Psychoanalysis and the post-*DSM* crisis

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I would like to open these reflections on the crisis in the new clinical norms with a look at the lively debates that have accompanied the publication of the most recent *DSM*. These debates vouch for the vitality, the power, and the diversity of the American universities. Their multi-polar character contrasts with the discretion of the French and European academics on the fundamental questions as to what is at stake regarding the place psychiatry holds in our society. The centralised European systems, dominated by the regulatory agencies of the healthcare bureaucracies, have been producing a false consensus obtained in shady negotiations held behind the closed doors of eclectic committees. Thanks to the debates on the North American continent, we now have at our disposal a series of answers to the question "What went wrong with the *DSM-5*?", as much from those who on the whole continue to support the *DSM* project as from those who are radically opposed to it. We are able to make out a convergence of agreement regarding the rupture that has been brought about by the most recent edition of the manual, without there being any agreement as to exactly what line has been crossed.

The crisis as seen by the insiders

One particular feature of the debates is that they include critical points of view voiced by former chief architects of the preceding editions, such as the founder of the *DSM* project itself, Robert Spitzer, or one of the eight people responsible for *DSM-III*, Nancy Andreasen – who was recently invited to Paris by the Franco-Argentine Psychiatry Association to speak about her recent views – or even Allen Frances, who was in charge of *DSM-IV*. We shall leave Spitzer's criticisms to one side for the moment, since they concern above all the bureaucratic processes that led to the development of *DSM-5*: the secrets, the confidentiality clauses, the hermetic nature of the committees, the delays in the clinical field trials, and so on.

For Nancy Andreasen[1], the essential harm has been done by the fact that the *DSM* was accepted as such a dominant reference that it swept aside all the other approaches in psychopathology. A monopoly has been established, with all the perverse effects that monopolies bring. She observes that there is no longer any other research in the field of psychopathology in the US. All that is left is a mobilization of the best specialists in the different fields to establish the criteria and items that will define the perfect empirical and positive language dreamt of by the conceptual architects of the manual. This is what has been shown by the laborious refinement of the *DSM-5*, which clocked up interminable hours spent in meetings involving thousands of different specialists.

For Nancy Andreasen, this voracious enterprise was perhaps a little too ambitious, with lofty ideals that were poorly defined, but it was necessary when it came to rectifying the specifically American deviations of the 1960s that were due to the attempts to construct a psychopathological system on the basis of psychoanalytic Ego Psychology. The emphasis that this psychoanalytical school of thought put on the "defence mechanisms" of the ego gave rise to a degree of distrust in relation to the symptom, distancing the American classification from the traditional forms of psychopathology. There was reaction from a certain number of clinical specialists who wanted to ally themselves with the international epidemiological reference of the time, which had not yet gone global, and which was dominated by the UK and what was then its new public healthcare system, the NHS. For the first *DSM* Task Force, the main objective was to establish a transatlantic reference system. This project has ultimately been too successful in achieving its goal, imposing the monopoly of its system and destroying the ecosystem of research in psychopathology.

The solution set out by Nancy Andreasen is to revitalise the phenomenological project in psychiatry. She proposes a return to meaning. She uses the striking formula of a

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[1] Andreasen N., "DSM 5 and the Ongoing Death of Phenomenology", talk presented at the Study Day *Who's afraid of DSM 5?* organised by the Franco-Argentine Psychiatry Association in Paris on 12 October 2013.

"reverse Marshall Plan" in which phenomenology, in the American sense of the term, that is to say, a fidelity to the description of the symptom that makes room for meaning, should put right the havoc wrought by the *DSM*'s linguistic wilderness. This project is an attractive one, but it is by no means certain that we have an economist of meaning at our disposal who would be able to play the role of Secretary of State Marshall in relation to the economy, nor that Harvard would share the view on this occasion and be quite so eager to administer the return of meaning in the same way that the Plan allowed for a return of growth in a Europe devastated by its fatal self-destruction. Be that as it may, this reference to the post-war period has the merit of reminding us of the urgent stakes of adopting a willing attitude in the face of disaster.

Allen Frances has recently dedicated an entire book[2] to examining the reasons that have allowed this monopolistic situation to prevail and the consequences it has had for the entire field of psychopathology. For Frances, the *DSM* project was crucial and saved the psychiatry of the 1980s, freeing it from the confusions and ambiguities at the heart of the psychoanalytic model. He observes quite rightly that the difficulty psychoanalysis meets when it comes to inspiring stable classifications is not linked to some contingent impotence or harmful bias.[3] Rather, it is consubstantial with its discourse. It is an impossibility that is logically inscribed from the outset. In his low-key manner, he says the following of this epistemological problem:

> The psychoanalytical model tended to be all-inclusive, but there was one notable exception – there is no real place in it for normal. […] No one is ever completely normal for Freud; everyone is neurotic.[4]

This is what Lacan radicalised with his "Everybody is mad, i.e. everyone is delusional."[5]

For Frances, it was this vocation for shaking up the norms that had contaminated psychiatry to the point that it needed to be saved. "Without Robert Spitzer, psychiatry might have become increasingly irrelevant, drifting back into its prewar obscurity."[6] Frances puts the emphasis on the people involved, whereas Nancy Andreasen speaks instead of a school of thought that brought together various different academics, "The Mid-Atlantics"[7], inspired by the UK, who reacted to the confusions of the 1960s and the dangers of moving away from the American mainstream system. Nevertheless, both authors describe the same swing towards a diagnostic concern and the adoption of a method founded on the use of a series of explicit criteria for sorting symptoms into

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[2] Frances, A., *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*, William Morrow, 2013.
[3] It should be noted that Allen Frances was trained as a psychoanalyst in the Columbia Institute.
[4] Frances, A., *Saving Normal*, *op. cit.*, p. 15.
[5] Lacan, J., "There are four discourses…", translated by A. R. Price in *Culture/Clinic*, Issue 1, 2013.
[6] Frances, A., *Saving Normal*, *op. cit.*, p. 62.
[7] Andreasen N., "DSM 5 and the Ongoing Death of Phenomenology", *op. cit.*

syndromes. So, according to Frances the *DSM* project is not only necessary, but a saviour. Moreover, being the *DSM-IV* director, he considers himself Spitzer's successor, possessing the same "intelligent and open conservatism".

Nevertheless, the *DSM-IV* did not prevent the outbreak of a downwards spiral that has seen an increase in the diagnoses handed out by psychiatrists and GPs, resulting in what he calls an "inflated bubble": over-diagnosis and over-medication. Why so? "What went wrong?" Frances asserts that the fault does not lie with the text, but with the "context", which has changed decisively, modifying the consequences of applying the *DSM* guidelines. The changes in context are many, but Frances highlights in particular the fact that in 1997, three years after *DSM-IV*, the pharmaceutical lab lobbyists were to notch up a great victory over common sense: the US became the only country in the world to allow direct-to-consumer advertising. From this date forth, there were no more limits on direct marketing to doctors and consumers and on the bad metaphors invented by healthcare publicists, our contemporary *Mad Men*. The success of the refrain "chemical imbalance", the eponymous metaphor of these simplifying slogans, was to know no bounds. According to Frances, the role of Big Pharma in over-medication and the promotion of the medicalisation of life has been pivotal. To this he adds the weight of the parents' associations who want to have access to the appropriate services for their children, access which is only granted once a diagnosis has been set, coupled with the role of consumer associations who are always seeking to accumulate more members. The respective weight of these different "contextual" factors is not evident, but the final result is that:

> There have been four explosive epidemics of mental disorder in the past fifteen years. Childhood bipolar disorder increased by a miraculous fortyfold; autism by a whopping twentyfold; attention deficit/hyperactivity has tripled; and adult bipolar disorder has doubled.[8]

Frances sometimes compares the role of Big Pharma to a sort of mechanistic Marxism, which is undoubtedly too direct: "Sixty billion dollars a year will go a long way to sell products and buy politicians".[9] Okay, but we're not on Wall Street, and greed doesn't explain everything. Besides, he categorically rejects explanations of the same ilk (bought experts) that seek to account for the ambiguity and inappropriate extensions that are evident in the drafting of the *DSM* text itself. He doesn't accept the explanation that points the finger at conflicts of interest and collusion between the expert psychiatrists of the *DSM* and Big Pharma, favouring competitive advantage in academia for some experts who seek to further their domain of interest at the expense of others.

So, for Frances, it is the change of context that has produced the diagnostic hyperinflation. Meanwhile, the laxity of the latest round of architects of *DSM-5* has seen to the rest and has confirmed the powerlessness of the APA when it comes to

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[8] Frances, A., *Saving Normal*, *op. cit.*, p. 104-5.
[9] *Ibid.*, p. 92.

overseeing the *DSM* project. Therefore, he is calling for the American Psychiatric Association to be deposed from its role as guarantor of the circulation of diagnostic labels. He makes a solitary plea for the construction of a new regulatory agency that would really know how to be responsible for the common epidemiological currency. This new type of bureaucracy, a vast and unwieldy sanitary machine, would have to regulate everything with a determined authoritarianism. This utopian project dreams of combining the highest virtues of the centralised European Systems with American-style legal regulation.[10]

Nevertheless, beyond laying the blame on Big Pharma, Frances perceives a phenomenon of civilization that constitutes the all-pervasive foundation of this slippery slope and which cannot be solved by a regulating decree from a welfare bureaucracy:

> Our world is homogenizing – we have increasingly less tolerance for individual difference or eccentricity and instead tend to medicalize it into illness.[11]

Frances observes that this tendency towards the normalisation of behaviours does not mean that we are sicker than we were before, but it remains to be seen why this taste, this choice forced in the direction of medicalisation, would be the only possible way out?

In Lacanian terms that lie closer to home, we may say that the mixture of different forms of jouissance, brought about as a result of a lifestyle that science has generalised across the globe[12], is giving rise to a particular discontent that is pushing in the direction of an impossible nomination on the part of panicky biopolitical agencies. This is the same movement of civilization that Michel Foucault perceived and named "The Birth of Biopolitics"[13]: a dominant means of population management that is replacing the old "clinical" project that described the illnesses of the social body. This swing towards the medical management of the life of citizens is even more pronounced in Europe, with its centralised healthcare systems that function by redistribution. It has opted for a pacifism that forbids it from resorting to the old-style management of strong identifications, which authorised the right to allow authoritarian states and regimes, or even warring democracies, to die. But let's set aside this examination of remote causes, to which we shall be returning later, to turn to another kind of commentary on the failings of the *DSM*. These do not concern the immediate causes identified by our two psychiatrists, Nancy Andreasen and Allen Frances, qualified experts if ever there were, having both

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[10] *Ibid.*, p. 212-9.
[11] *Ibid.*, p. 82.
[12] "Mankind is entering a period that has been called 'global', in which it will find out about this something that is emerging from the destruction of an old social order […]: what can we do so that human masses, which are destined to occupy the same space, not only geographically, but sometimes in a familial sense, remain separate?", Lacan, J., "Address on Child Psychoses", translated by A. R. Price & B. Khiara-Foxton in *Hurly-Burly*, Issue 8, October 2012, p. 271.
[13] Foucault, M., *The Birth of Biopolitics, Lectures at the Collège de France, 1978-1979*, translated by G. Burchell, Palgrave Macmillan, Basingstoke/New York, 2008.

participated in the process of developing the *DSM*, but the responses given to the question "What went wrong?" by two epistemologists, Steeves Demazeux and Ian Hacking, neither of whom are psychiatrists.

The crisis as seen by the epistemologists

For Steeves Demazeux[14], the *DSM* project, launched by Spitzer and sustained throughout its thirty years of existence, is a philosophical project rooted in the logical-positivist current that was so influential in post-war American philosophy. From this point of view, it has been a perfectly coherent project. Its aim was to invent a transparent and perfect language in which the question of reference would be replaced by empirical signifieds of perfectly defined criteria. It consisted in defining an artificial language to be imposed upon clinical specialists, eliminating any imprecision, meaning-shifts, or misunderstanding. The classification sought above all to rectify the inaccuracies of the Babel of clinical traditions – in the plural – in favour of a language that would afford a rigid designation of clinical categories that were imagined to be perfectly distinct, regardless of any irreducible "comorbidity" at the factual level. The goal of making clinical language univocal was supposed to be achieved by clinical definitions that were said to be "operational"[15]. In the 1970s, Spitzer's *DSM-III* was inspired by the statistical refinements of American academic psychology, which had never given up on its grand characteriological classifications, always aiming to bring the psychiatric clinic to the same level as the latest statistical requirements. The main emphasis would be placed on those techniques that would ensure "inter-rater reliability", in other words, the fact of zero possible variation across the description of observed phenomena. The *DSM*'s "a-theoretical" classification was to prove to be increasingly based on a theory of statistics. Clinical questions *per se* were soon to be swallowed up by questions that basically belonged to the field of statistical technique.[16]

The logical form chosen by the *DSM* is that of a formal tree that classifies mental illnesses in keeping with a "botanical" model of genera, species and subspecies, that

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[14] Demazeaux, S., *Qu'est-ce que le DSM ?*, Éditions d'Ithaque, Paris, 2013.

[15] Already in 1955, in "The Freudian Thing", Lacan was making fun of the use of the word "op-er-a-tion-al" in its attempt to do away with the rational, especially with respect to the use of the operational criteria by which Ego Psychology was seeking to become a part of general psychology. See Lacan, J., "The Freudian Thing" in *Écrits, The First Complete Edition in English*, translated by B. Fink, R. Grigg & H. Fink, Norton, New York, 2006, p. 350.

[16] This point was carefully noted back in 1992 by Stuart Kirk and Herb Kutchins in their book *The Selling of DSM. The Rhetoric of Science in Psychiatry,* New Brunswick: Aldine Transaction (wrongly translated into French in 1998 as *Aimez-vous le DSM? Le Triomphe de la psychiatrie americaine*).

was first presented by Linnaeus in his *Systema Naturae* and later adopted by Darwin. What went wrong with the *DSM-5* is that, to start with, new words entered the language without having a reliable inter-rater signification, and more profoundly still, the perfect language had to face up to the fact that it does not refer to any reference whatsoever. Its validity was thus called into question. Our epistemologist Demazeux, who thinks that the *DSM* is "on the whole positive", does, however, observe that the logical-positivist project has reached its limit and cannot go on resorting to the usual remedies: an appeal for yet more description and yet more empiricism. He suggests as a possible solution a revision of the logical-positivist premises, making use of Quine's logical contributions in order to look afresh at the classification of "natural kinds" and to accept a classification that is able to include both natural kinds and other items that are not natural kinds. The aim is to save the *DSM* by divorcing it from its epistemological foundation. The *DSM* should then be able to distinguish explicitly and knowingly between those categories with limited "scientific" validity and other categories that present themselves merely as artefacts that are to a lesser of greater extent "well-constructed". This would mean doing away with the hypothesis that a classification only has to be put together well for it to refer to something.

The Canadian epistemologist Ian Hacking is more radical. He considers that the *DSM* project is founded on a much deeper epistemological error[17]. In the second part of his distinguished book *History of Madness*, Foucault dedicated an enlightening chapter to the "The madman in the garden of species"[18]. He mentioned the projects of two important eighteenth-century doctors, the French Boissier de Sauvages and the English Thomas Sydenham. For Sauvages, as for the *DSM*, "the definition of a sickness should be the enumeration of symptoms that can be used to identify its type and species, that distinguish it from all other forms."[19] But there is more still, says Foucault:

> Behind the greatest concern of the classifiers of the eighteenth century is a metaphor as recurrent and as persistent as a myth, where the disorders of diseases are transferred to the order of the vegetal. "It is necessary", said Sydenham, "that all sicknesses should be reduced to certain and definite Species, with the same diligence we see it done by Botanick Writers in their Herbals".[20]

Hacking points out that in this respect the *DSM* still belongs to this same botanical realm, albeit revamped by the logical-positivist project. It is a classification into genera,

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[17] Hacking, I., "Lost in the Forest" in *London Review of Books*, Vol. 35, No. 15, pp. 7-8.
[18] Foucault, M., *History of Madness*, translated by J. Murphy & J. Khalfa, Routledge, 2006, pp. 175-207.
[19] Sauvages, B. de, *Nosologie méthodique*, translated from the Latin to French by Gouvion, Lyon, 1772, p. 159, quoted in *ibid*., p. 186.
[20] *Ibid.*, p. 188. For the Sydenham quote: see Sydenham, T., Preface to *The Whole Works of that excellent Practical Physician Thomas Sydenham*, 8th Edition, translated from the Latin by J. Pechey, Darby & Poulson, 1772, p. vi.

species and subspecies, a classification based on the model of the "tree of life" for the vegetable kingdom in botany. Hacking concludes with a devastating statement:

> Perhaps in the end the *DSM* will be regarded as a *reductio ad absurdum* of the botanical project in the field of insanity. I do not say this because I believe that most psychiatry will, some day, be reduced to neuroscience, biochemistry and genetics. I take no stance on that here. […] I am making a claim grounded more on logic than on medicine. Sauvages's dream of classifying mental illness on the model of botany was just as misguided as the plan to classify the chemical elements on the model of botany. There is an amazingly deep organisation of the elements – the periodic table – but it is quite unlike the organisation of plants, which arises ultimately from descent. Linnaean tables of elements (there were plenty) did not represent nature.[21]

Hacking's objection is a radical one since he reads the entire *DSM* project as a veritable epistemological obstacle (in the sense that French epistemology understands this) to the intelligibility of phenomena. It should be noted that this is an objection that Allen Frances has completely overlooked, since in his books he refers to the projects of Linnaeus and Mendeleev as two successes in the project of the description of species, without realising how deeply incompatible they are in epistemological terms.

From the point of view of this epistemologist, the objection to the *DSM* is neither contingent, nor related to the mistakes, ineptitude or irrefutable bureaucratic onerousness that slipped into the process of putting together the *DSM-5*. The failing was present from the very outset, in its conception, which ultimately neither the might of the American Psychiatric Association, nor its attempted seductions of the powers that be and the health bureaucracy of America's National Institute of Mental Health (NIMH), have been able to conceal.

The supposedly a-theoretical nature of the project immediately consolidated the power of biological statisticians over clinicians. Then, this power grew further and further, at the expense of the clinicians who were increasingly constrained by the limiting goals of protocols to be universally applied in the practice of Evidence-Based Medicine (EBM). This even reached the point that, as a model for psychiatry, and indeed for the medical industry as whole, the aeronautic model was proposed, in which the pilot is conceived of as having an ancillary role with respect to the computer. In this sense, the *DSM* bears the stamp of a power-grab by researchers over practitioners in the clinical field. This stranglehold tightened its grip over the thirty years of the project's existence. In their quest for a perfect language, the researchers have sought to rectify all the "bad habits" of the clinical community. At the end of the process, one can now say that with the *DSM-5* the break between research and the clinicians is complete.

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[21] Hacking, I., "Lost in the Forest", *op. cit.*, p. 8.

The crisis of the research models

This is what the director of the NIMH observed in a momentous announcement on 29 April 2013, a fortnight prior to the release of the *DSM-5*[22]. In one fell swoop he brushed aside all the subtleties of inclusion and exclusion in the new categories obtained from the long waking hours of expert commissions, which can nevertheless give rise to interesting debates. He sees few variations between the *DSM-IV-R* and version 5. The latest version of the dictionary that had been organising the field of psychopathology has conserved both its strength and its weakness. Its strength remains its "inter-rater reliability", and its weakness remains its lack of "scientific validity". In other words, the language is perfect but it means nothing to the extent that it has completely forgotten that it is supposed to be measuring something other than itself. The director of the NIMH notes that the *DSM* is based on "a consensus about clusters of symptoms" that can be easily spotted, and not on the "objective" measure of anything whatsoever. This is why over the last two years the NIMH has been launching a project that is very different from the *DSM-5*. It has been pooling together "research domain criteria" (RDoC) that include all the elements that have been isolated by research into objective signs in the field of psychopathology: neuro-imagery, likely bio-markers, alterations in cognitive function, and objectifiable neurological circuits across the three registers of cognition, emotion, and behavior. The collecting and assembling of these elements is performed without any regard for commonly accepted clinical categories, which they think of as mere surface effects.

> This is why NIMH will be re-orienting its research away from *DSM* categories. Going forward, we will be supporting research projects that look across current categories.

Once the initial astonishment was over, the damage-control spin got underway without a moment's ado. On 13 May, just prior to the opening of the APA's annual congress, its new president Jeffrey Lieberman (from Columbia as is Allen Frances) issued a joint statement with Thomas Insel (the NIMH director) on *DSM-5* and RDoc[23], assuring us, needless to say, that both projects held their own specific relevance.

The fact remains that there has been a rupture. The NIMH now wants to attach its project to the Obama administration's BRAIN Initiative research into cerebral functioning and modelling, while maintaining its specific wish to integrate results from both genetics and the neurosciences. The project to translate advances in genetics into therapeutic results that can be exploited straightaway does not fall solely within the remit of the public sector. One of the most dynamic Silicon Valley firms has a very

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[22] Posted on the *Director's Blog* on the NIMH website.
[23] The joint statement can be read on the APA website.

similar project. 23andMe, the startup founded by Anne Wojcicki, a geneticist who since 2007 has been married to one of the creators of Google, Sergey Brin[24], offers for the modest sum of $99 a saliva sampling kit that can be conveniently taken to their central laboratory for DNA decoding.[25] The advertising slogan that accompanies this gets straight to the point: "Get to know yourself". "Your health and your genealogy start right here", the site continues, offering "reports on 240+ possible health conditions and traits", and the chance to "discover your lineage, find relatives, and more". You can "get updates on your DNA as science advances". The company's ambition is as high as Google's: "We're changing the way the world sees genetics, so it's no surprise to see people everywhere talking about 23andMe. It's leadership you can count on."[26] On Wikipedia, we learn that the husband and wife collaboration has recently run into some trouble. Since August 2013, they have been living apart following Sergey's affair with Google employee Amanda Rosenberg. Nevertheless, the couple's projects are bound together in the tightest possible way. Sergey's mother was diagnosed with Parkinson's disease. Brin used the 23andMe service and discovered that, despite the fact that Parkinson's is not generally hereditary, he shares with his mother a mutation of the LRRK2 gene that leaves him with a 20-80% likelihood of developing the disease. In an interview with *The Economist* in 2008[27], he thought that this extra knowledge would allow him to organise his life and "take measures". Perhaps the fateful encounter with Amanda Rosenberg is an unforeseen consequence of this insight into his destiny?

Be that as it may, on 18 September Google announced a project that now offers an extra dimension to the initial goals of 23andMe. They have created Calico:

> Grand ambitions sustain this Google affiliate, which sets its sights on the long term – between ten and twenty years – and intends to explore innovative and previously unenvisaged technological means of delaying and eventually "killing off" death.[28]

Thus, Google is asserting its project to gather all the useful data that may be used from contributions in genetics, biology and the nanotechnologies in order to define a radically "individualised" medicine. In this sense, two major projects are facing up to one another, both of which lean on the development of know-how in the handling of enormous databases. The developments in "Big Data" science and its "Bayesian" statistical principles[29] are sustaining both the gathering of vast series of case statistics, as is practiced in EBM, and the paradigm of customised medicine which seeks to gather *all* the biological data on each individual. These two paradigms of the medicine of the

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[24] Adopting the onomastic English transliteration of his Russian name.
[25] On this subject, see the 28 August 2013 broadcast of the Today Show (NBCnews.com), available on the 23andMe website.
[26] These comments come straight from the 23andMe website.
[27] "Enlightenment Man", in *The Economist*, 4 December 2008.
[28] Alexandre, L., "Google contre la mort, carte blanche", in *Le Monde*, 2 October 2013.
[29] Silver, N., *The Signal and the Noise, Why Most Predictions Fail – but Some Don't*, Penguin, 2013.

future stand at loggerheads. The vast series is generally favoured by the healthcare bureaucracies in search of universal protocols for regulating "good practice". The Google project is an individualised and planetary medicine that enters into direct conflict with the national bureaucracies. The correlation between the launch of Calico and the ongoing embarrassments of the Obama administration in setting up an effective internet portal to host the medical insurance system established by the most important Act to be passed during the president's first term gives us the idea that David and Goliath do not necessarily stand on the sides we thought they did.

One day, there will be a Google Health portal that will give us access to applications that will make all the various biological data that concern us available for live streaming. The portal will be private access, just as the Apple Store system for distributing cultural goods is at present. This might even enable Google to ensure the success of its Android system, which is struggling to supplant its rival.

Things will go faster than we can possibly imagine. Even so, the heady mixture of science, myth and hope that individualised predictive medicine is brewing should not make us forget that, as far as psychiatric psychopathology is concerned, brain modelling is still in its infancy. John Horgan at *Scientific American* sums up the lie of the land by saying that we are in a situation that "resembles genetics before the discovery of the double helix"[30]. The field lacks any organising principle and so we are a long way from being able to tie the various biological clues to the different clinical levels open to observation. Three decades of the *DSM* project have failed to introduce any meaningful discoveries, but the RDoC scientific project which is supposed to be taking up the baton remains up in the air. Condemning the *DSM* project's lack of scientific pertinence does not change the fact that there is nothing to replace it. The break that has thereby been brought about between research and clinic effectively cuts the clinicians loose. They remain on their own, without any support from the ground of science.

The symptoms of this lack of organising principle keep cropping up across this post-*DSM* landscape. This summer, as has been noted by Jean-Charles Troadec[31], we have heard two series of contradictory news reports. On the one hand, a patent has been issued for a biological test that detects a suicide risk confirmed by the presence of two genes, while on the other, Big Pharma has let it be known, in equal doses of threat and reality, that research into the new generation of psychotropic drugs has been suspended, indeed to all intents and purposes abandoned, because they are too costly and too risky to develop, regardless of the hopes that had been pinned on the glutamate chain[32]. In

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[30] John Horgan's blog is hosted by the *Scientific American* website.
[31] Troadec J.-C., "A simple twist of test", in *Lacan Quotidien* No. 343, 9 October 2013, available on the *LQ* website.
[32] See the article cited by Troadec: Friedman, R., "A dry pipeline for psychiatric drugs", in *The New York Times*, 19 August 2013.

France, the informative François Gonon[33] regularly warns us of the discrepancies between the promises and the scientific effectiveness of biological psychiatry. In the UK, a study recently published by *Nature Reviews Neuroscience*[34] revealed just how low the degree of reproducibility is in psychiatric neurobiology or genetics tests due to the small sample sizes, which mean that the results fall far short of the reliability of the large numbers targeted by EBM. The artificial recourse to meta-analyses does not manage to supplant this radical fault. One can read studies in the field of autism that look at just twelve cases and deduce from them marvels of irreproducible certainty.

The real of "abandon and survey"

The impasse of the *DSM* project is culminating in the evacuation of "clinical types" in favour of chimeras that drift off into the empyrean of calculus. There remains one real phenomenon: abandonment. The abandonment of patients faced with the growing scarcity of credits allocated to a psychiatry that is considered to be increasingly costly; and the abandonment of an ever-larger population who end up on the street, in jail, or on excessive quantities of medication. This abandonment is relayed by the relentless surveillance of populations who are being left to their own devices in this way.

On the side of abandonment, the television series *The Wire* and *Treme*, as well as the books by David Simon, have popularised and given visibility to the consequences that the "war on drugs" has had on poor and black populations. On the side of surveillance, the present-day relevance of Orwell's Big Brother is ever more astonishing, and teaches us the degree to which we are watched, listened in on, and recorded, thanks to the phenomenal processing power at the disposal of health and safety bureaucracies that are becoming more fully integrated as time goes on, as the NSA monitoring scandal has highlighted. Google, the eponymous enterprise dedicated to the digitalisation of the world, is being revealed as a partner of choice for the US administration in every aspect of the construction of our "new digital age". In the same year of 2013 during which Edward Snowdon exposed the might of the NSA's spying, Eric Scmidt and Jared Cohen explained to us what our Googleised future will look like.[35]

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[33] Gonon, F., "La psychiatrie biologique : une bulle spéculative ?" in *Esprit*, November 2011. Cf. Monier, F., "Neurosciences, les limites et la méthode", in *Le Monde (science et technologie)*, 30 September 2013.

[34] The article by Katherine S. Button ("Power failure: why small sample size undermines the reliability of neuroscience", *Nature Reviews Neuroscience*, Issue 14, May 2013, pp. 365-76) is cited by Monier, F., *ibid*.

[35] Schmidt, E., & Cohen, J., *The New Digital Age*, Alfred A. Knopf, New York, 2013.

Whilst the *DSM* instrument has not given rise to any discoveries, it has proven itself to be a powerful instrument for population management, assigning subjects to tick-boxes that can be processed ever-more efficiently by administrative language, then widening the administrative use of these categories beyond the healthcare field to include the spheres of insurance, social rights, and law. This extension, which was first seen in the US, has now gone global. As an instrument of management, it meets its limitations, even its failure, in the creation of inflationary bubble categories into which subjects are slotted, or even seek to be slotted. The assigning of subjects to different categories can be computed by healthcare bureaucracies, but the uses and wishes of those who find themselves assigned to them are unpredictable. Thus, there are constant shifts that in turn give rise to a particular kind of "slippery soap effect".

Next, when managers seek to reduce statistically observable "epidemics" by modifying their defining criteria, they come up against the wishes of the subjects themselves who might want, for example, to be considered "hyperactive" between thirty-five and forty-five years of age so as to be prescribed amphetamines; or who might want to be considered "bipolar" because this label is less stigmatising than others; or who might even want to be considered "Asperger" so as to have access to special education programmes.

This kind of disoriented classificatory reshaping produces contradictory effects. The dropping of pathological classifications for most of the behaviours that were considered sexually deviant at the start of the last century is going hand in hand with a pathologisation of manifold aspects of everyday life, right down to the most commonplace emotions. The constant and ongoing extension of the domain of depression is one of the most striking examples, but limits between normal and pathological are collapsing across the board.

The overly descriptive character of the clinical categories inherited from the clinic of the gaze, which have since been invalidated by science, are being referred to a continuum with those organic processes that are expected to be objectifiable at some future date, in keeping with the model of dementia processes that will evolve for upwards of fifteen years before finding an observable clinical translation. Instead of categories that can lead to belief in false distinctions, the researchers prefer a model that privileges continuity. The flipside of the "medicalisation of everyday life" process is precisely the recognition that "psychiatric patients are merely people who are a little less 'normal' that the rest". In its difficulty to set down the limits between normal and pathological, the *DSM-5* is confirming in its own way that "everyone is mad, i.e. everyone is delusional", as Lacan said in his reformulation of Freud's "everyone is neurotic" (which Frances spotted very well) on the side of madness. But this move towards calling into question what is "normal" is happening within a clinic that forecloses the subject with no possibility of return. In the stead of the subject, we find "personality disorders" that have been reformatted and given a psychological cast by using complex matrices of "personality traits", revamped "characterologies" or "temperaments", and a seamless integration of symptoms and personalities. The new

DSM has shrunk back from the enormity of this task, simply confining all of this to an appendix. These makeshift throw-togethers that maintain on the horizon a description of pathology in terms of "excesses of personality" remind us that the pathology of excess is particularly in step with the way that our era is experiencing the drive as mediated by the superego. The absence of the limits that used to provide the subject with firm identifications is leading all identifications to become both fluid and particularly sensitive to limitlessness as the index of a world falling under the sway of the superego. The extension of the clinic of addictions vouches for this.

The response of the subject to the real

What the *DSM* bureaucracy is not able to control is a democratic movement that is seeing subjects taking the categories that are given to them by specialists and putting them to "off-label use". This does not apply to drugs alone. For example, "psychotic" is clearly a category that nobody wants, and nobody claimed it when it was being all but cleaned out of the *DSM* categories, but this is not the case for the three categories of bipolar, autistic and hyperactive. People are calling themselves bipolar: "I'm bipolar, I know I am, but I'm not mad". We can see the Hollywood version that presents one possible "I'm bipolar" narrative with the with film *Silver Linings Playbook*, whose scriptwriter, an actor, and the director's son, testified to having been qualified as bipolar. Meanwhile, "hyperactive" is a category in which people call themselves hyperactive and want to be. We can thus understand the astonishing success of Ritalin and Adderall, which are the best-selling "off-label use" drugs in the whole pharmacopoeia.

As for autism, this is a category where parents' associations want their children to be recognised as autistic because it gives them special rights, particularly in the US where pathology probably gives the highest access to services. Furthermore, the subjects who are autistic are aligning themselves with the label, and have been making people aware of their experience in a sizeable literature than now extends to several shelves in the bookstores. These are testimonies from autistic subjects who demand this status without the distance from the category that psychosis, the madness of the twentieth century, once implied.

Contrary to what the architects of *DSM-III* or *DSM-IV* believe in their struggle with *DSM-5*, this won't come to a stop through statistical artifacts. They will have to go via political choices. This falls within the field of what Ian Hacking called the "looping effect", which refers to the fact that as soon as a category has been named, the subject seizes hold of it and aligns himself with it. Pierre Bourdieu isolated the same mechanism in sociology. One of the main stakes of democracy in the twenty-first

century will be the fact that labels will be demanded as such, through an ironic effect, similar to how segregated populations have been demanding their segregation, as Kanye West and Jay-Z have done in using the term "nigger" in their "Niggas in Paris". The inflationary over-diagnosis bubbles will not be reduced by merely changing some minimal point in the inclusion criteria or by sheer statistical mechanics.

The three roads that open up for psychoanalysis in this crisis in the classifications are now clearly visible. First of all, we have to privilege, in the field of psychopathology, the critique of the effects of abandonment produced by these clinical approaches that foreclose the subject. This approach is evident in the project of reviving a perfect classification that would be able to describe the subject exhaustively on the basis of psychopathology. Next, we need to be attentive to the effects of subverting the categories, the drugs, and all the instruments of the clinical field, by means of "off-label uses" (a term of which I am rather fond). More than wanting at any price to propose a new classification based on the subject and to redo a systematically updated clinic of the subject, psychoanalysis has to remain attentive to the subject's subversion that follows any classification like its shadow, in keeping with the way that the classification is lived. Subjects who come to see psychoanalysts effectively come along, in a certain number of cases, brandishing labels, living with them and finding their bearings in them by using them to organise their experience. On the basis of the subversive uses that the subjects make of the classifications, and the way that each of them live with the labelling they have received, the psychoanalyst will try to discern how this anchors the subject's history as a whole and gives order to it. Lastly, we have to call subjects back to the singularity of their desire, their fantasy, and their symptom, through the specific power of the psychoanalytic discourse. This is a discourse that underlines the dimension of the subject that lies outside the box, with its fundamental subversion of the categories, and an aspect that necessarily lies wide of the norm. This is where the psychoanalytic project of calling each subject back to the singularity of his delusion, in Lacan's terms, meets Allen Frances's project, which at first sight seeks the opposite because it is all about "saving normal". Contrary to this, we seek to put paid to the different forms of prestige, and radically so. Luckily, what Frances calls "saving normal" is actually about reminding us that everyone is a little ill, offbeat, out of step, and eccentric with respect to any category that seeks to centre the subject. It is this ex-sistence that needs to be highlighted in any discourse.

The specific ways of organising one's jouissance, the singularity of the fantasy, the singularity of the pattern of jouissance in each subject, come to find order on the basis of this crisis in the classifications. The crisis in classifications is an excellent thing because it leaves an increasing number of opportunities open to each subject to find their own place and their own path, and to find some kind of accommodation that will finally defy the universal protocols, enabling the subject to make some possible use of the ineluctable encounter with any given mode of pigeon-holing and the purpose to which one may put it. This is how each subject manages to accommodate the fundamental failing of his "mentality", in Lacan's sense:

People speak about illness. At the same time people say that there isn't any, that there isn't any mental illness, for example. They are quite right to say so, in the sense that this would be a *nosological entity*, as one used to say in the past. Mental illness is on no account a given entity. It's rather the case that mentality has flaws.[36]

Translated from the French by A. R. Price

[36] Lacan J., *Le séminaire livre XIX, ... ou Pire*, Seuil, Paris, 2011, p. 223.