yet the goal is not to indefinitely cure the individual against the threat of freedom and the exposure of a flawed government. Moreover, through monitoring the ill and the insane, it is possible for the government to acquire their information and to maintain their autonomous power as well as the permanent position of the sacred physician. In summation, the individualôs body is a prison susceptible to punishment and through its function of maintaining a submissive role far distanced from liberation.

As society strengthens (and depends upon) its relationship with medicine, sociology likewise expands to investigate the implications of this relationship. As it relates to the medical jurisdiction of the twentieth century, Conrad (2007) defines medicalization as ña process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders,ò (p. 4); the growth of which demonstrates a powerful transformation in Western medicine. Conrad (2007) alludes to a set of questions which are paramount in the investigation of the impact of expansion of medical problems, which will be reiterated here: given that the amount of life problems categorized as a medical concern has skyrocketed in the past fifty years, could this be interpreted as ña new epidemic of medical problemsò (p. 3) or an advancement in the identification and intervention of existing issues? Or is it possible that a wider range of life problems have snowballed into diagnosable medical problems despite questionable legitimacy?

Conrad (2007) explains that ñit is important to remember that medicalization describes a process,ò (p. 5); medicalization lies within its conceptualization in regards to

medical terminology and language, as well as its adoption, application, and treatment (Conrad, 2007). The growing concern of medicalization in the discipline of sociology relates to the dozens of arising examples according to gender, personal experiences, behavior, and age; as such, a ñcorresponding body of literature has loosely been called [é the] ómedicalization theoryô (Williams & Calnan, 1996),ò (Conrad, 2007, p. 5). Problematic concerns that arise throughout oneôs life are not illnesses or disorders without being accepted as such, and while medical professionals may hold a large percentage of influence, ñsome active agents are necessary for most problems to become medicalized,ò (Conrad, 2007, p. 6). Legitimacy may be quite biased, depending on its substantiality; the premises of problematic concerns may be objective to the individual (the patient or physician) or a group and it is often the education provided by the media where the presence of a perceived medical problem is dispersed.

Medicalization is bidirectional, which means that there exists both an ñexpansion of medical jurisdictionò (p. 7) and demedicalization, which occurs as the result of a problem no longer appearing appropriate to receive medical treatment[24] (Conrad, 2007). The perception of symptoms within a heavily medicalized Western society are distorted to a point of lower thresholds and less tolerance for the most mild of symptoms, and bodily distress or discomfort are magnified and reformulated as a legitimate disease (Conrad, 2007). In regards to active agents, cases which arise for medicalization (or demedicalization) may be accomplished by a social movement, patient organizations, or

[24] In regards to demedicalization, there are two cases to arise during the twentieth century ï homosexuality and masturbation, with the former as the result of advocacy and a social movement (Conrad, 2007).

even individuals and later adopted by physicians as a disease or illness (Conrad, 2007). ñIn recent years,ò Conrad (2007) argues, ñcorporate entities like the pharmaceutical industry and potential patients as consumers have begun to play more significant roles in medicalization,ò (p. 6). Moreover, it appears to be that medicalization legitimizes life experiences as being pathological by expanding condition classifications and the narrowing particularity of what is socially acceptable and normal.

As contended by Conrad (2007) ñthe greatest social control power comes from having the authority to define certain behaviors, persons and things,ò (Conrad & Schneider, 1992, p. 8; *see* Conrad, 2007, p. 8). Medicalization points the focus of the problem originating from the individual rather than the environment which encompasses them. It is undeniably easier to diagnose, treat, and rehabilitate the individual than to appropriate a collective blame and address possible solutions for society as a whole. With an expanding medical jurisdiction, ñmedicalization increases the amount of medical social control over human behavior,ò (Conrad, 2007, p. 8) and will ultimately replace all other forms of social control ï ergo, mass sedation. However, the grassroots of medicalization as it relates to mental health began during the latter half of the nineteenth century, where accessibility to therapy (disciplined in psychoanalysis) was exclusively for individuals with a disposable income.

Psychoanalysis and a Political Consciousness

Psychoanalytic therapy, in retrospect, is quite time-consuming and expensive; typically, therapy includes an intimate, one-on-one appointment with the therapist and client for approximately one hour, several times per week, over the course of several months (or more commonly, years). During therapy, the client is encouraged to freely

associate in order to understand their behavior or motives, which may remain unconscious, and how it affects their relationships with others and their pattern of consciousness (American Psychoanalytic Association, 2014). Over the course of these appointments, the goal of therapy is to establish a safe relationship with the therapist in order to unearth repressed experiences and analyze how it affects current aspects of the clientôs life. The therapist engages in providing ñenlightenmentò to the client by providing insight to their limitations in order to remove said barriers and alter their perception of the world and themselves. With that in mind, it is undoubtedly exhausting to provide therapy to several clients over the span of many years and impossible to provide such attention to a majority of the population. Moreover, psychoanalysis is manipulative as it relates to the therapist altering the behavior of the client; given that its practice is discriminatively exclusive in preference for the powerful, the behavior of the elite is structured to be exemplary.

The dominant class remains relatively exclusive in order to reflect the status quo, and the transition of the dominant practice from psychoanalysis to psychiatry reflects an expansion of the sovereign gaze. Psychoanalytical therapy is to the elite as institutionalization is to the subservient class; accessibility accentuates privilege and the dueling classes shape the role and function of its counterpart. The first two editions of the DSM reflect the dominant discipline of psychology at the time of their publications ï psychoanalysis, which contends that personality disorders are the manifestation of unconscious factors that affect behavior. More specifically, personality disorders distort the balance of power between the *id* and *superego*, so it is the position of the therapist to take upon the role as the clientôs *ego*. By imposing the identification of what it means to

be normal, the elite can project an image of superiority and thusly externalize the ego to the majority in exchange for their internalization of a generic identity. However, it is the imposition of an American document (i.e., the DSM), formulated by an authority of an exempt select few, who assemble an extreme form of American Exceptionalism via unconscious observation.

American Exceptionalism is a sociological theory which warrants that the United States is a capitalist, democratic country that is qualitatively different from other nations (Lipset, 1996). Lipset (1996) explains that the United States is the product of revolution and surrounds itself in ña set of dogmas about the nature of a good society,ò (p. 31). More specifically, the notion of American Exceptionalism entails that the United States and its people differ from other countries in regards to economic superiority and political strength, which entitles the United States to be representative of the ñcorrect modelò of aspiration for other countries. As a self-sufficient, autonomous, democratic economy, the U.S. government gets to define how other countriesô governments are inadequate through a typology of flaws (e.g., authoritarian, totalitarian) which ultimately extends to their citizens as well. ñAmericanism,ò Lipset (1996) contends, ñas different people have pointed out, is an ôismô or ideology in the same way that communism or fascism or liberalism are isms,ò (p. 31).

The core of American Exceptionalism is to separate what is good from bad and to associate this dichotomy with separatism ï ñusò or ñnot usò. Americanism is perceivably quite myopic and vastly different from other nationalists; in specific, it is a country that does not share an identity based solely on history. To be an American is to accept its values, nee birthright. Furthermore, Americanism and being an American is an

ñideological commitment,ò (Lipset, 1996, p. 31) in lieu of a sense of community, despite other political agendas (e.g., communist Englishmen; Lipset, 1996). Moreover, American conservatism is weak in comparison to European and Canadian polities; in America, an ñobligation of the leaders of society and the economy to protect the less fortunate,ò (Lipset, 1996, p. 35) is a mirage. The allure of Americanism, success, and potential citizenry is quite appealing to immigrants because they are unconsciously observing from the valley the function of a nation set on top of a hill. In this regard, those individuals who are looking from afar in adoration have accepted American values wholeheartedly without reading the fine print.

Given that the DSM is the product of militarization, it may also be understood that the military is an extension of politics, and thus, the dichotomy of DSM diagnoses parallel with dichotomies of political typology. In regards to psychoanalysis, the extent to which the DSM utilizes such a discipline to develop a model of contextual normality is relatively weakened by an inability to supplement classifications with scientific research. Psychoanalysis in the DSM, in turn, is the final ñhoorahò of the pre-electronic age and the transition to psychiatry by the third edition of the DSM (APA, 1980) has political ties relating to the Cold War, advancing technology, ideologies, and the preservation of duality. Psychiatry allows for scientific research to expand classifications and the elaboration of abnormal human behavior; more broadly, to reform typology to something that is new and fresh yet biologically confirming of past biases and status quo. Moreover, the DSM and its current discipline of psychiatry maintains the status quo because it is etiologically the same, yet garbed in unchallenging scientific research that is confirmed as legitimate because it is functional to the existence of American Exceptionalism.

Number of Diagnoses, Number of Personality Disorders Diagnoses, and Total Number of Pages in the DSM Versions I-V (American Psychiatric Association, 1952-2013)				
Version	Year	Total Number of Diagnoses	Total Number of Personality Disorders	Total Number of Pages (Total Number of Pages for Personality Disorder Diagnoses)
I	1952	106	24	130(8)
II	1968	182	12	134(3)
III	1980	265	14	494(25)
III-R	1987	292	12	567(23)
IV	1994	297	11	886(44)
IV-TR	2000	365	11	915(44)
V	2013	380	13	947(39)

Table 4.1, Number of diagnoses, number of personality disorder diagnoses, and total number of pages in the DSM versions I-V (APA, 1952-2013), adapted from Mayes & Horwitz (2005; *see* Conrad, 2007).

Table 4.1 provides a digestible comprehension of each version of the DSM as it relates to their total number of diagnoses, the total number of personality disorder diagnoses, and the total number of pages. While the books may appear intimidating by their weight and size, a hefty portion of the text relates to properly utilizing the diagnostic material as well as an elaboration in regards to criteria, symptomology, and prevalence rates (e.g., sex ratio, age, co-morbidities) for each disorder. However, what is of particular intrigue is twofold. Firstly, the relationship between the total number of diagnoses and the total number of pages displays a peculiar result. In the first edition of the DSM (APA, 1952), there are 106 diagnoses within 130 pages of text and by the next edition in 1968, an additional 76 diagnoses are squeezed into an additional 4 pages of text. Furthermore, as psychiatry becomes the discipline of choice (over psychoanalysis), the third edition of the DSM in 1980 contains 265 diagnoses within 494 pages of text. This is important to note

because, as mentioned earlier, psychiatry incorporates scientific research in order to elaborate with further ñexpertiseò and confidence that what is legitimately disordered is exemplified by scientific support. Moreover, after the third edition, the positive relationship between diagnoses and page numbers has sharply increased in the following four versions, with particular attention to be focused on page numbers in relation to total diagnoses.

Secondly, the relationship between the total number of personality disorder diagnoses and the total number of pages demonstrates a negative relationship over the span of the seven published versions. In the first edition of the DSM, there are a total of 24 personality disorder diagnoses within the 130 total pages, 8 of which cover personality disorder diagnoses; by the second edition in 1968, there are 12 personality disorder diagnoses within 134 total pages with only three pages dedicated to personality disorder diagnoses. Psychoanalysis, which particularly focuses on disorders of the personality (or more specifically, the imbalance of the id and superego and its effect on the individual) enters into the diagnostic world with a thunderous roar and quickly subsides by the second edition. Moreover, by the third edition and onward (with minor exceptions), the number of personality disorder diagnoses decline in number but increase in depth; for example, in the DSM-IV-TR (APA, 2000), there are 11 personality disorder diagnoses and 44 pages which explain the diagnoses. Moreover, by the fifth edition of the DSM in 2013, there are 13 diagnoses and 39 pages which discuss the diagnoses. Given this minor insight with the use of comparisons in Table 4.1, it would appear that power is the ability to define as well as the perimeters and necessity for elaborating upon its truths.

During World War II, Allied forces were fighting against a larger enemy (i.e., Axis

nations) which viewed Western capitalism and communism as the deterioration of civilization. The ñBig Threeò Allied forces (i.e., United States, Britain, and Soviet Russia) cooperated with one another against a larger enemy which threatened their position of power, despite their political differences. However, after the end of WWII and the enforcement of the Marshall Plan, the anonymity between the Western Bloc (more specifically, American democracy) and Eastern Bloc is amplified during a 30-year political and militaristic standoff for world leadership. Albeit there was never a combat utilizing force between the two superpowers, the ominous political competition and readiness for a full-scale nuclear attack affected every asset of American life. The United States sought to differentiate itself in every way possible from Soviet Russia, leading the government and more specifically, the military, to become a quasi-factor in implementing power for the elite and a reaffirmation of dueling typologies.

Chapter Three explains that there is a relative consistency to the world and reality, where the non-problematic concept of normality is frequently approached. By looking at the political economy, an answer to the question of searching for normalcy and approaching punishment reveals that normalcy is desired because there is nothing superior. Normalcy separates ñusò from ñthemò by implementing its truths into the core of the social group ï their identity. The DSM is an inventory system that reports what the United States conceptualizes as reality and how its citizens function within the given reality. The DSM functions to weed out abnormalities in human behavior while providing a perception of justice for separatism. More specifically, it would appear that the DSM has served its purpose of a political master model of duality because it provides maintenance of political consciousness and coercion. Moreover, it is when Americans begin to embrace

these aspects as wholly truthful that duality is able to be sustained without a second thought, which serves to preserve their existence and exemplify the superiority of technology and capitalism. The government is a product of coercion by which the elite are coercive because the general population desires that way of life; therefore, implementing the clause of separatism and superiority is accomplished through such a purpose of duality and normalcy.

The pre-modern religious dualities relates to dichotomies of healthy/not healthy, or sacred/not sacred to provide a notion of self-serving ethnocentrism. As technology begins to envelop every facet of American capitalism and Western medicine, a new affirmation of duality struggles to define what is healthy and not healthy, so the direction of dichotomies is geared towards defining what is normal through what it is not with the assistance of science and technology. Normalcy cannot be defined because it would constrain the elite and show the irrationality underlying normalcy and the relationship between the elite and subservient. The solution becomes tinkering and shifting the perimeters of abnormal behaviors around to make the same concept appear new during temporal progression, which is strengthened under the guise of a political agenda. In specific, the DSM successfully separates Americans from the ñotherò by being a model of aspirations for other countries, which reaffirms the notion of its citizens being qualitatively different from other countries. Furthermore, the DSM domestically separates the subservient class from the elite by reaffirming the power of the elite to maintain a society by which the subservient class agrees to abide in return for protection and a life of comfort.

As briefly discussed in the current chapter, power lies within the ability to define

and inhibit contestation or alternative thinking. Power has transformed a nation born from revolution into the standardization for other nations, coupled by a set of dogmas enveloped in myopic ideologies and values. With the assistance of Lipset (1996), American Exceptionalism highlights how the United States has turned its ideologies and polity into an ism unlike any other, where allegiance supersedes birthright and power remains selfishly within the hands of a few (i.e., the elite). As a demonstration of its debilitating power, the United States utilizes the DSM as a reaffirmation of power and politics to define what is normal by highlighting what is contextually abnormal. Throughout the history of the DSM and its seven editions, science has capitalized on supporting these diagnoses and moreover, encapsulated an entire nation to submission and dependence. With the help of Conrad (2007), medicalization accentuates the implications of a widespread medical jurisdiction on both a macro and micro scale of American economics and the importance for sociological research. No longer are occurrences throughout the lifespan seen as such, nor are personalities to be unique; advocacy groups, people, and physicians play a role in the legitimization of disorders and diseases. Furthermore, the top rung of Hunterôs (2014) hierarchy of social adhesion, Medicalization and Punishment, is discussed at the beginning of the current chapter and describes the sovereign gaze which parenthesizes the individual and their attributes. Moreover, the influence of science and the physician has replaced religion and the church, as they are now the ñpriests of the bodyò (Foucault, 1963, p. 32) and shape the current state of reality.

In the following chapter, a summary of the current thesis will cover what the purposes of its defense are, as well as future research and its implications for what is now uncovered. Likewise, the proposed hypotheses from the introduction will be revisited and

a personal revelation will close the chapter of the book, as well as one chapter in the life of a scholar.

Chapter Five

ñWar is peace. Freedom is slavery. Ignorance is strength,ò (1984; George Orwell, 1949, p. 6).

First and foremost, I will open this final chapter by defending my position to write in first-person. Given the nature of the current defense, it would appear quite hypocritical to explain my position from an omniscient and encompassing perspective. I do not claim to be any wiser or knowledgeable than my neighbor, and I humbly give my gratitude to those who have opened my eyes to a realization beyond science and standardization. As I have made this journey through the current defense, I have questioned myself and struggled against the currents of abstract thinking, far beyond what my background in psychology could provide. Within my defense, I aim to provide another way of thinking about reality and the function of society, at least from the point of view that seven still-frames impact the perception of the American way of life. In the current chapter, I will first briefly summarize a few major points of my defense, followed by revisiting the hypotheses from the first chapter, as well as possibilities for future research and implications. In closing the chapter, I will discuss a few limitations from the study, as well as implications for future research

A major theme of my defense is the influence of elitism as well as the function of individuals and subservient groups within society. My arguments are made possible by utilizing the works of Marcuse (1964), Foucault (1963, 1964), the medicalization theory provided by Conrad (2007), and the theory of American Exceptionalism as briefly provided by Lipset (1996) to make one point abundantly clear: *power lies in the details*. Moreover, my defense is framed around hegemony, yet it is not credited and must therefore be given its breath now. Antonio Gramsci, a member of the Italian Communist Party during the first half of the twentieth century, coined the term hegemony to reflect its sovereignty through many social devices, including churches, schools, trade unions, and within the household (Kertzer, 1979). Hegemonic control implies that whatever the view of the nation or the world may be at a given time, it is accepted and becomes ñpart of what is thought of as common sense,ò (p. 324). Moreover, successful ñódominant conceptionôé becomes a ófaithôwhich is not consciously articulated,ò (p. 324) and it is what keeps contradictions from collapsing and ultimately overthrowing all that is controllably accepted as truth as well as securing the position of the coercive party.

Discussion

American politics controls and manipulates nearly every facet of the economy, from education, employment, technology, militarization, to medicalization and everything in between. As common sense, or dominant conception, relates to medicalization and psychiatry, the DSM articulates a notion of common sense that has never been done before. The DSM is a materialization of discriminatory dichotomies which functions to articulate how and why an individual is abnormal and it avoids contradiction by shifting its perimeters around via revisions and updated versions.

Moreover, the newness of each edition prompts that scientific research and harmonization provide groundbreaking details, thus securing the value of its truths and the position of the elite. In congruence with symbolic interactionism, concepts such as *ego-syntonic* and *maladaptive* are useful to describe abnormalities because the problem no longer depends upon the detection of the individual but how others view that individual within the perimeters of an idealist reality.

The functional position of the madman throughout history has transitioned from folly and tales, to apocalyptic nightmares meandering upon an aimless ship, to institutionalized livestock, to parenthesized subjects residing on the negative scale of a dangerous dichotomy. Concurrently, the physical position of the madman has gradually transitioned from the perimeters to the center as the methods for control has gradually refined a course of containment and observation. Furthermore, the connection to the DSM and the unconscious observation of other nations lies within this understanding of the madmanôs transitional purpose; by corralling the insane towards the center, power is easily reinforced and societal shame is hidden. In specific, by containing the insane (and the subservient class in extension) within the center of society, their presence does not blemish our impression as the leader on the world stage. It is with this realization in mind that Foucaultôs (1964) concept of ñmadness of vain presumptionò (p. 29; *see* p. 44) is applicable to an entire nation. To recant the question that was posed earlier, which asks ñhow then, with all respect, is the ónormalô population of society any different than the madman to whom is caged?ò (p. 44) the answer is that we are all caged ï we are all parenthesized.

Two hypotheses were stated in the introduction of my defense, and will now be revisited to gage their accuracy. The first hypothesis states that the transition from psychoanalysis to psychiatry in the DSM-III (APA, 1980) will result in an expected increase in the average amount of personality disorder classifications. Contrary to my initial assumption, the transition to psychiatry as the dominant discipline in psychology actually results in an initial decrease in the total number of personality disorder classifications, as demonstrated in Table 4.1. However, my first hypothesis is not wholly incorrect; in the DSM-V (APA, 2013), there appears to be an increase in the number of personality disorder classifications as well as the breadth of information reported. There are 13 personality disorder classifications in the DSM-V (APA, 2013), which is one more classification than the DSM-III-R (APA, 1987) and one less classification than in the DSM-III (1980). Likewise, while the total number of personality disorder classifications has generally expressed a downward trend, the number of pages which cover Axis II personality disorder classifications has reflected a nearly twofold increase since the third version of the DSM.

The second hypothesis states that since the introduction of psychiatry as the dominant discipline of professional psychology, the revisions and refinement of published personality disorder classifications correlates in a political manner which separates American behavior from the ñotherò as well as from one another. Throughout my defense, I try to include historical context around the DSM publications, particularly during the height of the Cold War and the Stonewall riots. It is to my understanding that the political agenda geared for the DSM-III is twofold in contribution ï advocacy and adversarial. In regards to advocacy, the LGBTQ community experienced a civil rights movement after

the Stonewall riots, including growing demands to eradicate homosexuality from the DSM.

As the political agenda relates to adversarial is in response to the duality between two superpowers, namely the Soviet Union and the United States. American ideologies did not tolerate resistance and sought to qualitatively differentiate itself and its citizens from communism and the citizens behind the Iron Curtain. In order to provide substantial justifications for a myopic dichotomy (i.e. ñusò/ònot usò, ñnormal/not normalò) to be common sense, scientific research provided *a posteriori* justification for abnormal or deviant behavior. Lastly, the rise in the number of personality disorders in the current version of the DSM may parallel the number of classifications from the DSM-III (APA, 1980) ï political conflict.

Limitations

Comparison limitations. With one minor exception to the trend noted in the relationship between classification numbers and page numbers which discuss personality disorders, the DSM-V (2013) serves to be an exception, albeit not significant. The decrease in number of pages covering Axis II personality disorder classifications and the increase in the number of personality disorder classifications may reflect a lack of evidence to fully support the new classifications, despite their perceived legitimacy for inclusion on the classification roster.

Cross-cultural limitations. A cross-cultural analysis of biomedicine cannot be conducted since biomedicine concerns Western medicine, including psychology. However, countries that are integrating biomedicine into their practices (e.g. India and China) may serve as useful comparisons for later research.

Conclusion and Future Research

Now that the information has been presented, what should be taken away from my defense? Upon completion of my defense, I have to admit that while I have not provided tangible change to the research world, it is my hope that my approach to the current state of affairs as it relates to the DSM and American Exceptionalism will inspire others to think outside of the box. The implications of medical jurisdiction are rapidly expanding and need to be researched from a sociological approach because it affects society on both a macro and micro scale, especially ethical and moral concerns. Ethically, medicalization and the DSM give the impression that the United States, its citizens, and their medical concerns are legitimately, qualitatively different. In specific, individuals seek to find answers to benign concerns that were previously accepted as changes throughout their lives. Likewise, the DSM is responsible for reaffirming the belief that American citizens are qualitatively different from other nations, as well as qualitatively different from one another.

False needs are emphasized through the media, particularly advertisements and technology, and this includes medicalization. Morally, medicalization suffocates American citizens by accentuating relatively mild symptoms to be attributable to bodily malfunction. Americans are preoccupied with avoiding the aging process, ostracism, and mental defect that medicalization results in a multi-billion dollar industry and a nation that is drowning in financial debt. The DSM, and particularly personality disorder classifications, is a materialized articulation which justifies that abnormalities are problematic and encourages unconscious separatism from within the nation and abroad.

Elitists are profiting from the subservient classô dependence on pharmaceuticals, incarceration, social desirability, and comfort without contestation.

It should be clarified that the DSM is a valuable tool, but the value may not be in relation to justifying its practicality in psychiatry (and more broadly, psychology). The compartmentalized, cultural specificity of the DSM is unique to the United States, but its value is specific to the political and economic reality of the given moment. Moreover, the DSM keeps businesses functioning; the DSM acts as an intermediary device for psychology and therapy, which fuels other businesses (e.g., intervention, pharmaceutical representatives) and prevents the infrastructure of psychology from collapsing. Advances in the name of science and technology are accredited for improved expertise of the individual and their conditions, instead of accepting imminent death. The DSM, specifically the third through fifth editions, utilizes science and technology to justify the borders of reality for subservient social groups. In a more broad sense, the DSM functions as a check and balance for compartmentalization, business excursion, and inadvertently articulating the parameters of behavior and thought by emphasizing what is socially unacceptable or abnormal.

Future research should include deeper historical research as it relates to diagnostic tools and criteria which serve as a basis for current biomedical research. Likewise, more sociological and anthropological research should investigate American Exceptionalism from an interdisciplinary perspective in order to understand the impact of science and technology on nationalist ideologies. Lastly, future research should include cross-cultural analyses with non-Western medicine as it pertains to mental disorders, behavior, and the societal function of the abnormal. In conclusion, the madman may still represent

apocalyptic premonitions and just transitioned to a new position within society, which contextually adapts based on temporal progression. Yet the question still remains, who is truly insane?

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